First meeting in 2023 of the Council held in PUBLIC
on Wednesday 22 March 2023 at 10am via Microsoft Teams

AGENDA

Item no.	Item	Reference	Lead	Page No.	Finish time
1.	**Welcome, apologies and Chair's introduction**	Oral	Chair	-	10am-10.05am (5 mins)
2.	**Declaration of interests**	C01(23)	Chair	3-7	
3.	**Minutes, actions and matters arising** 3.1 **Minutes – 7 December 2022** For approval 3.2 **Updated actions** For noting 3.3 **Matters arising**	C02(23) C03(23)	Chair	8-13 14-15	10.05am-10.10am (5 mins)
FOR DECISION					
4.	**DHSC regulatory reform proposals and GOC call for evidence analysis**	C04(23)	Director of Regulatory Strategy	16-198	10.10am-12.10pm (120 mins)
12.10pm - 12.25pm Tea break (15 mins)					
5.	**Investment policy**	C05(23)	Director of Corporate Services	199-207	12.25pm-12.35pm (10 mins)
6.	**Significant incidents policy**	C06(23)	Head of Governance	208-227	12.35pm-12.45pm (10 mins)
12.45pm - 1.30pm Lunch (45 mins)					
7.	**External business plan and budget 2023/24**	C07(23)	Director of Corporate Services	228-250	1.30pm-2pm (30 mins)
8.	**Communications and public affairs strategy**	C08(23)	Director of Regulatory Strategy	251-266	2pm-2.30pm (30 mins)
FOR ASSURANCE					

9.	**Business plan assurance Q3 update** For noting	C09(23)	Head of Governance	267-276	2.30pm-2.40pm (10 mins)
10.	**Balanced scorecard Q3 update** For noting	C10(23)	Head of Governance	277-278	2.40pm-2.50 pm (10 mins)
2.50pm - 3pm Tea break (10 mins)					
11.	**Q3 Financial performance report** For noting	C11(23)	Director of Corporate Services	279-300	3pm-3.15pm (15 mins)
FOR DISCUSSION					
12.	**Chair's report** For noting	C12(23)	Chair	301-304	3.15pm-3.25pm (10 mins)
13.	**Chief Executive and Registrar's report** For noting	C13(23)	Chief Executive and Registrar	305-321	3.25pm-3.45pm (20 mins)
FOR NOTING (Council Members are asked to advise the Chair in advance if they wish to discuss any of these items)					
14.	**Advisory panel – 10 March 2023 Minutes and advice for Council** To be considered alongside item 4	C14(23)	Head of Governance	322-334	To be considered alongside item 4.
15.	**Council forward plan** For noting	C15(23)	Head of Governance	335-337	3.45pm-3.50pm (5 mins)
16.	**Any other business** (Items must be notified to the Chair 24 hours before the meeting)	-	Chair	-	3.50pm-4pm (10 mins)
Meeting Close – 4pm					
Date of next meeting – Wednesday 28 June 2023					

	Own interests				Connected Persons interests
	Current interests	**Professional memberships**	**Previous interests**	**GOC committee memberships**	
Sinead **BURNS** Lay Member	• Registered Psychologist: Health and Care Professions Council • Registrant Member: Fitness to Practice Panel, Health and Care Professions Council	• Registered Fellow: Chartered Institute of Personnel and Development	• Former Vice President Pharmaceutical Society Northern Ireland	• Lay Member: Council • Chair: Audit, Risk and Finance Committee	• None
Dr Josie **FORTE** Registrant (OO)	• Part-time Lecturer: Plymouth University • Employed optometrist and director (with shareholding): Specsavers (Plymouth Armada Way; Plymstock; and Plymouth Marsh Mills) • Consultant: Specsavers Optical Superstores • Lead assessor: Wales Optometry Postgraduate Education Centre, Cardiff University • Lecturer (occasional, visiting): Plymouth University • Vice chair (acting): Devon Local Eye Health Network • Vice chair (acting): Cornwall Local Eye Health Network • VisionForte Ltd (50% shareholding)	• Member: College of Optometrists • Registered with the Optometrists and Dispensing Opticians Board of New Zealand • Liveryman: Worshipful Company of Spectacle Makers • Member: Clinical Committee at FODO	• Member: Devon Local Optical Committee (end May 2017) • Optometrist: Specsavers Torquay (end Apr 2014) • Optometrist: Lascelles Opticians Plymouth (end Jun 2006) • Specsavers Plymouth Cornwall Street Ltd (ended April 2020) • Specsavers Saltash Ltd (ended April 2020) • Specsavers Devon2 Domiciliary (ended January 2020) • Board trustee: Inspiring Schools Partnership, Plymouth • Member: AOP[6] • Board member: Federation of Ophthalmic and Dispensing Opticians (until 29th December 2022)	• Registrant Council Member • Chair: Standards Committee • Member: Remuneration Committee	• None

	Own interests				Connected Persons interests
	Current interests	**Professional memberships**	**Previous interests**	**GOC committee memberships**	
Mike **GALVIN** Lay Member	• Non-executive Director: Martello Technologies Group Inc • Non-executive Director: ThinkRF • Director of Streetwave Ltd (a company registered in the UK)	• Member: Institution of Engineering and Technology • Fellow: Institute of Telecom Professionals.	• None	• Lay member: Council • Chair: Education Committee • Member: Audit, Risk and Finance Committee • Council Lead: GOC Refresh	• None
Lisa **GERSON** Registrant (OO)	• Primary Care Supervisor: Cardiff University • Has observer status on Regional Optical Committee (ROC) meetings across Wales	• Member of AOP • Member of College of Optometry	• Chair: Optometry Wales • Member: GOC Hearings Panel • Member/Acting Chair: GOC Investigation Panel • Member: GOC Education Visitor Panel • College Counsellor: College of Optometrists • Trustee: College of Optometrists • Trustee: AOP • Employee: Ronald Brown Group • Employee: Boots Optician	• Registration Committee Chair • Nominations Committee Member • Council lead for FtP	• None
Ken **GILL**	• Vice Chair of Board and Chair of Audit Committee at the Countess of Chester NHS Foundation Trust. • Study Portals. UK Advisory Board member. • Independent member of the Audit and Risk Committee of the General Medical Council (Until 31 March 2023). • Independent member of the Audit and Risk Committee of the Royal College of Veterinary Surgeons. (Resigned with effect from 6 February 2023). • Independent Management Board member of the Council of the Inns of Court.	• Chartered Accountant Member of the Chartered Institute of Public Finance and Accountancy. • Chartered Member of the Chartered Institute of Personnel and Development • Fellow of the Royal Society of Arts	• None	• Member: Lay Council member • Member: Audit, Risk & Finance Committee	• None

Clare **MINCHINGTON** Lay Member	• None	• Fellow: Association of Chartered Certified Accountants • Fellow: Institute of Chartered Accountants of England and Wales	• None	• Lay Member: Senior Council Member • Chair: Remuneration Committee	• None
Frank **MUNRO** Registrant (OO)	• Director Munro Eyecare Limited (T/A Munro Optometrists) • Professional Clinical Advisor, Optometry Scotland • Acting Optometric Advisor, NHS Lanarkshire • Lead Optometrist, Glasgow City(South) Health & Social care Partnership • Visiting Lecturer, Glasgow Caledonian University • Visiting Lecturer, Edinburgh University (MSc Ophthalmology programme)	• Member of the College of Optometrists • Member NHS Greater Glasgow & Clyde Prescribing Review Group	• None	• Member: Council • Member: Education Committee	• None

	Own interests				Connected Persons interests
	Current interests	**Professional memberships**	**Previous interests**	**GOC committee memberships**	
Dr David **PARKINS** Registrant (OO)	• Trustee: Spectacle Makers Charity • Chair: London Eye Health Network (NHS England) • Member: London Clinical Senate Council • Director: BP Eyecare Ltd • Provided short informal feedback (22 March 2022) to MOptom Programme Director, Cardiff University on high level course structure (no financials involved)	• Fellow: College of Optometrists • Fellow, European Academy of Optometry and Optics • Life Member: Vision Aid Overseas • Liveryman: Worshipful Company of Spectacle Makers	• President: College of Optometrists (end Mar 2016) • Board Trustee: College of Optometrists (end Mar 2018) • Previous CET provider (ended 2015) • Chair: Clinical Council for Eye Health Commissioning (2015-2017) • Vice Chair: Clinical Council for Eye Health Commissioning (2017-2021) • Member: British Contact Lens Association	• Member: Council • Member: Audit, Risk and Finance Committee • Member: Investment Committee • Council Lead: Legislative Reform	• Close Relative: General Optical Council Case Examiner • Close Relative: Member, College of Optometrists • Spouse: Director - BP Eyecare Ltd
Tim **PARKINSON** Lay Member	• Directorship for own limited company: Tim Parkinson Limited (consultancy not to optical sector or organisations linked to optical sector)	• Fellow: Chartered Management Institute • Membership of the Institute of Water	• None	• Lay member: Council • Chair: Investment Committee • Chair: Companies Committee • Council Lead: FTP	• None
Roshni **SAMRA** Registrant (OO)	• Locum optometrist (occasional): various high street or independent practices • Professional Clinic Manager: City Sight, City University • Student: City University (MSc in Clinical Optometry)	• None	• None	• Member: Council • Member: Registration Committee • Council Lead: GOC Refresh (People Plan)	• Works with a current General Optical Council Case Examiner

William **STOCKDALE**	• Own an organisation in the Optical Sector - Optomise Ltd 50% Shareholding. • Own an organisation in the Optical Sector - Telford Opticians 50% Stake.	• Member of a representative body in the Optical Sector. • Member of a representative body in the Optical Sector Committee Member of Optometry Northern Ireland. • Member of a representative body in the Optical Sector Committee Member BSO Ophthalmic Committee.	• None	• Member: Registrant Council Member • Member: Nominations Committee	• None
Dr Anne **WRIGHT** CBE Lay Chair	• None	• None	• Committee member: The Shaw Society • Director of Circa management company	• Chair: Council • Chair: Nominations Committee	• None

GENERAL OPTICAL COUNCIL
DRAFT Minutes of the public Council
meeting held on Wednesday 7 December 2022 at 10am via Microsoft Teams

Present:	Dr Anne Wright CBE (Chair), Sinead Burns (until 1pm), Josie Forte, Mike Galvin, Lisa Gerson, Clare Minchington, Frank Munro, David Parkins, Tim Parkinson, Roshni Samra and Glenn Tomison. Harry Singh and Kaiya Anwar (Council Associates).
GOC Attendees:	Joanne Abbott (CPD Manager), Kayleigh Allen (Head of Case Progression) (Case Management System Procurement) (Strategic risk discussion), Marie Bunby (Head of Strategy, Policy & Co-production) (Deputising for Director of Regulatory Strategy), Philipsia Greenway (Director of Change), Leonie Milliner (Chief Executive Officer and Registrar), John Duncan (EDI Manager) (EDI Report), Joshua Hamilton (Performance and Planning Officer), Samara Morgan (Head of Education Development) (Deputising for Director of Regulatory Strategy), Elena Panayiotou (Legal Administrator), Vikram Saklani (Communications Officer), Ivon Sergey (Governance Officer) (Minutes), Dionne Spence (Director of Regulatory Operations), Andy Spragg (Head of Governance) and Manori Wickremasinghe (Head of Finance) (Deputising for Director of Corporate Services).
External Attendees	Alan Tinger (FODO) and Steve Wright (PSA).

	Welcome and Apologies
1.	The Chair welcomed those in attendance.
2.	Apologies were received from Steve Brooker (Director of Regulatory Strategy) and Yeslin Gearty (Director of Corporate Services).
	Declaration of Interests
3.	Registrant Council members declared an interest in the registrant fees rules and fee strategy 2023/2024 item. It was also noted all Council members had an interest in the Gifts and Hospitality policy and Governance Review items. Neither of these interests required further action to be managed.
	Minutes of the meeting held on 21 September 2022 C46(22)
4.	The minutes were approved as an accurate record of the meeting.
	Action points update C47(22)
5.	Council noted an update on outstanding actions as follows:

	Q1 Council Internal Business Plan Exceptions Report Update 21.09.2022 – Completed – Detail provided in the Chief Executive report. **Balanced Scorecard 21.09.2022** - Ongoing – Work was being scoped to assess the balanced scorecard measures for 23-24, which will incorporate EDI activity.
	Matters arising
6.	There were none.
	Registrant fees rules and fee strategy 2023/2024 C48(22)
7.	Council noted registrant fees had been held at £360 a year for the last three years and agreed the proposed 5.56% increase was well-balanced and proportionate. Council discussed the risk and impact of current and future economic instability on GOC income, expenditure and reserves and agreed that future years' annual fee increases should be in line or above inflation over the medium term. Whilst it was positive the GOC had made a below inflationary increase this time, the GOC relied on fee income to enable it in future years to business plan and execute its statutory role effectively.
8.	Council queried the basis for a single flat fee for body corporates and suggested a broader review of the remainder of the fees be carried out for next year, suggesting fee increase comparisons be made with other healthcare regulators. It was noted that future plans for regulating body corporates also depended on legislative reform. **Action: Director of Corporate Services to review the remainder of fees charged, including the rational for the single fee for body corporates.** **Action: Director of Corporate Services to look at how the fee increase compared with other healthcare regulators.**
9.	Council **agreed** to increase the 2023-24 retention fee for fully qualified registrants and body corporates by 5.56%, whilst extending the low-income fee discount; maintain all other fees at their current levels and continue the approach of raising fees in line with or above inflation over the medium term; and **considered** and **approved** the draft fee rules, as set out in annex one.
	Gifts and hospitality policy C49(22)
10.	Head of Governance advised the policy had been reviewed by the internal Policy Review Group (PRG), Senior Management Team (SMT) and Audit, Finance and Risk Committee (ARC). The main changes to the policy were that it now included references to GOC values, clarity of responsibilities and reporting process, as well as being consistent with GOC corporate branding.
11.	Council was advised ARC carried out an annual review of declared gifts and hospitality, as an assurance mechanism, should any issues emerge. Council agreed it was important the policy be widely communicated and visible to staff, members and workers, with the core message of transparency. **Action: Head of Governance to consider how to ensure employees, members and workers understand their responsibilities and remain compliant.**
12.	Council

	approved the revised gifts and hospitality policy; and **delegated** any final revisions to gifts and hospitality policy to the Chief Executive (in consultation with the Chair of Council)
	Equality, diversity and inclusion annual report C50(22)
13.	Council was advised the report combined EDI data analysis and an action plan with progress to date. The report satisfied all requirements by the Equality Act 2010. Council applauded the outstanding achievements in EDI and suggested broad external communication. Council was informed the Registrant Gender Reassignment policy would be going out to consultation on 12 December 2022.
14.	Council suggested the following areas be addressed in future reports: • Richer data to understand trends, such as intersectionality, maternity leave and gender. • Further analysis on why more Fitness to Practise (FTP) complaints are made against male Asian registrants although there is a larger female registrant pool, and comparisons with other regulators to be reviewed. • Determining if there is built-in bias in the system when complaints are received. • Analysis on how to encourage more underrepresented groups to engage and apply to Council roles. • Allyship in glossary to clarify it includes allies to any group. • Language used under religion to be amended to remove the reference “including Catholics”. • Inclusion of the highlights from the EDI data and analysis in the annual report and accounts to raise its profile.
15.	Council was advised the sharing of data sets had concluded the evidential base for action was consistent across regulators. Council agreed it was important to determine what we do with the data, how to measure progress and what the success measures are. Council **noted** the EDI Annual Report for Year End 31 March 2022 (annex one).
	Governance review C51(22)
16.	The Head of Governance provided an update on progress. Council member role profiles would be consulted on. This would benefit prospective Council members in respect to recruitment, appointment induction, review, and ongoing development. Council noted the importance of engaging appropriately with colleagues joining from the devolved nations. Council was asked to note the Charities Commission Governance Code self-assessment tool. Some elements of the Governance Review, including assessment of member support and development, were also included in the business plan for 2023/24.
17.	Council **noted** the delivery plan for the Governance Review (annex 2) and progress to date; **noted** the proposed self-assessment against the Charities Commission Governance Code (annex 3) and commented as required; and **delegated** the power to make minor updates to Council’s policies to the Chief Executive (in consultation with the Chair of Council).

	Health & Safety (H&S) assurance report C52(22)
18.	The Chief Executive introduced the report. Council was informed the external annual audit had resulted in an overall gold standard rating of 96%. The four high priority actions identified had now been completed. A separate internal audit had also been carried out which resulted in an opinion of substantial appearance. It was concluded current measures in place were strong and effective.
19.	Council suggested future reporting include a more rounded view on how self-assessment was carried out, including commentary about near misses and learning, key risks and how these are managed, DSE complaints from home working and mental health and safety measures. Council was assured these details were available in the H&S risk register and would be included in future reports to Council. Council **noted** the contents of the updated health and safety compliance report and internal audit.
	Q2 Business plan assurance report C53(22)
20.	Council noted all essential and critical activities had been completed and an explanation for any activities that were not on track was included in the report. Council was advised the Audit, Risk and Finance Committee (ARC) reviewed targets annually to ensure the right measures were in place. Council suggested the education approved qualifications target of 100% by September 2025, should also include shorter term targets. Council **noted** the contents of the reports.
	Balanced Scorecard C54(22)
21.	Council noted the People Engagement Index was marked green, as the annual staff survey had received 76% participation, which was above industry standard. Council noted vacancy gaps were now more stable and staff turnover was stabilising. Council suggested including a narrative for underspend to provide a clearer picture of whether this was a risk or a success. Council was advised an internal audit of business performance measures was planned for next year, in which consideration would be given on how to improve scorecard presentation to Council.
	Q2 2022/23 Financial performance and forecast report C55(22)
22.	The Head of Finance provided an overview of the reports. Council was assured finances and in particular reserves, were being closely monitored, as these were tied up in GOC investments. Council was advised ARC had discussed the difficulty of estimating FTP costs and the risk of needing to use investment savings. Council noted some of the reasons for expenditure increase in Q2 forecast for this year versus the forecast for next year, had come from part-heard hearings and staff vacancies.
23.	Council **noted** the financial performance for the six months ending 30 September 2022 in annex one; **noted** the Q2 forecast for the current year 2022-23 in annex two; and **noted** the latest forecast for 2023/24 under Q2 forecast year 2 in annex two.
	Chair's report C56(22)

24.	Council noted the report and thanked Juliet Oliver for her service as Investigation Committee Chair. Council **approved** appointment of the new Registrant (Dispensing Optician) Member to Nominations Committee; **approved** appointment of the new Lay Member to Audit, Risk and Finance Committee (ARC); and **approved** the appointment of Nick Arthur as Chair of Investigation Committee until 31 December 2023.
	Chief Executive and Registrar's report C57(22)
25.	Council was reminded of changes in committee memberships to come into effect from January 2023. Council was encouraged to take up opportunities offered by the launch of the optical practice familiarisation programme for staff and members. Council noted ruling by the Advertising Standards Authority (ASA) against an optical business claim about visual stress and dyslexia had resulted in increased enquiries to the GOC, and developments in ftp concerns were being actively reviewed.
26.	Council was advised the planned review of GOC professional standards would have a 6-month stepped approach, which would be provide enhanced opportunities for stakeholder engagement. The Staff Wellbeing and Engagement Group (SWEG) Chair, Nadia Denton, and SWEG network were thanked for their work, noting the GOC had been nominated for the Inclusivity Excellence Award. Council was advised the Registration team would be consulting on plans to assess international applications to determine patterns in the spring 2023. There were 4 approaches being developed on the pre-registration year being retained as a qualification and the outcome of the consultation would be provided in the new year.
27.	Council was advised student roadshows would remain online and the GOC would work closely with providers of approved qualifications to ensure optimal timing and encourage greater engagement. Council was advised, as we were coming to the end of the first year of the CPD cycle, any issues with registrants not reaching the minimum points required would be reviewed by the new Education Operations team in the new year. Council asked to be provided with an update on the 2023 Serious Concerns review. **Action: Chief Executive to provide an update on the 2023 Serious Concerns review to Council.**
	Advisory Panel minutes – 14 October 2022 C58(22)
28.	Council **noted** the minutes of the Advisory Panel, which include minutes of the separate committee group sessions.
	Council Forward Plan C59(22)
29.	Council **noted** the Council forward plan.
	Any Other Business
	Farewell to Council members
30.	Council members Glenn Tomison and Rosie Glazebrook were thanked for their huge contribution made in the sector and wished well in their future endeavours.

	Date of the next meeting
31.	Council noted the date of the next meeting as Wednesday 22 March 2023.
	Close
	The meeting closed at 1pm.

PUBLIC
C03(23)

COUNCIL

Actions arising from Public Council meetings

Meeting Date: **22 March 2023** **Status:** **For noting**

Lead Responsibility and Paper Author: Andy Spragg, Head of Governance

Purpose

This paper provides Council with progress made on actions from the last public meeting along with any other actions which are outstanding from previous meetings.

The paper is broken down into 3 parts: (1) action points relating to the last meeting, (2) action points from previous meetings which remain outstanding, and (3) action points previously outstanding but now completed. Once actions are complete and have been reported to Council they will be removed from the list.

Part 1: Action Points from the Council meeting held on 7 December 2022

Reference	By	Description	Deadline	Notes
Registrant fees rules and fee strategy 2023/2024 C48(22)	Director of Corporate Services	Director of Corporate Services to review level of fees charged, including the rationale for the single fee for all body corporates.	**Q1 23/24**	**Ongoing –** review to commence in Q1 to inform 24/25 budget.
Registrant fees rules and fee strategy 2023/2024 C48(22)	Director of Corporate Services	Director of Corporate Services to look at how the fee increase compared with other healthcare regulators.	**Q1 23/24**	**Ongoing –** work has commenced. Other regulators have different financial years/fee setting points. All data will be collated and compared in Q1
Gifts and hospitality policy C49(22)	Head of Governance	Head of Governance to consider how to ensure employees, members and workers understand their responsibilities and remain compliant.	**March 2023**	**Complete:** Training has now been delivered for employees and Council members. Emails have gone out to members and workers and training will be considered as part of future

				development days.
Chief Executive and Registrar's report C57(22)	Chief Executive	Chief Executive to provide an update on the 2023 Serious Concerns review to Council.	**March 2023**	**Complete –** please see relevant section in the Chief Executive's report

Part 2: Action points from previous meetings which remain outstanding

Reference	By	Description	Deadline	Notes
Balanced Scorecard 21.09.2022	Head of Governance/ Director of Corporate Services	Next iteration of the balanced scorecard include an Equality, Diversity and Inclusion (EDI) measure.	**May 2022**	**Ongoing –** Work is being scoped to assess the balanced scorecard measures for 23-24, and EDI will be incorporated.

Part 3: Action points previously outstanding but now completed.

Reference	By	Description	Deadline	Notes
Q1 Council Internal Business Plan Exceptions Report Update 21.09.2022	Director of Regulatory Operations	An update on Part-Heard Hearings to be provided to Council in December 2022.	**December 2022**	**Completed –** Please see relevant section in the Chief Executive's report.

C04(23)

COUNCIL

Legislative reform and analysis of call for evidence

Meeting: 22 March 2023 **Status:** For decision

Lead responsibility: Steve Brooker (Director of Regulatory Strategy)
Paper Author(s): Marie Bunby (Policy Manager)
Council Lead(s): David Parkins

Purpose

1. To update Council on our legislative reform programme and seek approval to publish our analysis and associated documents related to our call for evidence on the Opticians Act 1989 ("the Act") and consultation on associated GOC policies.

Recommendations

2. Council is asked to:
   - consider the analysis of responses received to the call for evidence and the proposed response (annex 1); analysis of refraction arguments (annex 2); advice on refraction from clinical advisors (annex 3); autorefraction vs retinoscopy (annex 4);
   - consider the advice from Council's committees (see annexes 5 and 6);
   - approve the publication of the proposed response to the call for evidence (annex 1); and
   - delegate approval of the response to the Department of Health and Social Care's (DHSC) consultation on Regulating anaesthesia associates and physician associates to the Chair of Council in consultation with Clare Minchington (Senior Council Member) and David Parkins (Council lead for Regulatory Reform).

Strategic objective

3. The legislative reform project work and analysis of evidence received from the 2022 call for evidence is included in the business plan for 2022/23, which supports our strategic objective of delivering world-class regulatory practice.

Background

DHSC-led regulatory reforms

4. The DHSC published its consultation on 'Regulating healthcare professionals, protecting the public' on 24 March 2021. We responded to this consultation positively as it is a once in a lifetime opportunity to modernise the regulatory frameworks for fitness to practise, education, registration and governance. We said that removing overly prescriptive, complex and rigid legislative frameworks will allow regulators greater freedom to respond to future challenges in a quicker and more effective way.

5. As part of the programme of work to reform the regulation of healthcare professionals, we have been engaging with the DHSC and the other healthcare regulators to review the draft legislation for the General Medical Council (GMC), which will be used as a blueprint for the other healthcare regulators' legislation. We were advised last year that the DHSC intended to separate out legislation to regulate physician associates and anaesthesia associates from the wider reform of regulation for the GMC, with the timetable introducing the former legislation likely to be laid in Parliament in the second half of 2023.

Call for evidence and consultation on associated GOC policies

6. As Council will be aware, we decided to use the opportunity of the DHSC-led reforms to carry out our own review of the Act in areas that are unique to the optical sector. As a first step in this process, we issued a call for evidence on 28 March 2022 to engage with stakeholders and encourage them to submit evidence to help us consider whether the Act is fit for purpose and whether there is any evidence of impact (positive or negative) to support any changes to the Act. We combined this with a consultation on associated GOC policies, specifically whether we should amend or remove our 2013 statement on testing of sight which provides that refraction cannot be delegated for the purposes of a sight test. A document describing frequently asked questions on sight testing legislation which provides more information on the sight test and who can perform it is published on the GOC's website here.

7. The reason we combined the call for evidence with a consultation on the associated GOC policies was because we had heard from some stakeholders that the Act and/or GOC policy is too prescriptive, for example, in terms of who can carry out a sight test and how this must be done. We have also heard from the professional body representing dispensing opticians, the Association of British Dispensing Opticians (ABDO) that dispensing opticians, with additional training, may be able to refract safely for the purpose the testing of sight. We wanted to understand stakeholders' views and evidence of impact to inform how we might move forward on this issue, and where there might be gaps in evidence (including evidence of risks and impact to the public).

8. Our call for evidence on the Act and associated GOC policies (hereinafter referred to as the 'call for evidence') closed on 18 July 2022. The call for evidence sought views, information and factual evidence on the impact and stakeholders' experience of the Act to help us to decide whether the Act and associated GOC policies should remain as they are or whether there is any evidence to support a case for change. We received 353 responses which included over 8,000 individual comments and we have carefully analysed each of these comments, considering the need and strength of the case for any changes, and pulling out themes and relevant quotes into the proposed GOC response (annex 1).

9. We agreed with Council at its meeting in September 2022 that we would prioritise the areas of refraction and business regulation, and carry out further research to fill the gaps in our knowledge and evidence base in these areas. We commissioned three agencies to provide research on the public and clinical perspectives on refraction and on business regulation. We also issued an invitation to tender for a fourth piece of research (international comparisons on refraction) but did not receive any bids, so we carried out this work in-house. Each of the research reports are published on our website (https://optical.org/en/publications/policy-and-research/research-associated-with-the-call-for-evidence-on-the-opticians-act) and the conclusions are summarised in paragraphs 88 and 108-110 of our proposed GOC response to the call for evidence.

10. We presented the research on refraction to Council at a seminar on 20 February 2023, providing an opportunity for Council to ask questions of the agencies that carried out the research. Council members asked for further analysis of the arguments for and against refraction put forward by respondents to the consultation, further clinical advice and more information about the different types of objective refraction (autorefraction vs retinoscopy). The information we gathered is provided at annexes 2, 3 and 4.

11. We shared an early draft version of the GOC response to the call for evidence at the Council strategy day on 2 March 2023, to give Council an opportunity to begin to discuss the wide range of issues covered in the call for evidence. We also provided the additional information we obtained following the seminar and the research on mapping of optical businesses.

Analysis

DHSC-led regulatory reforms

12. DHSC published its response to the 2021 consultation on 17 February 2023, alongside its consultation on Regulating anaesthesia associates and physician associates which includes a draft section 60 order for the GMC. We continue to work closely with DHSC officials and other healthcare regulators to review the draft. We are generally content with the draft order and the policy intention behind it, although there will be some areas we want to focus on, such as membership of the unitary board, setting of fees, use of reserves and budget-setting.

13. Implementing changes to our regulatory functions resulting from changes to the legislation will be a substantial change project for the GOC and the Executive will consider how we can appropriately resource ourselves to prepare for and implement the changes. It will be difficult to plan appropriately without having a clearer timetable from the DHSC as to when our legislation might be amended.

14. The deadline for responding to the DHSC's consultation on Regulating anaesthesia associates and physician associates is 16 May 2023. We are asking Council to

delegate approval of our proposed response to the Chair of Council, in consultation with the Senior Council Member and Council Lead for Regulatory Reform.

Call for evidence and consultation on associated GOC policies

15. Our analysis of the call for evidence responses suggests that there is a large degree of stakeholder consensus in many areas, such as duties to be performed on sight testing, fitting of contact lenses, verification of a copy of a contact lens specification, zero powered contact lenses, and sale and supply of spectacles by non-registrants. While Council's discussion is likely to focus on more contentious areas, we should not lose sight of the potential positive impact for change in these less contentious areas. The more consensus there is about the direction of travel, legislative reform and the updating of associated policies should have an easier passage.

16. The proposed GOC response to the call for evidence (annex 1) identifies that whilst legislative reform is necessary to advance some proposed areas of change, there is much that we can do within our current regulatory framework to advance public protection, for example, through our forthcoming review of our standards and the issuing of position statements. The executive summary of our proposed response to the call for evidence outlines our proposed commitments we have made in the proposed 'GOC response' sections of the report and the proposed response in respect of our consultation on refraction by dispensing opticians for the purposes of the sight test.

17. The executive summary of the proposed response lists: the six areas we intend to address through a request to change legislation; the two areas we intend to address through the review of our standards; the two areas we intend to discuss further with DHSC; the four issues we will consider addressing through a GOC position statement; and the seven topics we will consider returning to and/or keep under review. In addition, we have identified three areas that were outside the scope of the call for evidence where we may undertake further work, including developing further guidance on supervision of students and trainees, review of declarations guidance and paediatric dispensing. This is a significant number of proposed commitments and if approved, represent a substantial body of work for the Executive to progress over the medium-term to ensure that the Act, our policies and standards are fit for the future given the ever-changing political, commissioning, technological, delivery of care and business landscape.

18. Notwithstanding the large degree of stakeholder consensus reported upon in the GOC analysis of evidence, there are two areas which require more detailed consideration by Council within the call related to a) refraction by dispensing opticians for the purposes of sight testing, and b) business regulation.

Refraction by dispensing opticians for the purposes of sight testing

19. As part of the call for evidence we received a range of strongly held views from stakeholders on the issue of refraction by dispensing opticians for the purposes of

sight testing. The information and views received from individuals and stakeholders alongside arguments in favour of and against refraction by dispensing opticians for the purposes of the sight test and a summary of studies that we were made aware of are analysed in section 4 of the proposed response to the call for evidence at annex 1.

20. As well as carefully considering submissions to the call for evidence we commissioned additional research to provide an expert clinical perspective on the issue of dispensing opticians refracting for the purposes of the sight test, commissioned independent qualitative and quantitative research with the public and patients, and carried out in-house desk research to explore international comparisons. All of this research is published on our website and the conclusions are summarised in paragraphs 108 and 110 of the report.

21. We also have sought the advice of our Council's committees on this issue at their meeting as an Advisory Panel on 10 March 2023. The Advisory Panel's advice is attached at annex 5.

22. As a healthcare regulator, our overriding consideration is public protection, patient safety and upholding public confidence in the professions we regulate. Based on the evidence and information received, the advice of the Advisory Panel and the outcome of the impact assessment screening tool at annex 7, we invite Council to consider paragraph 111 in the report which describes the proposed response to our analysis of evidence and information received on refraction by dispensing opticians for the purpose of the sight test, as follows:

    "Based on the information collected during the call for evidence and findings from the subsequent research, at this point in time we are not satisfied that dispensing opticians should be permitted to refract for the purposes of the sight test. Our main concern is undetected pathologies, including subtle clues about eye health during refraction and ophthalmoscopy that may be missed if different professionals conduct these sight test components. This risk would remain even if dispensing opticians were to receive further training/accreditation and be under the supervision/oversight of an optometrist or registered medical practitioner."

23. We also invite Council to consider proposed paragraph 114 of the proposed response to the call for evidence, which describes our proposal to consider updating our 2013 statement on the testing of sight to clarify the position in relation to pre-screening tests, triage checks and technological developments.

24. The risk and impacts of Council approving, or not approving, the publication of the proposed response, including the more contentious paragraphs 111 and 114 described above, are discussed later in the 'risks' section of this paper.

25. Should Council wish to make minor drafting amendments to paragraphs 111 and 114, or indeed to other paragraphs or sections of the proposed response, Council may wish to consider delegating final approval of any amendments prior to the publication of the proposed response to the Chair of Council in consultation with the Senior Council Member and the Chief Executive and Registrar.

26. Alternatively, Council may wish to consider further the issue of refraction by dispensing opticians for the purposes of sight testing, and/or commission further research or seek additional information. The costs and risks of this approach are explored in the 'finance' and 'risks' sections later in this paper.

Business regulation

27. There was broad agreement in the evidence and information received from individuals and stakeholders that the GOC should have a consistent form of business regulation that should include all businesses providing functions that are restricted under the Act. The main area of contention related to whether the GOC should have inspection powers and how these should be used.

28. We sought the views of Companies Committee on the research into the mapping of optical businesses and asked whether there were any reasons why we should not be extending business regulation. Companies Committee was content with the principle of extending business regulation, provided that regulation was proportionate and applied consistently. The advice from Companies Committee to Council is attached at annex 6.

29. Should Council approve the publication of section 3 of the proposed response which describes our proposed approach to progressing issues associated with the regulation of businesses, we will need to embark on a significant programme of work over the course of the next 12 months to develop our policy proposals in this area. We propose in due course to consult on a proposed framework for business regulation. Any consultation will cover areas relating to business and ownership structures, regulatory supervision (including assessing the effectiveness and cost of any potential assurance or compliance activity), enforcement approach and sanctions, access to consumer redress and the setting of registration fees charged to optical businesses.

30. We invite Council to consider paragraphs 83-90 of the proposed response and consider if this sets out the right direction of travel for the regulation of businesses.

Publication of the proposed GOC response to the call for evidence

31. We have prepared the report at annex 1 based on the consultation responses, research and advice from the Advisory Panel. We invite Council to consider approving the publication of the proposed GOC response to the call for evidence at annex 1.

32. The alternative is for Council to further consider the issues discussed in the call for evidence and consultation on associated policies, commission further research or to seek additional information. The risks, impacts and cost of Council approving or not approving the publication of the proposed response to the call for evidence are discussed later in this paper.

33. Should Council wish to make minor drafting amendments to one or more paragraphs of the proposed response, Council may wish to consider delegating final approval to the Chair of Council in consultation with the Senior Council Member and the Chief Executive.

Finance

34. We do not have any specific funding set aside for implementation of the call for evidence or progression of the workstreams indicated in the report's executive summary. Our resource for follow-up work will be delivered by our existing Policy and Standards team. If this is not sufficient, a business case will be prepared for Council approval for use of the strategic reserve.

35. If Council considers that any further research, information and/or evidence gathering is required to inform further drafting before being able to approve the final publication of the proposed GOC response to the call for evidence, this is likely to require additional resources (staffing and/or research resource), depending on the scale of the request. If this is the decision of Council, a business case will be prepared for Council approval for use of the strategic reserve for this purpose.

36. Similarly, the costs of implementing changes to our regulatory functions resulting from DHSC-led reform to our legislation will be significant. Having a clearer timetable from the DHSC as to when our legislation might be amended will assist the Executive in planning appropriately and in considering how we can appropriately resource ourselves to prepare for and implement the changes.

Risks

37. There are risks of delay to legislative reform if Council requests further work before making decisions. Although the GOC is not in the first wave of regulators in the DHSC-led reforms, until the GOC can indicate when its blueprint for legislative reform will be ready, the DHSC is unlikely to commit to a timescale of its own in respect of the GOC's section 60 order.

38. A decision by Council not to approve the publication of the proposed response (annex 1) would have negative impact on business planning as well as carrying reputational risks. Given the small size of the Policy team, any additional work due to a delay in the publication of the proposed response will have a consequential delay making progress on the proposed commitments listed in the executive summary of the proposed response and/or other items in the 2023/24 business plan, which may

well then leave us unprepared for the next wave of DHSC's regulatory reform programme.

39. The Executive intends to bring a paper to the next Council meeting outlining the planned timetable for delivering the proposed commitments listed in the executive summary of the proposed response. As noted in the 'finance' section of this paper, if additional resources are required, depending on the scale of the request, a business case will be prepared for Council approval for use of the strategic reserve for this purpose. Alternatively, Council may decide not to progress some of the proposed commitments, deliver them over a longer period and/or re-scope work on other issues.

40. There is also a risk that additional research, in particular on refraction or business regulation, would not fill knowledge gaps. Council should only request further research if it is confident this would be methodologically possible, affordable and would make a material difference to its decision. No evidence can provide a complete picture or is perfect; Council's role is to exercise sound judgement based on the best available evidence.

41. These are contentious areas of policy with consequences for stakeholder groups bringing reputational and other risks. These risks are being mitigated through carrying out significant stakeholder engagement, evidence collection and transparent decision-making. It will be important for Council to clearly explain the reasons for its decisions, which will be reflected in the final documents and associated communications.

Equality Impacts

42. An impact assessment screening tool is attached at annex 7.

43. We will complete an equality impact assessment for each proposed change in legislation or policy consulted upon further. At this point in time, we will complete impact assessments (including equality and diversity impacts, and financial impacts) taking into account information already gathered during the call for evidence.

Devolved nations

44. We are a UK-wide regulator and any legislative or policy changes will therefore apply across all the nations. We have engaged with stakeholders across the nations (including the devolved governments) and will continue to do so as this area of work progresses.

Communications

External communications

45. We published a press release the day after the call for evidence closed, thanking stakeholders for responding to the consultation and setting out next steps. We will

continue to keep stakeholders updated at appropriate intervals as we move forward, including publishing our response to the DHSC's consultation and our GOC response to the call for evidence on our website. Any further consultations will be available on our consultation hub and we will promote these through our usual channels.

46. We will also engage with specific stakeholders as outlined in our proposed GOC response to the call for evidence.

Internal communications

47. We have been keeping relevant staff updated and will make them aware of publication of our responses to the DHSC consultation and our call for evidence.

Next steps

48. We will draft our response to the DHSC consultation by the deadline of 16 May 2023, seeking approval for our response as outlined above. As noted in the 'finance' section of this document, we will next consider how we can appropriately resource ourselves to prepare for and implement what will be a significant change project.

49. Providing Council is content with our draft GOC response to the call for evidence, we plan to publish the response in early April 2023. If amendments are required, we will seek to make these as soon as possible in line with any delegations agreed by Council.

50. Once we have a clear steer from Council on the way it wants us to progress the work outlined in our response to the call for evidence, we will be able to carry out detailed business planning with regard to any plans for policy development, further consultation and stakeholder engagement.

Attachments

Annex 1: Proposed GOC response to call for evidence on the Opticians Act and consultation on associated GOC policies
Annex 2: Analysis of refraction arguments
Annex 3: Advice on refraction from clinical advisors
Annex 4: Autorefraction vs retinoscopy
Annex 5: Extract from Advisory Panel minutes on refraction
Annex 6: Extract from Companies Committee minutes on business regulation
Annex 7: Impact assessment screening tool

GOC response to call for evidence on the Opticians Act and consultation on associated GOC policies

XXX 2023

Contents page

Executive summary

1. The General Optical Council (GOC) is using the opportunity offered by the Department of Health and Social Care's (DHSC) programme of legislative reform for the healthcare regulators to review whether further changes are required to the aspects of the Opticians Act 1989 ('the Act') that are unique to the GOC or the practice of optometry and dispensing optics.

2. We released a call for evidence on the Act and associated GOC policies between March and July 2022 and received 353 responses which included over 8,000 individual comments. This document summarises our analysis of the consultation responses and our initial response to the analysis.

3. Our vision for legislative reform is to ensure that we can continue to protect the public and that the Act is fit for the future given the ever-changing political, commissioning, technological, delivery of care and business landscape.

4. Our analysis is that legislative reform is necessary, but we have also identified opportunities to advance public protection without legislative change, for example, through our forthcoming standards review and position statements.

5. The table below outlines the commitments we have made in the GOC response sections of this report and our decision in respect of our consultation on refraction by dispensing opticians for the purposes of the sight test.

Areas we intend to address through a request to change legislation

- *Regulatory objectives:* Patient and public safety should remain the GOC's overriding statutory objective in common with the other healthcare regulators. We propose an additional secondary consumer protection objective on the face of the legislation, reflecting the nature of risks to the public in the optical sector and our plans for expanding business regulation.

- *Restricted functions:* We are not proposing changes to the list of restricted functions now, but the optical sector is changing rapidly. To future-proof the legislation we propose a mechanism for the GOC to make recommendations to the Secretary of State to alter the list of restricted functions without the need for primary legislation.

- *Business regulation:* We welcome the broad stakeholder support for extending regulation to all businesses carrying out restricted functions. We think regulation should apply to all such businesses regardless of their name, corporate structure or who owns and manages them. We will next develop proposals and consult on an updated framework for business regulation.

- *Verification of contact lens specifications:* We agree that verification of a copy of a contact lens specification is no longer necessary, provided that the specification is clear, does not contain any obvious errors and has not obviously been tampered with. We therefore intend to seek legislative change to allow us to set out more detailed requirements in rules/guidance.

- *Definition of low vision:* We have reviewed the definition of low vision appliances in the legislation[1] and agree that it could be clearer. We produced a position statement on low vision aids in 2012. We will review the legislation in the context of our statement and consult on any changes as part of a future consultation on any new draft legislation for the GOC as part of the DHSC's legislative reform programme.

- *Protected titles in section 28(1)(a) of the Opticians Act 1989:* We will review the ordering of the wording in this section of the Act listing protected titles, as the ordering is not logical and we think it could be made clearer in any new legislation as part of the DHSC's legislative reform programme.

Areas we intend to address through the review of our standards

- *Dispensing to vulnerable patients:* Where services are provided to patients who could be considered 'vulnerable', we will consider whether any issues can be addressed by amending our standards.

- *Use of technology:* We have heard from stakeholders that the use of technology and artificial intelligence (AI) can cause uncertainty for registrants, for example, as the boundaries of decision-making and accountability become blurred. We will address these issues in the review of our standards and guidance to reflect developments in this field.

Areas we intend to discuss further with DHSC

- *Regulations related to criteria for visual impairment:* Under the Care and Support (Sight-impaired and Severely Sight-impaired Adults) Regulations 2014, a person is to be treated as being sight impaired / severely sight impaired if so certified by a consultant ophthalmologist. We will discuss with DHSC whether it would be possible to have regulations that provide a different definition but are concerned that the resulting inconsistency could be complicated.

[1] Regulation 1(2)(d)(b) of the Sale of Optical Appliances Order 1984: "any appliance sold or to be sold in pursuance of a prescription which identifies the appliance to be sold as being a low vision aid (whether by means of the words "low vision aid" or some other similar words), and includes frames or mounts which are intended for use as part of eyeglasses so designed and are sold or supplied without lenses and lenses so intended which are sold or supplied without frames or mounts"

- *Online spectacle sales:* We note that the Sale of Optical Appliances Order 1984 does not reflect the reality of online supplies since it predates internet sales. We will discuss this further with DHSC.

Areas we will consider addressing through a GOC position statement

- *Refraction by dispensing opticians:* At this point in time we are not satisfied that dispensing opticians should be permitted to refract for the purposes of the sight test. Our main concern is undetected pathologies, including subtle clues about eye health during refraction and ophthalmoscopy that may be missed if different professionals conduct these sight test components.

- We will consider updating our 2013 statement on testing of sight to clarify the position in relation to pre-screening tests and triage checks related to the sight test that may be carried out by persons other than the optometrist or registered medical practitioner. Over time, advances in technology have meant various steps in the patient journey have become automated and safely delegated as part of pre-screening and triage. If we decide to update our 2013 statement, we will carry out further consultation on this aspect of the testing of sight.

- Our interpretation is that the Act does not specifically prohibit separation of the elements of the sight test by time, place or person. Business models are evolving alongside developments in technology. There were a range of views about this, and we plan to consider developments in more detail. We may clarify our position in a statement or seek a change in the law.

- We will further discuss the issues connected with orthoptists refracting for the purposes of sight testing with the Health and Care Professions Council (HCPC – the regulator for orthoptists) and the British and Irish Orthoptic Society.

- *Verification of contact lens specifications:* We will consider issuing a position statement to say we will not enforce the requirement to verify a copy of a specification (until such time that legislation can be amended). We will also consider extending this statement to prescriptions for spectacles.

- *Definition of aftercare:* We will consider whether it would be helpful to provide a definition of aftercare in a GOC position statement so that it is clear what sellers of contact lenses are obliged to do in order to meet their legal obligations.

Areas we will consider returning to and/or keep under review

- *Domiciliary care:* We recognise that domiciliary care is a particular area of risk and will continue to monitor fitness to practise and Optical Consumer Complaints Service (OCCS) complaints in this area, working with the optical

sector, governments and national health services to review the position as research and evidence emerges.

- *Zero powered contact lens legislation:* There may be a risk that the current legislation drives zero powered contact lens wearers to unregulated sources, thereby increasing the potential risk of harm to the public. At the current time we do not propose to make any changes to legislation in this area but we may return to the issue in the future.

- *Public protection threats of growing online sales and optical services delivered online:* We recognise that overseas online sales, whether illegal or otherwise, are a genuine challenge facing the sector. The GOC has recently updated its illegal practice protocol. The PSA has challenged DHSC to provide regulators with the agility to respond to these issues. We will keep our position under review and work with relevant healthcare regulators, the PSA and governments to explore possible solutions in these areas.

- *Spectacles prescription contents:* We have considered the suggestion that the Sight Testing (Examination and Prescription) (No. 2) Regulations 1989 should be changed so that a prescription should include the tested visual acuities for any prescribed working distances. We will discuss this further with the professional bodies to understand the case for change.

- *Substitution of contact lenses:* We do not propose introducing a specific legal requirement to supply contact lenses only in accordance with the contact lens specification since the evidence suggests that professionals exercising their clinical judgement can substitute safely. We will continue to keep this situation under review as research progresses.

- *Latest developments in technology:* The optical sector would benefit from a shared understanding of the latest developments in technology and a mechanism to keep this knowledge up to date. We will discuss with stakeholders how best to achieve this.

- *Deposits for sight tests:* It seems reasonable to be able to take a deposit for a sight test given that other healthcare professionals may charge cancellation fees. If we consider that we do wish to pursue a change in this area, we will carry out further consultation to further understand the impacts and ensure that there are no unintended consequences of a change in policy and/or legislation.

Areas outside the scope of the call for evidence

- *Further guidance on supervision of students and trainees, including how employers can support supervisors:* We will keep this under review with education providers and professional bodies. It may be that it is more appropriate for providers of approved qualifications to issue this guidance to

those employers or placement providers offering periods of professional and clinical experience or other forms of experiential learning.

- *Review of declarations guidance:* The Association of Optometrists (AOP) raised the need to review our declarations guidance, as they often receive queries from members on this process related to health declarations. We are planning a review of this guidance and will take the AOP's comments into consideration as part of the review.
- *Paediatric dispensing:* ABDO asked us to provide good practice guidance on paediatric dispensing. This falls outside the scope of the call for evidence but we will discuss the issues further with ABDO.

Next steps

6. We will review the commitments set out in the above table and prepare a timetable. Where we consider changes to legislation or GOC policy are necessary and can be evidenced, we will carry out further public and targeted stakeholder consultation activities on our proposals. We look forward to engaging further with stakeholders.

Introduction

7. The GOC is one of a number of organisations in the UK known as health and social care regulators. These organisations oversee the health and social care professions by regulating individual professionals and some businesses/premises. We are the regulator for the optical professions in the UK. We currently register around 33,500 optometrists, dispensing opticians, student opticians and optical businesses.

8. We have four primary functions:

    - setting standards for optical education and training, performance and conduct;
    - approving qualifications leading to registration;
    - maintaining a register of those who are qualified and fit to practise, train or carry on business as optometrists and dispensing opticians; and
    - investigating and acting where registrants' fitness to practise, train or carry on business is impaired.

Background to the consultation

9. The GOC's governing legislation is the Opticians Act. The original Opticians Act was published in 1958. This was replaced by the Opticians Act 1989 ('the Act'), but still retained large sections of the 1958 Act. There have been various amendments since 1989 such as introducing Continuing Professional Development (CPD) in 2005. During this time, the sector has evolved significantly with the roles of optometrists and dispensing opticians developing to realise their full professional capability as well as occupying different roles, including enhanced clinical roles, across each nation of the UK. Technological developments including remote care have also impacted on the way optical services are delivered to patients. We were keen to gather evidence and insight to better understand how our legislation needs to develop to match advances in technology, service delivery and professional capability, and associated risks to patient care and public benefit.

10. In addition, the Act contains other areas that may require reform, such as protecting function (i.e. activities such as sight testing) and professional title. We need to ensure the Act is fit for purpose and does not create unnecessary restrictions that limit the ability of registrants to fully utilise their professional capability to the benefit of patients. We were also keen to understand where the limit of such changes should be and their impact, so as to not unnecessarily restrict competition in the market. These factors must be balanced against the need to maintain patient care, safety and public benefit.

11. The DHSC is currently carrying out a review of all healthcare regulators' legislation to ensure consistency between the powers that all healthcare regulators have to deliver their regulatory functions of registration, education, fitness to practise, standards and the overall governance and operating framework of the regulator. We used the opportunity offered by the DHSC to review whether further changes are required to the aspects of the Act that are unique to the GOC or the practice of optometry and dispensing optics.

Consultation process

12. We published a call for evidence on the Act and a consultation on associated GOC policies to seek views, information and factual evidence on the need for change to the Act and any associated GOC policies. The call for evidence was open for 16 weeks from 28 March to 18 July 2022.

13. We received 353 written consultation responses from a range of stakeholders. These were made up of:

- five members of the public;
- one optical patient;
- 182 optometrists;
- 76 dispensing opticians;
- 20 contact lens opticians;
- seven student optometrists;
- four student dispensing opticians;
- ten business registrants/employers;
- four education providers;
- one CPD provider;
- 24 professional/representative bodies (including two charities and six local optical committees); and
- 19 'other' (four individuals and 15 organisations including two charities, three business registrant/employers, two local optical committees and two government/NHS bodies).

14. The organisations that were willing to be named were:

- Association of British Dispensing Opticians (ABDO)
- Association of Optometrists (AOP)
- Association for Independent Optometrists and Dispensing Opticians (AIO)
- Aston University
- Avon Local Optical Committee
- Bexley, Bromley & Greenwich Local Optical Committee
- BBR Optometry Ltd
- British Contact Lens Association (BCLA)
- The College of Optometrists

- Dudley Local Optical Committee
- FODO (The Association for Eye Care Providers)
- Glaucoma UK
- Gloucestershire Local Optical Committee
- Kensington Chelsea Westminster Hammersmith and Fulham Local Optical Committee
- Local Optical Committee Support Unit (LOCSU)
- Macular Society
- The Northumberland, Tyne and Wear Local Optical Committee
- Optical Consumer Complaints Service (OCCS)
- Optical Suppliers' Association
- Optometry Northern Ireland
- Optometry Schools Council
- The Professional Standards Authority for Health and Social Care (PSA)
- RNIB
- Royal College of Ophthalmologists
- SeeAbility
- Specsavers Optical Group
- Staffordshire Local Optical Committee
- Welsh Government
- Wolverhampton Local Optical Committee
- The Worshipful Company of Spectacle Makers

15. We are grateful for all the feedback we received and have taken this into account in deciding our next steps.

Approach to producing this response

16. Respondents were encouraged to provide comments throughout the call for evidence. We reviewed every comment received, of which there were just over 8,000. We are unable to include individual responses to all of these comments within this report due to the volume that we received.

17. Any comments that have been included are produced verbatim, although we have made minor corrections to spelling and/or grammatical errors where we considered that these were obvious.

18. We have only included comments where the respondent has consented to their response being published (either alongside their name or anonymously). It is our practice not to include the names of individual respondents, even where they have given their consent for us to publish their response.

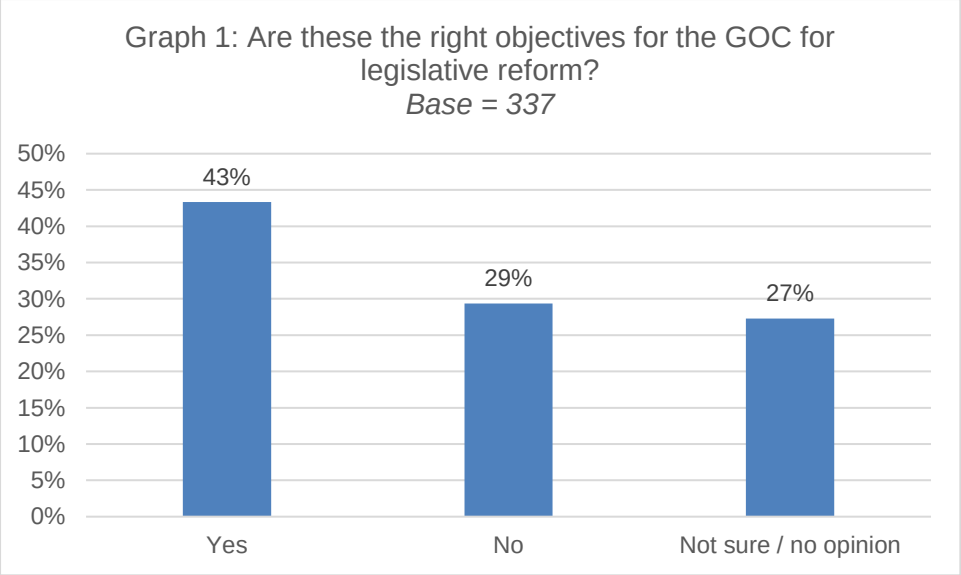
Findings

Section 1: Objectives for legislative reform

19. We set out eight non-hierarchical objectives for legislation reform:

- objective 1: maintaining patient and public safety – our primary objective in everything we do as a regulator;
- objective 2: ensuring that legislation reflects current and future context of healthcare delivery and is more flexible to accommodate changes going forward;
- objective 3: ensuring that our legislation is flexible enough to accommodate future workforce needs and does not unnecessarily restrict the development of different roles needed to deliver the eye care needs of the UK;
- objective 4: the GOC has sufficient powers to regulate a changing landscape in terms of developments within technology and the potential increase of care delivered into the UK;
- objective 5: ensuring that there is consistency in the regulation of optometry/optician practices/businesses, i.e. the regulation of the system in which our optometrists and dispensing opticians work;
- objective 6: regulatory interventions should take account of the national objective to reduce healthcare inequalities where possible and not put up any unnecessary regulatory barriers to this aim;
- objective 7: reform should take the path of least resistance where this is appropriate, i.e. considering other regulatory levers, such as standards and guidance if these would be more effective than changing legislation; and
- objective 8: ensuring that any changes do not impose disproportionate administrative or financial impacts on patients, the sector and our stakeholders.

20. We asked stakeholders whether they thought these were the right objectives. Of the 337 respondents that answered the question, 43% considered that these were the right objectives, 29% did not and 27% were not sure or had no opinion.



21. The following themes were identified from the comments:

- general support for the objectives but the first objective around patient and public safety should be the over-arching priority – it should not be part of the non-hierarchical objectives;
- there should be an objective about better regulation of online sales (particularly those suppliers who are currently operating illegally);
- the importance of education and training for the current and future optical workforce could be better highlighted, so that integration of health and social services can be realised through a workforce trained to work in multi-professional and multi-disciplinary teams, with the skills to work in different models of care;
- some of the objectives regarding regulation should refer to appropriateness and/or proportionality (e.g. objectives 4, 7 and 8);
- suggestion for the word 'maintaining' (patient and public safety) in objective 1 to be replaced with 'enhancing';
- objective 2 is too vague; and
- the 'path of least resistance' in objective 7 should be reworded to be clearer.

22. A sample of comments is available in the box below.

> *"These are acceptable objectives provided the over-riding statutory objective to protect the public is never forgotten and given primary importance."*
> Gloucestershire Local Optical Committee

"…The objectives should also explain that the burden of proof for any prospective case for the removal of existing legal restrictions should be a robust demonstration that changes to the Act will maintain public protection, and not introduce new risks of harm…" AOP

"We feel that objective 1 should be amended to 'Enhancing patient and public safety'. The aim of reviewing the legislation should be to improve the protections currently offered, not to maintain the status quo." Local optical committee

"Objective 2: This is too vague. Changes to models and delivery of care need to be scrutinised heavily by GOC before delivery. The current system promotes an 'acceptable unless told otherwise' model of change with the GOC taking a reactive stance. We would prefer to see the GOC take a proactive role in the progression of healthcare and be more active in discussions relating to change…" AIO

"On Objective 7, we agree that some important and urgent reforms may not need a change in legislation, which could be a long and uncertain process to achieve. However, any decision to use alternative ways such as standards and guidance should be made in full consultation with stakeholders. We suggest rewording this objective as follows: "reform should take the simplest approach where this is appropriate and agreed in consultation with registrants and our stakeholders, i.e. considering other regulatory levers, such as standards and guidance if these would be more effective than changing legislation." The College of Optometrists

"Objective 8 should be extended to ensure that there is no undue or disproportionate restriction on how patients choose to access services and goods." Optical Suppliers' Association

GOC response – objectives for legislative reform

23. It is important to distinguish the objectives of the GOC's legislative reform project from the GOC's future statutory objectives. The DHSC's intention is to set common statutory objectives for all the healthcare regulators through legislative change. The draft orders will be subject to public consultation.

24. We agree that patient and public safety should be the over-riding objective separate to the others in line with our purpose as a healthcare regulator.

25. We consider that the GOC should have an additional secondary objective to protect consumers reflecting the nature of risks to the public in the optical sector and our plans for expanding business regulation. However, these two objectives would sit in a clear hierarchy: should there be any conflict, the safety objective would always have primacy.

26. The DHSC is currently consulting on a draft section 60 order, which would allow the General Medical Council (GMC) to regulate anaesthesia associates and physician associates. This is intended to serve as a template for the future

regulation of other healthcare professionals, including dispensing opticians and optometrists. Our reading of the draft legislation is that it would allow the GOC to support workforce planning efforts where this is consistent with our statutory objectives and functions, which we would support.

27. The DHSC intends to incorporate the better regulation principles (e.g. proportionality) into legislation and the GOC supports this move.

28. The statutory objectives will only be viable if we have the right statutory functions to deliver them. Some suggestions, such as educating the public, are not currently within our core functions and would therefore require legislative change and we would need to be resourced to deliver them. It is likely that resourcing such an additional function would need to come from registrant fees rather than public funds or other sources. At present we are not convinced that the GOC should acquire new statutory functions. We provide commentary on public education in paragraph 247 of this document.

29. We note that some stakeholders are seeking reassurance from us that we will commit to further consultation prior to any changes to legislation to ensure that we consider any unintended consequences of changing legislation. It is our intention to consult further where we consider that any changes to legislation might be necessary so that we can fully understand the impact of these.

30. We note that even where there are areas where we might wish to seek legislative change, the timetable for this is uncertain and we will therefore make best use of the current framework until then. Further, in some areas, such as developments in technology, we consider that it would be both possible and preferable (for example, due to the need to be agile) to make progress by revising our standards and guidance instead of updating legislation.

Section 2: Protection of title, restricted activities and registers (sections 7, 8A, 9 and 24-30A of the Act)

31. Protection of title means that certain titles in section 28 of the Act are reserved for individual or business registrants of the GOC and it is illegal for anyone else to use them. All health and social care regulators protect titles as this is a key aspect of public protection and provides assurance to the public that someone using that title is competent and safe to practise.

32. Our Act goes further than protection of title and also restricts the activities of non-registrants[2]. For example, part IV of the Act restricts the testing of sight (section 24), fitting of contact lenses (section 25), and the sale and supply of optical appliances (with specific exemptions) and zero powered contact lenses[3] (section 27).

33. In effect, the Act specifies those activities which only our registrants can do, or which require their supervision or general direction. The Act protects the public from unregistered persons who are not bound by the GOC's standards, as well as from dishonest individuals who mislead people as to their registration status.

Restrictions for registrants and non-registrants

34. We asked stakeholders what activities non-registrants should be restricted/prevented from doing.

35. There was a clear view that the current restrictions under the Act should remain. In addition, there was a long list of other activities which respondents suggested should also be restricted to registrants:

- any dispensing activities;
- dispensing/supplying without supervision of a registrant;
- dispensing high/complex prescriptions;
- dispensing/supplying to vulnerable patients (examples included those with learning disabilities, dementia, facial/head abnormalities, special educational needs, reduced capacity to consent and living in care homes);
- dispensing to drivers/pilots;
- dispensing safety spectacles e.g. for sport;

[2] Non-registrants are those persons who are not registered with the GOC as dispensing opticians or optometrists

[3] Zero powered contact lenses are cosmetic, non-corrective lenses (i.e. without a prescription) to change the colour or appearance of the eye

- refraction for the purposes of prescribing optical appliances;
- testing of binocular vision[4];
- prescribing prism lenses (including plano[5] prisms);
- carrying out 'pre-screening' tests prior to the sight test, including using an autorefractor;
- interpreting results of tests;
- supplying contact lenses;
- teaching patients how to insert, remove and care for contact lenses;
- supplying a different contact lens to that specified on the contact lens specification;
- contact lens review/aftercare appointments;
- supplying prescription spectacles;
- supplying 'ready-readers'[6];
- supplying bifocals/varifocals (with additional measurements);
- enhanced/community services;
- referring patients to secondary care;
- myopia management[7] advice and treatment;
- treatment for visual stress and behavioural optometry;
- triaging patients; and
- giving advice to patients.

36. In the responses to this section, ABDO provided detailed commentary regarding the need for paediatric dispensing to be restricted to registrants, i.e. that non-registrants should not be allowed to do this, even under the supervision of a registrant. They asked us to consider producing good practice guidance in this area, consider revising our standards to specifically mention

[4] The ability to maintain visual focus on an object with both eyes, creating a single visual image https://www.moorfields.nhs.uk/faq/eye-conditions
[5] Lenses that provide no corrective focusing power
[6] Ready-made reading spectacles are available without a prescription, each lens of which has spherical surfaces and is of a positive power not exceeding five dioptres
[7] Myopia management is an intervention to slow down the progression of myopia (short-sightedness), normally through use of spectacles, contact lenses or eye drops

paediatric dispensing and called for further research into the quality of paediatric dispensing.

37. They made arguments for preventing non-registrants from providing advice on or carrying out treatment for myopia management. They also made a case for restricting non-registrants from dispensing to vulnerable groups (as did the AOP), which is explored further in section 6. Recognising that legislative change could take some time, they suggested we revise our standards "to make clear the need for specialist expertise in relation to dispensing spectacles to patient groups that may be described as vulnerable and giving advice and treatment in relation to myopia management and the importance of registrants operating within their individual scopes of practice".

38. A sample of comments is available in the box below.

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

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

"The current balance of protections and restrictions works well, and these should remain as they are… we see no evidence-based reason to require any change to the existing framework…

During our engagement events, some stakeholders expressed frustration with NHS commissioning standards in England and felt that the Opticians Act could be amended to compel NHS England to improve standards of commissioning. We find no evidence to support this approach and feel that any changes to the Opticians Act to try and force NHS England to commission differently would be unsuccessful, increase the risk of unintended consequences, and be inconsistent with the GOC objectives in section one." FODO

"The Act currently protects the public from unregistered persons who are not bound by the GOC standards, by protecting both title and function. We believe that the current restrictions on the activity of non-registrants should remain for the benefit of the public. This protection ensures all people receive safe and appropriate care, maintain good eye health and avoid preventable sight loss…" The College of Optometrists

"We see no case for change from the present restrictions. The current system protects patient and public safety without setting unnecessary barriers to effective primary eye care provision. All registrants should work within their scope of

practice and although this may evolve over time, the Act does not and has not prevented that from happening..." LOCSU

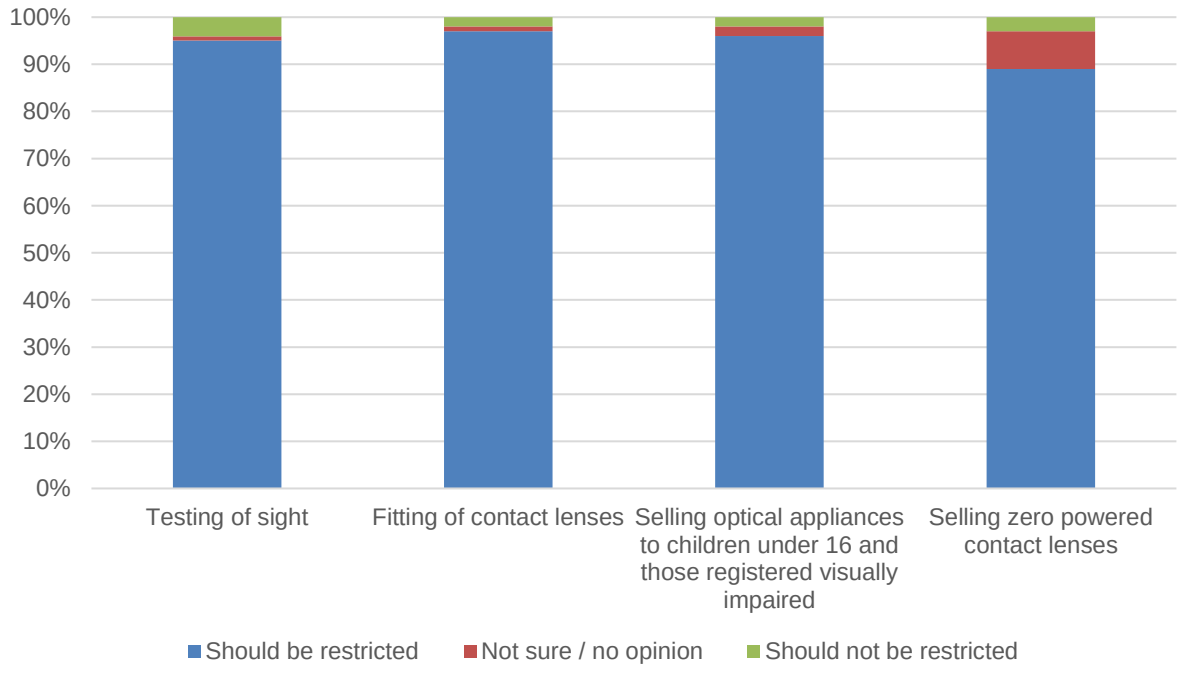
Continuation of existing restricted activities

39. We asked stakeholders what their views were about continuing to restrict/prevent non-registrants from carrying out the following activities:

    - testing of sight;
    - fitting of contact lenses;
    - selling optical appliances to children under 16 and those registered visually impaired; and
    - selling zero powered contact lenses.

40. Graph 2 shows that for the first three categories mentioned above, more than 95% of respondents who answered the questions felt that these categories should be restricted. There was slightly more variation in relation to selling zero powered contact lenses, with 89% of respondents answering that this should be restricted and a slightly higher percentage of respondents being unsure or having no opinion (8%). There was little variation between categories of respondent.

Graph 2: What are your views about continuing to restrict/prevent non-registrants from carrying out the following activities?
Base: 343-345 respondents



Additional restricted activities

41. We asked stakeholders whether there were any additional activities they thought should be restricted to registrants. No additional activities were identified that had not already been mentioned in response to the question around what activities non-registrants should be restricted/prevented from doing (at the beginning of section 2).

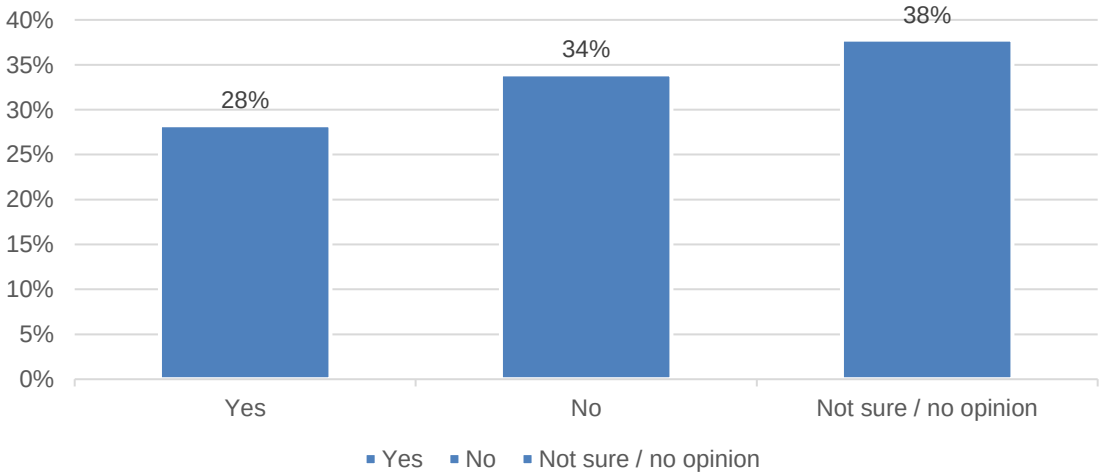
42. The College of Optometrists considered that we might need to provide additional clarity in the Act to ensure a) it is clear that the testing of sight remotely and the testing of sight by automated means (in person or virtual) must be restricted to UK-based registrants or registered medical practitioners, and b) that the supply of optical appliances from non-UK jurisdictions must be prevented or provided under the supervision of a UK-based registrant or registered medical practitioner. (We have responded to these points at the end of this section.)

Post-registration skills, qualifications or training

43. We asked stakeholders whether there was 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).

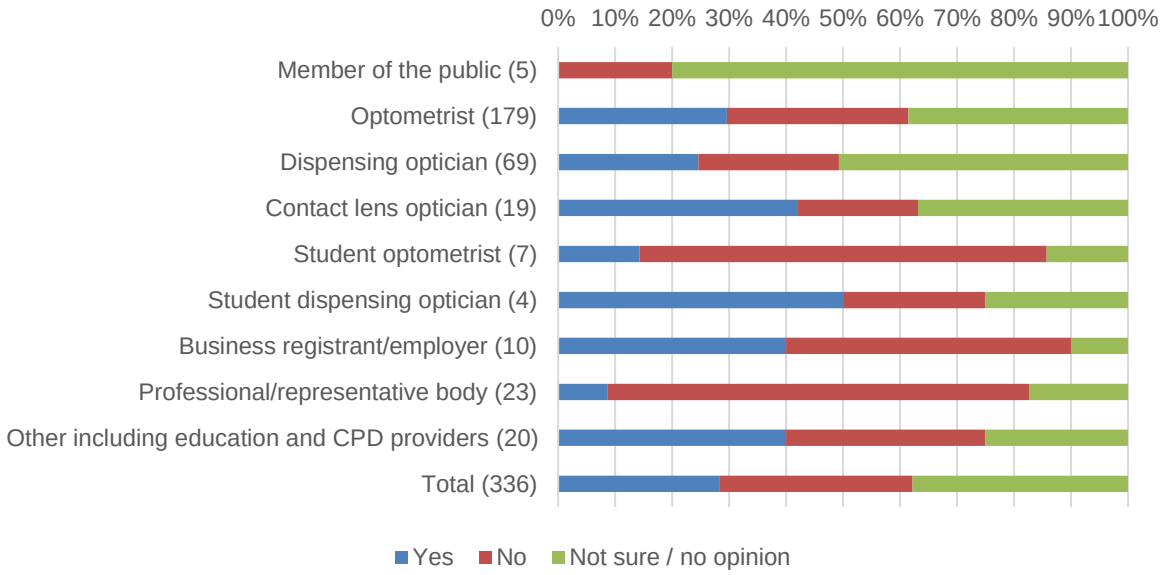
44. Of the 336 respondents that answered the question, graph 3 shows that 34% did not think that there was any evidence, 28% felt that there was evidence and 38% were not sure or had no opinion.

Graph 3: 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)?
Base: 336



45. Graph 4 shows that professional/representative bodies and student optometrists were more likely to answer no to this question than other categories of respondent.

Graph 4: 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)?
By category of respondent



46. Those who thought that we should approve or accredit further qualifications commented on changing professional roles and the specialist expertise needed in advanced areas of practice (Masters level or equivalent) and that regulation would improve public safety and reassure the public. Inconsistencies were highlighted where the GOC approves some specialist qualifications but not others. Another argument was that it would support a strategic and coordinated sector approach to training as part of a stronger focus on upstream regulation which prevents harm from occurring in the first place.

47. Separately, it was also argued that the GOC should have the ability to add new qualifications as time progresses in areas like technology.

48. Suggestions for further qualifications/services that should be approved or accredited by the GOC included:

- refraction qualification for dispensing opticians;
- glaucoma management/refinement;
- medical retina monitoring;
- macular degeneration referral filtering and monitoring;

- myopia control;
- emergency eye care;
- minor eye conditions (such as the Minor Eye Conditions Service (MECS) or Community Urgent Eyecare Services or COVID-19 Urgent Eyecare Service (CUES)) such as dry or red eyes, discomfort or pain;
- children's services;
- low vision services;
- clinical imaging, including interpretation of results;
- behavioural optometry / visual stress testing;
- therapeutic laser therapy;
- consultations and aftercare for refractive laser surgery; and
- all postgraduate qualifications.

49. Those not in favour of the GOC approving or accrediting further qualifications made the following points:

- there is no evidence to support this change and existing controls are sufficient to mitigate the risks. These controls include the existing CPD system and GOC's standards for registrants (e.g. recognise and work within the limits of your scope of practice);
- concern this would lead to the need for further CPD requirements for registrants (in the same way that the current specialty registers do);
- other healthcare regulators do not accredit postgraduate qualifications, so this would make the GOC an outlier;
- concern about possible unintended consequences including negative impact on service commissioning, delivery and patient access (as people would assume existing accreditation is not sufficient), which could lead to slowing down or reducing commissioning altogether; and
- some evidence was presented about the success of existing schemes in the community requiring postgraduate qualifications[8], presented in the context of the GOC not needing to accredit those qualifications.

[8] Gunn, P.J.G. et al (2019). Clinical effectiveness of the Manchester Glaucoma Enhanced Referral Scheme. *Br J Ophthalmol*. 2019 Aug; 103(8):1,066-1,071

50. Although not within the remit of the question, many commented in the context of the GOC's new education and training requirements that the four-year optometry degree course should provide all the skills required for a modern optometrist including glaucoma, medical retina management and prescribing.

51. Some commented that the GOC register could better support patient choice by giving information about additional qualifications and that it could assist with decisions on commissioning services in specific geographical areas.

52. A sample of comments is available in the box below.

"There could be value in having specialist post-registration qualifications or training for treating dry eyes. There are an increasing number of specialist dry eye clinics without any specialist expertise in how to treat dry eyes appropriately. It's important that any specialist public health service has professionals with the right qualifications and training to ensure the best quality of care for patients.

Additionally, introducing standard qualifications for low vision or extended roles specialising in glaucoma, AMD [age-related macular degeneration] *or similar could further improve consistency and quality of care. We would also be supportive of other additional qualifications being introduced if it could further improve the quality of care provision."* RNIB

"Currently the addition qualification skills are enough, but this should be expanded as technology and knowledge advances (eg skills in detecting pathology using new technology)" Local optical committee

"…We have concerns about the possible thinking behind this proposal. While we recognise that the Act does not legislate the scope and delivery of NHS General Ophthalmic Services (GOS) or NHS extended primary eyecare services, this proposal if enacted would likely impact on service commissioning, delivery and patient access to relevant services… The consequence of this proposal would be that commissioners and potentially patients would likely infer that the current mix of registrant core competencies and legislated post-qualification skills are insufficient for service delivery… We urge the GOC to very carefully consider the wider ramifications of this proposal and unintended consequences to national objectives." LOCSU

"…We do not think there is evidence that GOC accreditation or approval of additional post-registration qualifications or training is necessary. It is unclear from the call for evidence what kind of process the GOC would use to accredit additional qualifications. We are not aware of other healthcare professional regulators, such as the General Medical Council (GMC), undertaking accreditation of additional post-registration qualifications. Were any such accreditation process to be introduced, it would need to be properly resourced, structured and

implemented by the GOC, and we think there would be risks of the process not working properly or creating unintended problems…" AOP

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

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

"The professional bodies for optometry and dispensing optics – The College of Optometrists and The Association of British Dispensing Opticians (ABDO) – are best placed to define and accredit qualifications that enable registrants to acquire new knowledge, skills and recognised qualifications. Registrants should be supported to develop and evolve their scope of practice and training autonomously, but within the high-level oversight and governance of the GOC's Standards of Practice…" The College of Optometrists

"NHS Wales is utilising optometrists with additional post graduate qualifications in medical retina, glaucoma and Independent Prescribing…The GOC only accredit/approve Independent Prescribing; however, it is not clear why the other post-graduate qualifications led by the College of Optometrists are not approved/accredited. It is also not clear what the GOC criteria is to accredit/approve. Optometrists must be able to develop their clinical skills without unnecessary barriers/bureaucracy, therefore consideration should be given to ensure that the GOC and College of Optometrists are aligned in their post-graduate programme to ensure quality standards. This is important due to the additional clinical pathways delivered in Wales but increasingly important to enable the rest of the UK to evolve." Welsh Government

GOC response – restricted activities

53. Our view is that the current activities restricted to optometrists and dispensing opticians (and registered medical practitioners) should remain so.

54. We note the comments regarding dispensing to vulnerable groups and respond in section 6 of this document. In summary, for reasons of insufficient evidence of harm and difficulty of practical implementation, we do not consider these activities should be restricted. As suggested by ABDO, where such services are provided by registrants, issues may be addressed by amending our standards, and we will consider this as part of our current review of the standards. ABDO also asked us to produce good practice guidance on paediatric dispensing.

Producing good practice guidance falls outside the scope of the call for evidence and we will discuss the issues further with ABDO.

55. As set out in the introduction, the roles of optometrists and dispensing opticians are developing to realise their full professional capability. This includes enhanced clinical roles that until recently were carried out in hospitals but are now increasingly available in primary care settings. Given the inherent risks to patient safety and the expertise needed to perform these roles, we see a case in principle to add these services to the list of restricted activities. Balanced against this, NHS commissioners perform an important quality assurance role – although there is scope for a private market to develop in England. Further, the GOC's standards apply to all services performed by registrants, not just the restricted activities, offering a measure of existing protection. There may also be challenges in defining the scope of these additional activities in legislation.

56. On balance, we do not consider the evidence is strong enough to justify restricting these activities now but see the conditions could change over time. Given the rapidly changing landscape and that opportunities to amend legislation are rare, it is important for our legislation to have in-built flexibility to adapt to future developments. Therefore, we will discuss with DHSC the possibility of a statutory mechanism for the GOC to make recommendations to the Secretary of State to add or remove from the list of restricted activities without the need for primary legislation. Should this proposal gain traction, we would consult on how such a mechanism would work in practice.

57. We note The College of Optometrists' comment that we might need to provide additional clarity in the Act to ensure that the testing of sight remotely and the testing of sight by automated means (in person or virtual) must be restricted to UK-based registrants or registered medical practitioners. We do not consider there to be a need to clarify the Act because:

    - the testing of sight is already restricted to optometrists and registered medical practitioners regardless of the methods used; and

    - since our regulatory jurisdiction extends beyond the UK (i.e. all our registrants irrespective of the country in which they are based are bound by our standards) it would not be appropriate to restrict testing to UK-based registrants.

58. We also note The College of Optometrists' comment that we might need to provide additional clarity in the Act to ensure that the supply of optical appliances from non-UK jurisdictions must be prevented or provided under the supervision of a UK-based registrant or registered medical practitioner. We do not consider that this is a point of clarity – rather, it would be a change in the Act that we would need to discuss with DHSC and provide evidence to justify the need for. We provide further commentary on the sale and supply of optical

appliances from overseas jurisdictions in paragraphs 311 to 314 of this document.

GOC response – post-registration qualifications and annotations on the register

59. The issues of restricted activities, approval or accreditation of post-registration qualifications and annotations on the register are closely linked. Like other healthcare regulators, our scope to approve post-registration qualifications in future will be determined by the outcome of the DHSC-led legislative reforms. We understand DHSC's policy intent is for regulators to continue to have the power to approve post-registration qualifications and to include such information on their registers as they see fit.

60. While responses indicate a shared aim for a system that supports registrants to reach their full professional capabilities and meet the public's eye care needs, views were mixed about whether the GOC should approve or accredit any further post-registration qualifications. Currently, we do not intend to approve or accredit further post-registration qualifications, although we see scope in the changing landscape for a more strategic, coordinated sector-wide approach. Should the GOC revisit this issue we will take account of stakeholder views and any proposals to accredit or approve additional post-registration qualifications would be subject to public consultation.

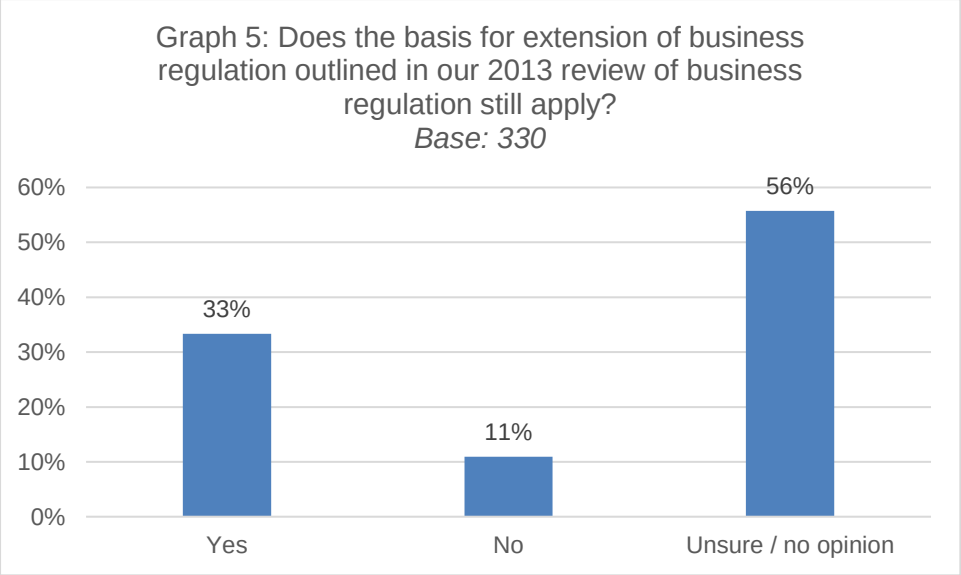
Section 3: Regulation of businesses (sections 9 and 28 of the Act)

61. The legislation around GOC business regulation is complex and does not currently provide for a clear and consistent system of regulation for optical businesses. In summary, the Act only allows us to register bodies corporate and only then if they meet certain eligibility requirements. Some bodies corporate must register and others can only do so if they change their structure. Further information can be found in section 3 of our call for evidence.

Extension of business regulation

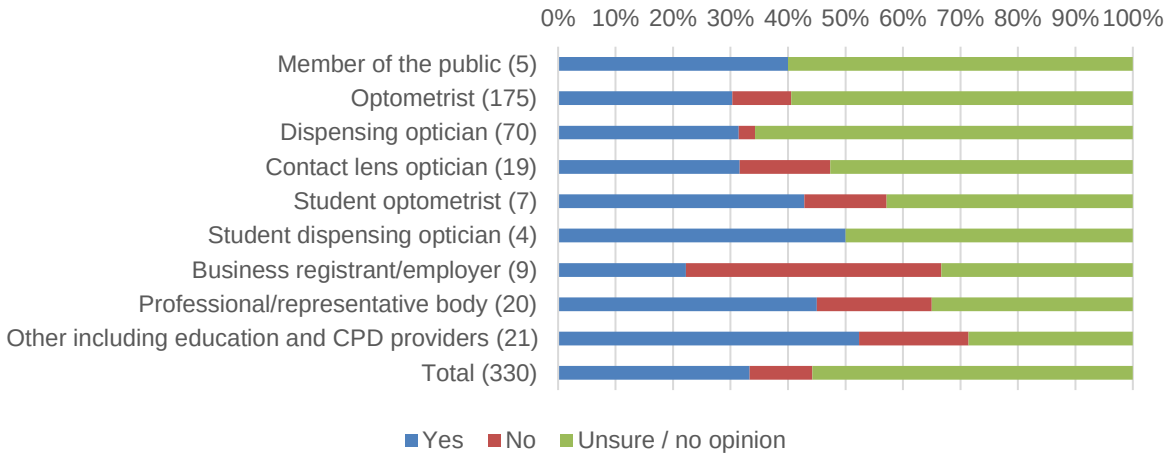
62. We asked stakeholders whether they thought the basis for extension of business regulation outlined in our 2013 review of business regulation still applied.

63. Of the 330 respondents who answered the question, 33% thought that the basis for extension of business regulation still applied, 11% thought that it didn't and 56% were unsure or had no opinion.



64. Graph 6 shows that business registrants/employers were significantly more likely than other categories of respondent to think that the basis of extending business regulation did not apply (although it should be noted that the base number is small).

Graph 6: Does the basis for extension of business regulation outlined in our 2013 review of business regulation still apply?
By category of respondent
Base: 330



65. The main themes that arose from the comments were:

- at the moment the system is complex, unequal and confusing to patients and the public as it's unclear why some businesses have to register with the GOC and others do not;
- there is support for a level playing field i.e. with all businesses carrying out restricted functions being required to register with the GOC. This would help ensure that all businesses adhere to the same regulatory standards set by the GOC which will help improve patient experience and patient care;
- business regulation should be extended to all businesses carrying out restricted functions because the patient experience is not just dependent on the individual providing the care but also the clinical environment in which care is delivered. This includes the premises, the equipment, internal business policies such as referral policies, record keeping, internal audit, pay incentives, and training and oversight of staff including unregulated staff and staff working under the supervision of a GOC registrant (including pre-registration placements undertaken by GOC registered optical students);
- since 2013 the growth of the internet is likely to mean the unregulated sector has also grown. The range of providers and the scope of services they offer is expanding, including remote optical care. Regulation needs to keep pace with these changes and should cover online businesses selling contact lenses and spectacles as this is where the greatest risks lie;

- the 2013 GOC statement on business regulation does not consider the transformation of eye care in terms of more remote care for patients and the introduction of new technologies. These factors are likely to increase the risk profile of optical care and it is important for all businesses providing these services to be registered with the GOC;
- business regulation and regulatory standards may help deter businesses from putting profits ahead of patient care;
- it is not always appropriate to hold an individual registrant to account but the business itself, so it is important that all businesses are held accountable and are required to register with the GOC;
- the market is already effective at disciplining itself with patient choice providing a powerful incentive for providers to improve quality and choice. Based on turnover, the large amount of primary eye care is delivered by GOC registered businesses and this sets market norms. Businesses also have a strong incentive to maintain high standards to keep insurance premiums low; and
- current levels of fines are small related to industry turnover and for business regulation to be effective the GOC needs proper powers of sanction.

66. A sample of comments is available in the box below.

"The basis for the extension of business regulation as outlined in the GOC's (July 2013) Review of business regulation: consultation still applies; and we welcome the latest proposals to extend the regulation to register all businesses who provide legally restricted optical services in the UK. With the introduction of new technologies, remote consultations and optometrists increasing clinical work since 2013, there may now be additional reasons to regulate all businesses in a more consistent way." The College of Optometrists

"In summary, the evidence shows that current optical regulation is working effectively and is not in need of a major change. There are sufficiently good incentives in primary eye care under the Act to drive competition based on safety and quality. There is no policy problem which needs solving by adding new GOC powers or cost to business regulation. There might however be some additional benefits by requiring all businesses which provide restricted activities to register with the GOC to safeguard and strengthen the existing model which works well in patients' interests." FODO

"The AIO are of the opinion that regulation of businesses should be compulsory. It is necessary in order to regulate the actions of a practice when it may not be appropriate to hold a registrant practitioner to account." AIO

"There remains a strong case for reforming business regulation. The increasing role of high street providers of health and care services and the growing importance of large corporate bodies and multi-nationals has raised a range of issues which current legislation may not be fully equipped to respond to. The current system for regulating optical business is complex, piecemeal, and may not be fit for purpose." PSA

"My personal opinion is that GOC registration should be compulsory to all businesses conducting restricted procedures on their premises. In the same way as an Optometrist or Dispensing Optician must be registered to practice so the business should be registered and agree to the key principles of code of conduct for business. Protecting the autonomy of the practitioner is paramount to protecting patients." Optometrist

"The BCLA would welcome any mandatory extension of business regulation. Unregulated supply of contact lenses remains an issue - and therefore risks patient eye health. Online suppliers are a challenge to audit, therefore extending business registration to these businesses could be a way to improve this." BCLA

"The current situation is unfair and it seems likely that businesses who are most in need of regulation avoid meeting the requirements for business registration so that can be essentially unregulated. I support the view that all UK businesses providing eye care services and/or supplying spectacles or contact lenses should have to be registered." Optometrist

"In my view it is important that any businesses providing optical services and/or appliances to the general public are registered with the GOC and meet the appropriate requirements that allow them to do so. Route to registration and regulation for business should be uniformed but robust and with strict criteria around compliance with current GOC regulation." Dispensing optician

Advantages, disadvantages and impacts of extending business regulation

67. We asked stakeholders whether there were 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. No new points were made that had not already been raised above or in the previous consultation, other than in relation to ownership restrictions.

Ownership restrictions

68. The current GOC requirements for business registration were considered to be potentially onerous, particularly in relation to the requirement that a majority of directors of a GOC registered business must be GOC registrants.

69. Arguments in favour of removing this requirement included:

- it allows businesses to avoid regulation;
- it is not reflective of many current business models;
- it is a barrier to small providers becoming regulated since they cannot fund sufficient individuals to meet the requirement; and
- alternative models could ensure standards without the requirement (e.g. a nominated person with overall responsibility for compliance).

70. Arguments in favour of retaining the current requirement included:

- a concern that non-clinical staff owning businesses has compromised standards of care due to a focus on commercial imperatives; and
- standards are already ensured since smaller providers comply with the GOC standards by virtue of their owners being individual registrants and/or employing individual registrants.

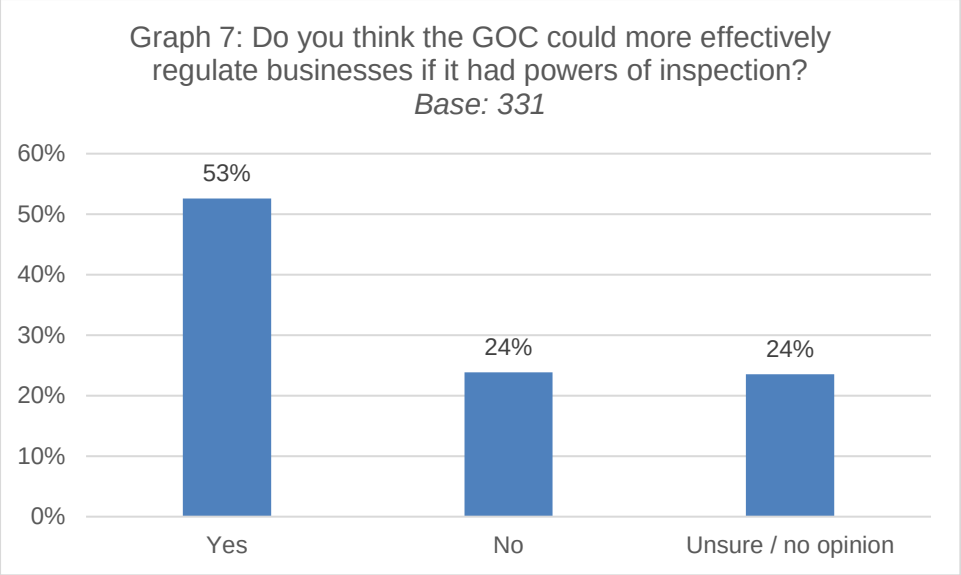
71. A sample of comments is available in the box below.

> *"We recognise the important role which registrant directors play in promoting high standards, but we think there would be value in reviewing whether it is proportionate to require a majority of registrant directors. This can lead to difficulties, including creating a barrier to business registration, encouraging businesses to have a single director and adding to administrative costs."* ABDO
>
> *"The restriction to have a majority of directors as GOC registrants to register as a body corporate doesn't reflect many current business models, and therefore allows them to slip through the net of GOC business standards, to a certain extent. To ensure the Act reflects changes in business ownership structure this, needs to change to encompass any business that sells prescription optical appliances, and to ensure public safety."* Dispensing optician

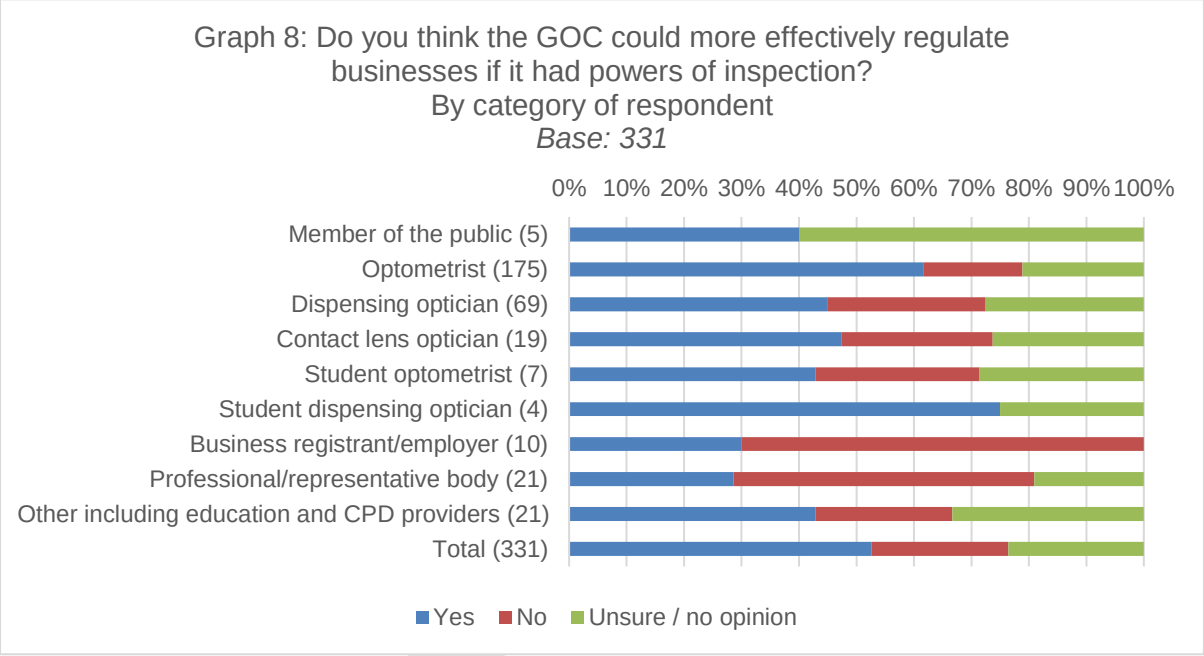
Inspection powers

72. We asked stakeholders if they thought that the GOC could more effectively regulate businesses if it had powers of inspection.

73. Of the 331 respondents who answered the question, 53% thought that the GOC could more effectively regulate businesses if it had powers of inspection, 24% thought that it couldn't and 24% were unsure or had no opinion.



74. Graph 8 shows that business registrants/employers and professional/representative bodies were significantly less likely than other categories of respondent to consider that the GOC could more effectively regulate businesses if it had powers of inspection.



75. The main themes that arose in support of inspection powers were:

- it could help ensure that GOC regulatory standards are complied with and effectively implemented which would help improve the quality of patient care and boost public confidence in optical services, for example, it could help prevent businesses from poor internal practices such as lack of / ineffective internal audit and record keeping;

- it could help ensure company sales and profit margins are not at the expense of patient care, for example, by helping to mitigate against poor clinical practice such as inadequate time limits for sight tests and unrealistic targets for the amount of sight tests conducted in a day;
- it could facilitate the transfer of care from the secondary to the primary care sector since secondary clinicians would have more confidence about standards of care optometrists and dispensing opticians could provide; and
- it would fill the gaps and inconsistencies in the current inspection regime.

76. The main themes that arose against the GOC having inspection powers were:

- the GOC must provide evidence that an inspection regime is a proportionate response to the level of risk it is seeking to manage;
- it is unclear where the evidence is to support any increase in regulatory powers and it was noted that there is a difference in risk between the regulation of pharmacy premises and optical premises;
- the Europe Economics research report (that the GOC commissioned in 2013) did not recommend introducing inspections and it is unclear why the GOC is now suggesting this approach without providing any evidence of risk or increased risk since 2013;
- the powers the GOC currently has are proportionate for the sector it regulates;
- since 2013 the GOC has effectively increased business regulation via its enhanced Standards for Optical Businesses, so further powers are not necessary;
- an inspection regime would result in increased costs for registrants which would be passed onto the public and patients;
- the cost and administrative burden on small businesses would be disproportionate and unfair;
- concern about how GOC inspections would fit with other inspection and contractual arrangements without duplicating or overlapping with regimes already in place or planned within the UK, particularly where General Ophthalmic Services (GOS) are commissioned; and
- the GOC could have more proactive powers to investigate potential breaches of regulatory standards that are raised, for example, via whistleblowing.

77. A sample of comments is available in the box below.

"GOC needs to inspect to ensure business profits are not put before patient safety." Dispensing optician

"Businesses should have more responsibility to have appropriately trained non-registered staff and I feel that the expectation of being inspected would instil a need to ensure that appropriate training is carried out." Dispensing optician

"While we would support certain powers of inspection in principle, we would welcome more details about the GOC's intention before being able to comment. We need to understand what the purpose of these inspections would be and how they would fit with the current inspections of GOS contract holders carried out by national health services, and to assess the benefits of these inspections to patients and practice." The College of Optometrists

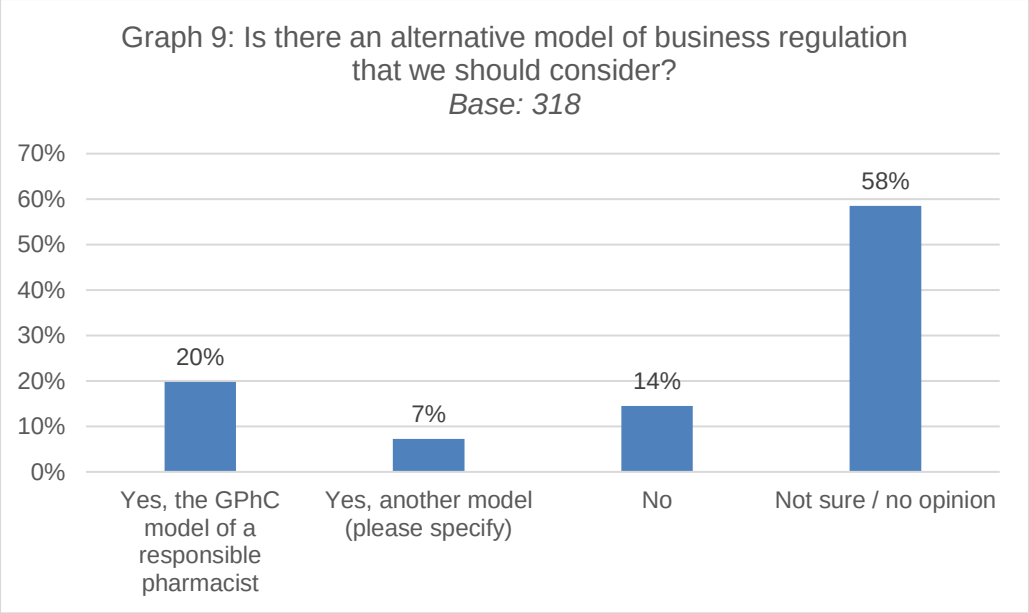
"We recognise how giving the GOC inspection powers could allow the GOC to assure itself that businesses are meeting its standards. However, we believe the use of inspection powers would place burdens on the sector that are likely to be disproportionate to the risks posed to the public and patients. In fact, a burdensome inspection regime could impair the ability of practices to deliver care services. The effectiveness of inspection regimes has been called into question several times in recent years when organisations which passed inspections were nonetheless found to be operating unsafely. Mid Staffordshire NHS hospital trust is the most notable example of this..." AOP

"In Scotland, a designated optometrist inspects every practice every 3 years to ensure NHS standards are met. Any GOC inspection would be unlikely to have different findings and as such they should utilise their resources doing other things rather than duplicating the work of others." Optometrist

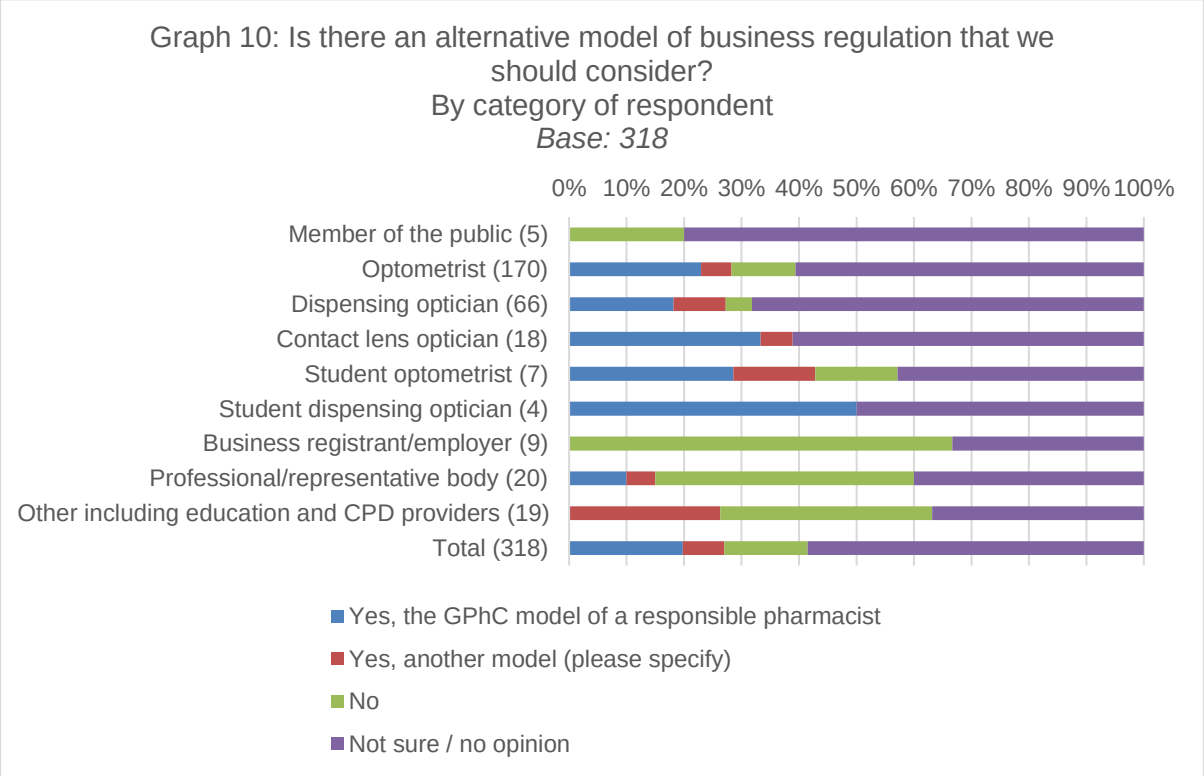
Alternative models of business regulation

78. We asked stakeholders if there was an alternative model of business regulation that they thought we should consider.

79. Of the 318 respondents who answered the question, 20% thought that the GPhC model of a responsible pharmacist should be considered, 7% thought another model should be considered, 14% thought that no other model should be considered and 58% were not sure or had no opinion.



80. Graph 10 shows that business registrants/employers, professional/representative bodies and other including education and CPD providers were more likely than other categories of respondent to conclude that an alternative model of business regulation should not be considered.



81. The main themes that arose in respect of different models of regulation were:

- not enough is known about the GPhC model of business regulation to give a view on whether it would be appropriate;

- an advantage of the GPhC model is that it would help increase accountability as one person would take overall responsibility for the business;
- there were concerns about whether the 'responsible pharmacist' model would work in our sector (i.e. a "responsible pharmacist" is a registered pharmacist who is appointed by the business to secure the safe and effective running of the pharmacy):
    - there were doubts about one person taking overall responsibility for the business, for example, an optometrist spends the vast majority of the day in a closed room so how could they effectively oversee the staff and business;
    - if responsibility rested with a GOC registrant (as the responsible officer), this could remove any liability from the non-registered business owner;
    - optical businesses differ to pharmacies as they are often a lot bigger in terms of the amount of staff they employ, and they employ staff who are not regulated, such as optical assistants. This could deter GOC registrants from taking on a role as the responsible officer as there may be an increased risk in overseeing a high number of staff who are not regulated and are not required to have any formal qualifications but who are involved in delivering patient care;
    - there would be a financial impact particularly for small businesses if there needed to be a responsible officer on the premises at all times; and
    - the GOC should not assume that the GPhC model of business regulation is without flaws and can be easily replicated in optometry;
- the Care Quality Commission (CQC) model was another recognised model of regulation applying to dentists and pharmacists. There was little detail given on how this might work or be adapted to the optical sector;
- other models of care that were less well known but nonetheless mentioned as an alternative were the Ofsted model and models in countries such as The Netherlands, the United States of America, New Zealand and in Europe; and
- the GOC should provide other models of business regulation that are evidenced based and appropriate for the sector.

82. A sample of comments is available in the box below.

"Whilst there are examples of optometrists in large practices taking on a supervisory role with confidence, we believe that the "responsible optometrist" concept could deflect responsibility for quality from the business owners – who set the organisational policies, procedures and culture. This could mean that individual registrants become scapegoats for problems caused by matters beyond their control. At this point in time, we are not clear what alternative model of business regulation would be appropriate for the profession." AOP

"We do not believe that the responsible registrant model would be appropriate or applicable to optometry in the same way that it works in pharmacy settings, as the operational nature and business model of pharmacy is different to that of optometry. For example, although pharmacy colleagues are supervised by the responsible registrant, there isn't formal delegation of clinical roles as there is in optometry. It is also far more common for community pharmacists to operate alone, or with just one other pharmacist in the pharmacy." The College of Optometrists

"As explained above, the evidence shows that the current regulatory regime works well. We think it is unhelpful to frame the GPhC model of responsible pharmacist in this way. We understand the GOC might have an interest in this model (paragraph 29), but it is not clear how The Medicines Act 1968: The Personal Control Requirement, the Health Act 2006, and the subsequent Department of Health consultations, read across to eye care regulation.

We have been unable to find evidence to support replicating the pharmacy model in primary eye care settings, as the risk profiles of the professions are not comparable in context. This non-comparison in risk profile is strongly supported by our members who also provide pharmacy services." FODO

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

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

GOC response – regulation of businesses

83. We welcome the broad stakeholder support for extending regulation to all businesses carrying out restricted functions. We think regulation should apply to all such businesses regardless of their name, corporate structure or who owns and manages them. Referencing our proposed statutory objectives, we consider this is necessary to both deliver patient safety and protect consumers.

84. A lot more work is needed to determine an appropriate model of regulation. This will need to be developed in depth ahead of any further consultation, including the issues relating to business and ownership structures, regulatory supervision (including assessing the effectiveness and cost of any potential assurance or compliance activity), enforcement approach and sanctions, access to consumer redress and registration fees charged to optical businesses.

85. Changes to business regulation may need to take account of the changing commissioning and provider landscape in England. For example, where prime provider companies act as the contracting vehicle between NHS commissioners and optical/optometry practices to provide a range of locally enhanced or extended eye health services beyond the sight test. These can include pre- and post-operative cataract services, glaucoma filtering, and urgent and minor eye conditions services. While care is delivered by registrants, sub-contractual and clinical governance requirements are agreed between the prime provider company and individual practices. We note that some prime provider companies may be registered with the Care Quality Commission (CQC) where the care being delivered extends into post-referral management, monitoring and treatment.

86. We continue to see merit in a system where named individuals have specific responsibilities within a wider system of regulation that demands accountability on individual professionals and businesses. This would promote effective leadership and culture in the context where business-level systems impact on patient safety. We need to identify the best model to achieve this aim reflecting the specific needs and characteristics of our sector. We note points about the benefits and drawbacks of different elements of the GPhC model and will consider this and similar models operating outside of the healthcare sector.

87. The GOC needs the right combination of tools to ensure that businesses are complying with our standards. As we develop a draft framework for business regulation, we will consider models of assurance in broad terms by exploring tools commonly used by regulators in other sectors, such as thematic reviews. We will not duplicate existing inspection regimes, although note that NHS-led inspections are not designed to cover all GOC standards. At present, we do not consider a comprehensive programme of regular inspections is necessary, but we do consider there is a need for us to have assurance, compliance and information gathering powers to support investigation of specific concerns.

88. Following the closing date of the call for evidence, we commissioned research to update the evidence base and help us understand more about the business landscape that is beyond our current remit. The research is published on our website alongside this response document. The research:

- estimated that there were around 5,500 optical businesses in the UK, with around 2,600 of these not regulated by the GOC;
- found that while the risks associated with optical businesses were low, there were “potential areas where risks could undermine patient care and outcomes”, with the key to addressing these risks being “the consistent application of GOC regulation and oversight”; the potential risks identified were:
    - the absence of formal clinical governance within businesses at the same time as an increasing scope of practice for practitioners;
    - growing/future risk areas such as remote care or the use of new technology;
    - gaps in regulatory oversight for online businesses such as the online supply of contact lenses; and
    - the management and oversight of locum practitioners; and
- examined a range of possible regulatory models (all of which centred on extending business regulation to all businesses providing restricted functions) and estimated one-off and ongoing costs for implementing these models, both for businesses and the GOC.

89. This research will help us to consider next steps in extending business regulation and estimating the scale of the number of businesses that will fall within our remit should there be a change in legislation. As outlined above, there will be further consultation before any changes are made.

90. We recognise that legislative change will take some time and we are considering whether there are ways of bringing more businesses within our remit without a change in legislation but using other regulatory levers. For example, we could consider whether it would be appropriate to amend our Standards of Practice for Optometrists and Dispensing Opticians to require any individual responsible for owning or managing a business to ensure that they also comply with the Standards for Optical Businesses.

Section 4: Testing of sight (sections 24 and 26 of the Act)

91. Restrictions in relation to testing of sight are set out in section 24 of the Act, and only optometrists or registered medical practitioners can test sight (with special provision for students). Our 2013 statement on testing of sight sets out that no part of the sight test can be delegated to a dispensing optician or contact lens optician, even under supervision. However, aspects of sight testing can be undertaken by others for purposes other than the sight test, for example, dispensing opticians undertaking refraction[9] to check accuracy of lenses, or optical assistants completing triage checks prior to the sight test. We have heard from some stakeholders that the Act and/or GOC policy is too prescriptive, for example, in terms of who can carry out a sight test and how this must be done, particularly as the roles of optometrists and dispensing opticians have evolved and expanded over the last few years, along with increasing pressures in ophthalmology departments. Further information can be found in section 4 of our call for evidence.

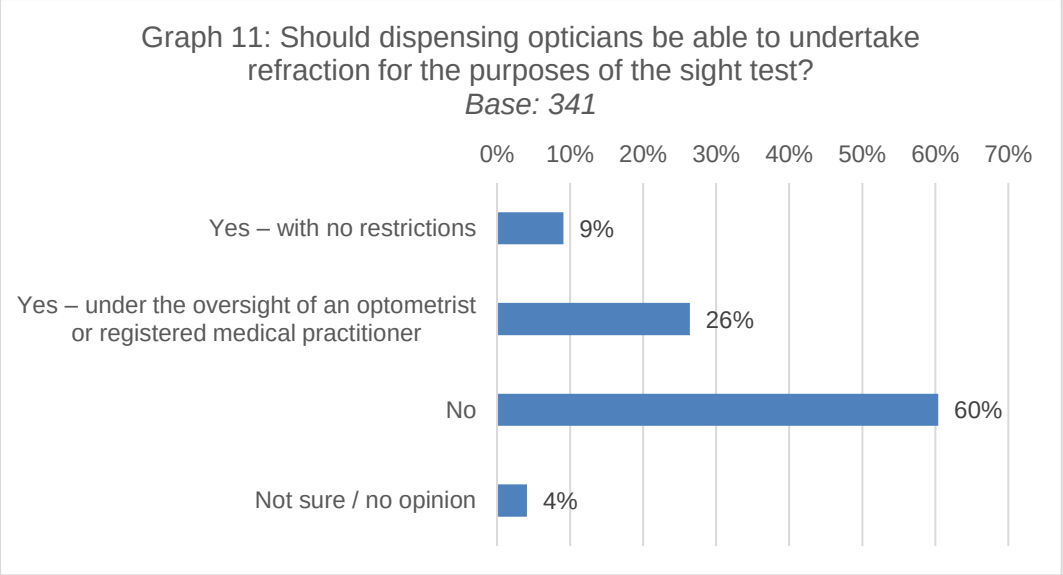
Consultation: refraction by dispensing opticians

Refraction by dispensing opticians for the purposes of the sight test

92. We asked stakeholders whether dispensing opticians should be able to undertake refraction for the purposes of the sight test, giving two options if they thought that dispensing opticians should be able to refract – one being with no restrictions and the other under the oversight of an optometrist or registered medical practitioner.

93. Of the 341 respondents that answered the question, 60% answered no, 26% answered that dispensing opticians should be able to refract for the purposes of the sight test under the oversight of an optometrist or registered medical practitioner, 9% answered that dispensing opticians should be able to refract without any restrictions and 4% were not sure or had no opinion.

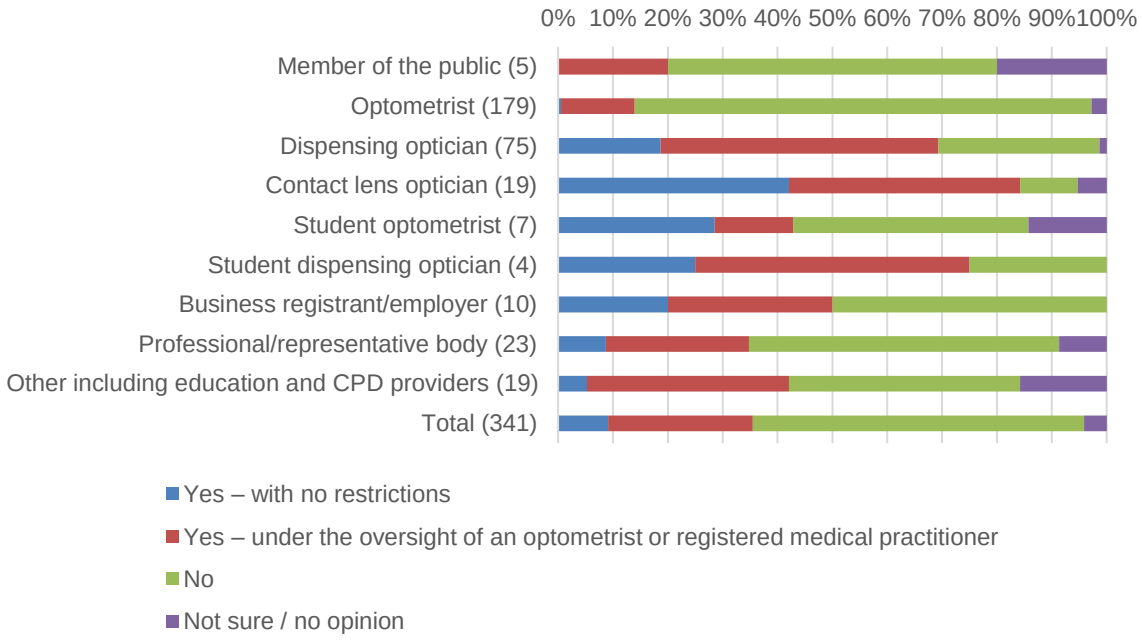
[9] Refraction as part of the sight test refers to a check of the patient's visual acuity i.e. how well they can see, and whether any corrective measures such as spectacles or contact lenses are required



94. Although FODO answered 'no' to the question of whether dispensing opticians should be able to undertake refraction for the purposes of the sight test, they went on to clarify that they would be supportive of us amending the 2013 statement on testing of sight to allow an optometrist or registered medical practitioner to work within a multidisciplinary team to test sight and meet patient needs in a safe and effective way that is consistent with the Act.

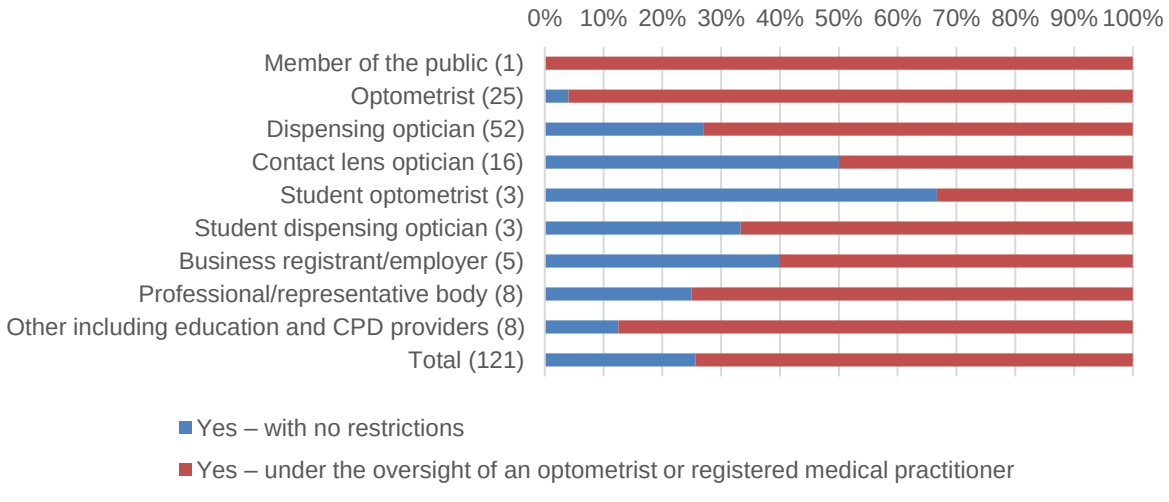
95. Graph 12 shows the responses broken down by category of respondent. The vast majority of optometrists were not supportive of refraction by dispensing opticians (even under oversight). It was interesting to note that of the 69% of dispensing opticians who felt that dispensing opticians should be able to refract for the purposes of the sight test, almost three-quarters of these felt it should be under the oversight of an optometrist or registered medical practitioner.

Graph 12: Should dispensing opticians be able to undertake refraction for the purposes of the sight test?
By category
Base: 341



96. Graph 13 shows those respondents who answered yes to whether dispensing opticians should be able to refract, with over 70% of respondents in most categories arguing that this should be under the oversight of an optometrist or registered medical practitioner, with the exceptions being contact lens opticians, student optometrists, student dispensing opticians and business registrants/employers.

Graph 13: Should dispensing opticians be able to undertake refraction for the purposes of the sight test?
'Yes' responses by category
Base: 121



Arguments in favour of refraction by dispensing opticians for the purposes of the sight test

97. The following themes were identified from the comments received in support of refraction by dispensing opticians and those who noted the advantages and positive impacts of amending or removing our 2013 statement on refraction so that dispensing opticians could refract for the purposes of the sight test:

- it would free up optometrists to deliver more medical ophthalmic care, provide additional services and/or see more patients, thereby easing the pressure on hospital eye services;
- support for a multidisciplinary team approach to patient care where healthcare professionals work together under the oversight of an optometrist or registered medical practitioner in a safe and effective manner. This was positioned in the context of the evolution of professional roles, new delivery models including developments in technology and challenges around ensuring access to a wide range of services in all geographical areas;
- dispensing opticians are already trained in refraction and would know how to detect signs of disease;
- standalone refractions could be done in between full sight tests, supported by technology, which could aid earlier diagnosis of disease – this would give a better service to patients who only need a re-check of their vision following a recent sight test, have dispensing issues or who are seen regularly by hospital eye services;
- some of the functions of the sight test, sometimes knows as 'pre-screening' tests/checks, are already delegated (e.g. visual field tests, fundus photography, intraocular pressures, optical coherence tomography (OCT), auto-refraction);
- dispensing opticians could expand their scope of practice, advance their careers and/or achieve better salaries;
- support for refraction by dispensing opticians, conditional on a series of factors:
    - they were trained and under the supervision of an optometrist;
    - if the training includes how to detect possible signs of pathology; and
    - if the refraction and eye health checks are linked and not carried out separately;

- access to eye care could be improved (particularly in remote areas) by more refraction / sight test appointments becoming available to the public;
- reduced labour costs for businesses and reduced costs for patients, as dispensing opticians are cheaper to employ than optometrists; and
- enable patient care to be provided in a more flexible way rather than the current model.

98. A sample of comments is available in the box below.

"It is crucial that optometrists are freed up and empowered to deliver more of the medical ophthalmic care as part of the transformation of eye care services and the integration of primary eye care into the whole end to end eye care pathway. To do so they need to be able to devolve as many aspects of their lower risk activities or "non medical" activities to other colleagues. This is exactly what has happened in hospital as technicians, health care assistants, orthoptic assistants etc do more, to allow in-hospital nurses, orthoptists and optometrists deliver enhanced and extended roles which were traditionally only done by doctors. I would argue that you should consider whether there are activities which can also be done by other colleagues beyond dispensing opticians eg by other technicians." Consultant Ophthalmologist

"I have always worked in areas where a proportion of my patients would have their eye health examination privately from an ophthalmologist…and then visit a dispensing optician for dispensing. Many ophthalmologists would rather not refract and in this environment it would make sense for dispensing opticians to be able to refract and issue the prescription for the spectacles they supply..." Dispensing optician

"The DO is in an excellent position to accurately refract due to the nature of their training and expertise... By creating this opportunity under the supervision of an Optometrist a two tier sight test would be avoided which would be in the patient's best interest. We must avoid circumstances where patients forgot [forego] *vital regular eye health checks."* Business registrant/employer

"With refraction being able to be carried out by Dispensing opticians, practices in remote areas could run a clinic, with the DO in store and the optometrist in another location, remotely supervising the overall examination and with the ability to intervene and recommend further tests or referral as necessary. More frequent refraction only appointments (perhaps yearly?) would give our profession more opportunities to intervene early, if a patient's visual acuity or prescription changed markedly…" Business registrant/employer

"RCOphth supports a competency based approach to assessing which clinician or health professional should perform a specific task. Given dispensing opticians will already undertake refraction for purposes other than the sight test, we can

therefore see a case for amending the GOC's legislative approach to potentially allow dispensing opticians (under the oversight of an optometrist or registered medical practitioner) to undertake refraction for the sight test.

This could help increase workforce capacity (coupled with a broader workforce strategy across the entire eye care workforce to ensure we have the staff needed to meet patient demand), enabling optometrists greater ability to support more clinical activities…" Royal College of Ophthalmologists

"…A refraction carried out by a dispensing optician for the purposes of the sight test would be under the oversight of an optometrist or medical practitioner. Therefore, an optometrist or medical practitioner would still have overall responsibility for the sight test and patients would continue to benefit from an eye health examination at the same time as a refraction. This is a major strength of the UK's system of eye care and enables eye and wider health issues to be identified and addressed at an early stage in line with the wider health policy focus on prevention…

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

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

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

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

"…Clinical services are evolving at pace in Wales as described through the NHS Wales Future Approach for Optometry Services. These clinical pathways require optometrists to work at the top of their clinical licence, reducing demand upon specialist secondary eye care services. To enable this clinical shift in services, and reduce the demand for secondary care services, the roles of all members of the primary care MDT [multi-disciplinary team] *will need to evolve to ensure that demand for primary care services can continue to be met. This includes*

dispensing opticians refracting patients as part of the MDT. There should be no separation of the eye health aspect from the testing of sight to ensure patient safety. The oversight of the responsible optometrist provides the required clinical governance to the clinical pathways and this process enables better use of the full multidisciplinary team..." Welsh Government

"We…are of the view that the GOC's 2013 statement is factually accurate. We therefore see no merit in simple removal of the statement as this would create further confusion and result in the same questions which led to the 2013 statement being published in the first instance…we also see no case for changing the legislation.

Considering the GOC objectives and our engagement with members, we feel that the principles here which need to be acknowledged are that with population needs changing:

- *Optometrists and medical practitioners will increasingly need to work on a multidisciplinary team (MDT) basis if the country is to meet growing patient needs in a sustainable way*
- *Each member of an MDT will need to be appropriately trained, overseen and competent in any support they provide to an optometrist or medical practitioner who is performing a sight test*

In considering this, and having undertaken an extensive consultation both with members and other optical bodies, we feel the most proportionate approach, and one that is aligned with all GOC objectives for this call for evidence and consultation, would be to update the 2013 statement…" FODO

"It is correct that no element of the sight test (a restricted activity) can be delegated, however, there is no contradiction in simultaneously recognising that as in all areas of modern clinical practice, a multidisciplinary team will naturally support and assist the registrant in their work – and it is here that trained colleagues, including registered dispensing opticians, can assist. ...the practitioner (optometrist) should continue to retain responsibility as well as accountability for performing the sight test, but can be assisted in so doing. It would be in line with the stated objectives for regulatory reform, to encourage the use of the multidisciplinary team to assist in this way, and could be achieved by updating the 2013 statement and by encouraging the professional bodies to issue guidance in support." Optometry Northern Ireland

Arguments against refraction by dispensing opticians for the purposes of the sight test

99. The following themes were identified from the comments received against refraction by dispensing opticians and those who noted the disadvantages and negative impacts of amending or removing our 2013 statement on testing of

sight so that dispensing opticians could refract for the purposes of the sight test:

- concerns that the sight test would completely separate the refraction and eye health checks resulting in eye disease and/or other health conditions going undetected, which could ultimately lead to increased pressure on hospital eye services, delayed treatment, preventable sight loss and a further increase in health inequalities due to:
    - businesses deliberately abusing the process by separating the different parts;
    - people being discouraged from having a full eye examination, perhaps due to costs (particularly for those on low incomes) or because they do not understand the importance of an eye health examination;
    - patients being confused, believing they have had a full sight test and not attending a further eye health examination;
- optometrists gather information during the history taking and refraction which leads to further investigation in eye health checks or a different approach to the refraction – this could result in a lower quality sight test where things could be missed that might result in eye disease and/or other health conditions going undetected;
- concerns about the risks of 'delegating' parts of the sight test, with an example of the Honey Rose case where pre-screening tests/checks were delegated;
- it is not clear there is any evidence of a need/demand for dispensing opticians to refract for the purposes of sight testing (particularly as many optometrists already use technology to assist) or how this would benefit patient safety;
- different aspects of the sight test are interdependent on each other and could not be carried out effectively by different people, even if one of those was under the oversight of an optometrist or registered medical practitioner;
- dispensing opticians don't have the qualifications, training or experience to undertake refraction and/or to identify pathology as part of the refraction;
- dispensing opticians can already take advantage of conversion courses to become an optometrist;
- refraction by dispensing opticians will only benefit practice/business owners keeping labour costs down and won't benefit patients –

commercial interests could force fast refractions and eye health checks where things could be missed;

- money may be saved in one area but might ultimately lead to higher costs in another area (e.g. the time it takes for an optometrist to check the work of a dispensing optician could increase the workload of an optometrist);
- oversight of dispensing opticians by optometrists could increase the pressure on optometrists, which could lead to shorter and inadequate sight testing times for checking work of others, ultimately leading to reduced patient care;
- concerns about who would be ultimately responsible/liable for the refraction and whether an optometrist would be able to rely on the results of a refraction that they had not carried out themselves, again resulting in more pressure on optometrists;
- it could de-value and de-skill optometrists and result in lower salaries and less of a need for them;
- it could bring the professions into disrepute and/or risking public confidence through lowering of standards;
- patients with additional needs such as dementia, learning disabilities or social anxiety will struggle with two people carrying out different aspects of the sight test – it might discourage them from going at all; and
- patient care/experience would suffer as it would be more complex/disjointed and they would be confused about the different roles.

100. A sample of comments is available in the box below.

"This would discourage people from choosing to have a full eye examination, and hence allow disease to go undetected. We already see this in patients who present with advanced glaucoma in our glaucoma clinic - they have saved money by buying ready-readers, but it has cost them their sight." Optometrist

"There are many occasions where a refraction needs to be tailored due to ocular health or patient history and this can only be done effectively if this is all done by one individual." Optometrist

"A separation between refraction and eye examination can lead to lots of patients not getting what can be life saving eye examination in some cases. Vision and eye health are interlinked." Local optical committee

"…we do not believe it would be of benefit to the public and may risk causing confusion and lowering standards. Refraction is a fundamental part of the sight

test, but a sight test is clearly more than a refraction and should not on public protection grounds be split into its component parts…" Specsavers Optical Group

"We are concerned about vulnerable individuals who have additional needs for example people with dementia, glaucoma, kerataconus for whom refraction might be more complicated." Glaucoma UK

"…from a patient perspective, we envisage little to no benefit to patients by allowing dispensing opticians to refract for the purposes of the sight loss [test]*. In our view, this change will not increase the number of patients seen and will only lead to a more fragmented sight test with an increased risk of patients missing out on vital eye health checks."* RNIB

"…the proposal on delegation of refraction comes with little evidence or data to support the public benefit case for it. Without seeing the evidence for a clear patient benefit (which is how the proposal should be judged), we do not support delegation. There does not seem to be any evidence of a shortage of eye examination appointments nationally and long waiting times. The proposal may suit commercial considerations, but in respect of eye health it could lead to further fragmentation and confusion as to the different elements of the sight test being performed by different people. As an example, breaking down of different elements of the eye examination in hospital eye care services can prove an ordeal as a person with a learning disability sees various different people at different times. This could happen in community practice if refraction is delegated." SeeAbility

"…Allowing dispensing opticians to refract, in particular without supervision, would create a significant risk of missed pathology which could endanger the nation's eye health… If we consider a scenario where dispensing opticians were able to perform refraction under the oversight of an optometrist or registered medical practitioner, that would serve to partially mitigate the risk of missed pathology. However, this could produce an unintended consequence in the form of increased pressure on optometrists who are in the role of providing this oversight. Our members, who are GOC registrants, have expressed concern that they may be provided with shorter appointment times that are insufficient to robustly check the refraction. This could increase workplace pressures and lead to clinical errors. These registrants have told us that the clinical governance, audit, and risk measures would need to be sufficiently robust to always ensure patient safety. Clarity of roles and responsibilities was also identified as a key requirement and was felt to be particularly important for locum practitioners." AOP

"…The College supports the general principle of collaborative working and delegation wherever possible, and we recognise that registrants should be able to utilise technology and innovative methods in order to perform the sight test, where they are satisfied it is in the patient's best interest…

…However refraction, due to its interdependence on binocular vision and ocular health assessment, cannot be performed effectively by another person, either independently or with oversight...

…We conducted a literature review and found no high quality or compelling scientific or economic evidence for the need to delegate refraction, or that it was advantageous to the public to enable dispensing opticians to perform refraction under supervision. In addition, we found no evidence it resulted in a more sustainable or accessible means of delivering population-led eye care in socioeconomically deprived populations…

There is no evidence that delegation of refraction would enable optometrists to provide more enhanced or advanced clinical services and alleviate pressures on hospital eye services.

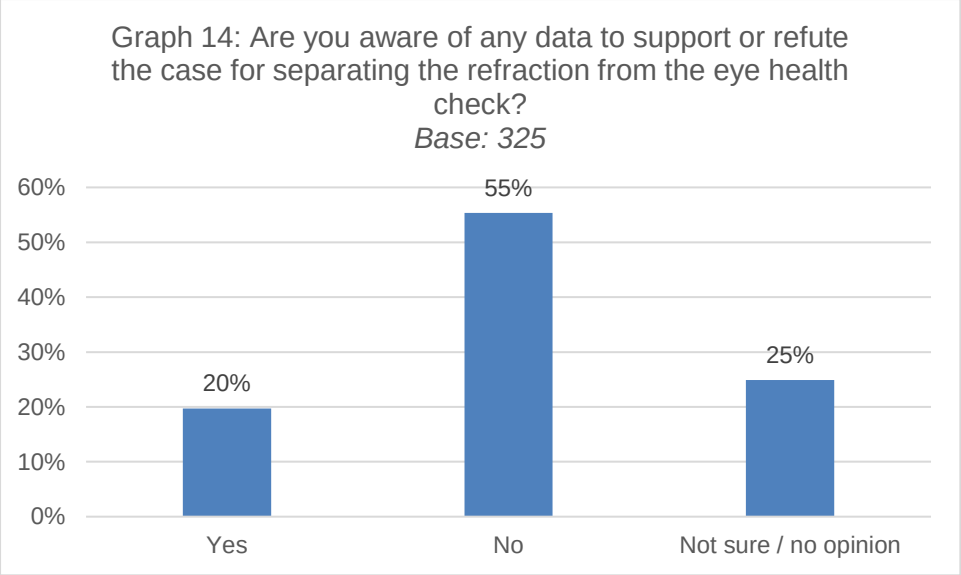
The College supports these new models of care and believes that optometrists can play a central role in delivering more services and improving patient outcomes. We are also leading work to model the eye care workforce, so we can understand current gaps or limitations and better support workforce planning in future.

However, we see the main lever to achieving new models of care relates to the appropriate funding and commissioning of services, and will not be solved by the delegation of refraction as part of the sight test.

The Act and supporting 2013 statement is for the benefit of the public and must continue to ensure all people receive safe and appropriate care, maintain good eye health and avoid preventable sight loss." The College of Optometrists

Data to support/refuse separating refraction from the eye health check

101. We asked stakeholders if they were aware of any data to support or refute the case for separating the refraction from the eye health check. Only 20% of respondents answering the question were aware of any data.



102. Respondents signposted us to case studies or articles that they felt were relevant to refute the case for separating the refraction from the eye health check, but these did not specifically address the case for keeping the refraction and eye health check together. Some of these studies pointed us to evidence such as the global figure for avoidable sight loss, concerns about how much avoidable sight loss and glaucoma in the UK is already unidentified, and the value of routine eye health examinations (including for the detection of glaucoma by optometrists). There was significant concern from the vast majority of respondents that the refraction and eye health check should not be separated, pointing out the vital public health role that the sight test plays in preventing and identifying disease, and the pressure that it would put on GPs and the hospital eye services.

103. The following are some studies that we were made aware of:

- the AOP told us about a study from Thomas et al (2011)[10] which involved a robust and detailed comparative analysis of the primary eye care systems in the UK, France and Germany. They said it concluded that each system had its own advantages, and all delivered effective services which were capable of high-quality delivery, and that whilst this paper does not show that the UK system is unambiguously better than other European countries, it shows that the system already delivers capably and effectively. The AOP also said that the study concluded that France and Germany should consider increasing the participation of dispensing opticians and optometrists to deal with upcoming challenges, in their view suggesting that the UK has the most sustainable eye care model;

[10] Thomas, D., Weegan, L., Walendzik, A., Wasem, J., Jahn, R. (2011), *Comparative Analysis of Delivery of Primary Eye Care in Three European Countries*, IBES Diskussionsbeitrag

- The College of Optometrists advised us that the Italian optometric system is predominantly based around optometrists refracting with no obligation to detect ocular pathology. They advised that a study by Cheloni et al (2021)[11] reported that there were several conditions that would likely remain undetected in this type of eye care model, and that the authors indicated that around 20% of patients may have ocular pathology that required treatment or monitoring and that would be undetected without the requirement for concurrent refraction and eye health examination; and

- several respondents pointed us to a study by Bowling et al (2005)[12] which found that 95% of suspected glaucoma cases, a leading cause of sight loss in the UK, are referred into the hospital eye service by optometrists.

104. We were advised to look at preventable sight loss rates in countries where the eye health system is different to the UK. There was a suggestion to commission our own literature review including late presentation of glaucoma cases due to the introduction and availability of 'ready readers' in retail settings.

105. We were also warned that the absence of evidence should not in itself be a reason not to change something, as it could simply be a weakness in the collection of evidence or not possible to collect.

106. FODO warned about drawing international comparison as many 'optometrists' in European countries operate at the level of a dispensing optician in the UK, and those countries have approximately double the amount of ophthalmologists than we do.

GOC response – refraction by dispensing opticians for the purposes of the sight test

107. We recognise there are strongly held views on the issue of dispensing opticians refracting for the purposes of the sight test. As well as carefully considering submissions to the call for evidence, we commissioned independent research to provide an expert clinical perspective, commissioned independent qualitative and quantitative research with the public and patients, and carried out in-house desk research to explore international comparisons. All this research is published on our website alongside this response document.

108. The patient and public research[13] found that most of the public would be supportive of dispensing opticians performing refraction as part of the sight test, provided that appropriate training and safeguards (such as supervision) were in place. The majority of the public spend little time thinking about eye care and

[11] Cheloni, R., Swystun, A. G., Frisani, M., & Davey, C. J. (2021), Referral in a routine Italian optometric examination: towards an evidence-based model*, Scandinavian Journal of Optometry and Visual Science*, 14(1), 1–11. https://doi.org/10.5384/sjovs.v14i1.129

[12] Bowling, B., Chen, S.D., Salmon, J.F. (2005), Outcomes of referrals by community optometrists to a hospital glaucoma service, *The British Journal of Ophthalmology*, 89(9), pp. 1102-4

[13] WA Research (2023), *Public views on refraction: Research report for the General Optical Council*

have limited embedded knowledge about procedures during sight tests. The public recognise there may be potential negative consequences of dispensing opticians refracting for the purposes of the sight test, but these were all considered to be surmountable with suitable safeguards put in place, with enhanced training being the most important of these.

109. The clinical research on refraction in the sight test[14] found that:

- there were differences in business models, with larger corporates making significant use of optical assistants during the sight test;
- there was a lack of consensus among healthcare professionals in relation to dispensing opticians refracting for the purposes of the sight test, with the greatest concern being the risks related to a 'refraction only' sight test;
- the eye health checks should be carried out by the same person who carries out the refraction, as retinoscopy (a kind of objective refraction) gives subtle clues about eye health;
- retinoscopy is a difficult clinical skill but this technique is increasingly being replaced by automated refraction technologies;
- there was concern that risks would increase if sight test components were carried out at different times or in different places, with their advice being that further research should be carried out to address the risks before making any changes in community practices; and
- orthoptists were capable of refracting young children during their work in the hospital eye service and argued for them to be able to issue prescriptions and optical vouchers.

110. Our in-house desk research into international comparisons on refraction with the UK sight test[15] noted the lack of research available to consider dispensing opticians refracting or the risks of different people carrying out different elements of the sight test; differences in professional roles across countries (including the role of ophthalmologists in Europe in carrying out the sight test); an interesting risk-based model where the equivalent of dispensing opticians can refract in parts of Canada but where experience has been mixed; and international comparison statistics on sight loss being inconclusive.

111. Our overriding consideration is patient safety. Based on the information collected during the call for evidence and findings from the subsequent research, at this point in time we are not satisfied that dispensing opticians

[14] Evans, B., Shah, R., Conway, M. and Chapman, L. (2023), *Clinical research on refraction in the sight test*
[15] General Optical Council (2023), *International comparisons on refraction services with the sight test model in the UK*

should be permitted to refract for the purposes of the sight test. Our main concern is undetected pathologies, including subtle clues about eye health during refraction and ophthalmoscopy that may be missed if different professionals conduct these sight test components. This risk would remain even if dispensing opticians were to receive further training/accreditation and be under the supervision/oversight of an optometrist or registered medical practitioner.

112. We nevertheless are keen for dispensing opticians to continue to develop their skills mix and meet their full professional capabilities. The development of contacts lens opticians is a recent example of where this has been achieved. There may be other areas, such as low vision services, which would be a natural extension of dispensing opticians' current scope of practice.

113. We will further discuss the issues connected with orthoptists refracting for the purposes of sight testing with the Health and Care Professions Council (HCPC – the regulator for orthoptists) and the British and Irish Orthoptic Society.

114. We will consider updating our 2013 statement on testing of sight to clarify the position in relation to pre-screening tests and triage checks related to the sight test that may be carried out by persons other than the optometrist or registered medical practitioner. Over time, advances in technology have meant various steps in the patient journey have become automated and safely delegated as part of pre-screening and triage. Use of autorefractors is one example of this and we understand further developments, including in relation to refraction, are on the horizon. If we decide to update our 2013 statement, we will carry out further consultation on this aspect of the testing of sight.

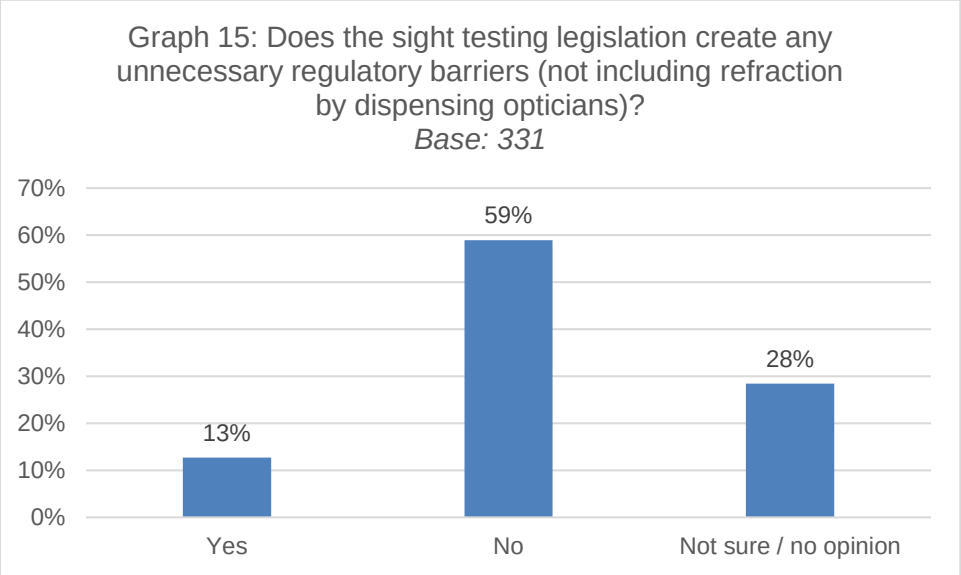
115. Our interpretation is that the Act does not specifically prohibit separation of the elements of the sight test by time, place or person. Business models are evolving alongside developments in technology. While relevant to refraction, this issue relates more generally to how the sight test is conducted, rather than which type of optical professional should perform different elements of the sight test. The call for evidence identified a range of views about this and we plan to consider developments in more detail. Depending on the outcome of this work, we may clarify our position in a statement or seek a change in the law.

Duties to be performed on sight testing

116. Section 26 of the Act sets out the duties to be performed on sight testing, which are commonly known as the refraction and the eye health check. The difference between these two areas is not always clearly understood by patients and the public. Current practice is that the refraction and the eye health check must be undertaken at the same time or within a reasonable time period of each other. Our interpretation is that the Act does not specifically prohibit separation of the elements of the sight test by time, place or person. Further information can be found on page 14 of the call for evidence.

117. We asked stakeholders if they thought that the sight testing legislation created any unnecessary regulatory barriers (*not* including refraction by dispensing opticians).

118. Of the 331 respondents who answered the question, 59% said no, 13% said yes (only one of which was a professional/representative body) and 28% were not sure or had no opinion.



Arguments in favour of duties to be performed on sight testing legislation remaining as it is

119. When reviewing the comments in response to this question, we noted that there appeared to be some confusion about the question – some respondents were commenting on refraction by dispensing opticians, whereas the question asked about any unnecessary regulatory barriers in the sight testing legislation that were *not* related to refraction by dispensing opticians.

120. The overwhelming theme from the majority of those who commented was that the sight testing legislation does not contain any unnecessary regulatory

barriers – it creates an appropriate framework whereby a full eye examination is carried out.

121. We asked stakeholders what the advantages, disadvantages and impacts (both positive and negative) would be of sight testing legislation remaining as it is currently. The following themes were identified from the comments received that identified advantages and positive impacts of the sight testing legislation remaining as it is currently:

- it will keep the public safe by ensuring that they receive an eye health check (carried out by appropriately qualified and trained professionals) and help early detection of pathology;
- patients understand the current system and what the sight test includes;
- it allows the refraction and eye health checks to be conducted at the same time which keeps the public safe by giving the opportunity to detect pathology – it also provides continuity of care for the patient;
- a high standard of care will be delivered by one individual (an optometrist);
- it allows good access to and affordability of sight tests for the population; and
- it protects the profession.

122. A sample of comments is available in the box below.

"… the sight testing legislation has provided a firm foundation on which the UK's eye health system is run, and without it we would have no effective way of meeting vision and eye health needs in a primary care (out of hospital) setting..." Business registrant/employer

"From the perspective of operating in many different markets, we regard the sight test as defined and regulated, offered and commissioned in the UK as a world leading model which provides significant patient and public health benefits. We cannot identify any disadvantages of sight testing legislation remaining as it is." Specsavers Optical Group

"The current legislation does not provide unnecessary regulatory barriers. Instead, it establishes a framework to ensure that when sight is tested, the eye health of the patient is also evaluated. This provides an opportunity for the detection of asymptomatic eye disease that otherwise may not be identified until significant, irreparable damage has already occurred. Given the importance of this role and the potential risk to the public, the profile/type of clinician who is able to conduct sight tests is quite reasonably restricted, to ensure that those testing sight are suitably qualified and trained…

…We do not recognise any disadvantages to the sight testing legislation remaining as it is, as in our members' view the current legislation is successful in serving to protect patients. However, we do feel that there could be a small risk that the legislation and/or associated guidance as it stands could restrict innovation and the ability to be flexible and reactive to change at the pace required to keep the profession agile within a complex and fast-paced primary eye care system. In our view this risk is not relevant as technological advancements that are used by the optometrist are already permitted, therefore the Act does not prevent their use." AOP

"The GOC's public perceptions research shows a high level of public satisfaction with and confidence in the services provided by registrants. This is an important indication that the current system of primary eye care is serving patients and the public well by providing accessible, high-quality, affordable and innovative care. This is in contrast with other parts of the primary care system, where there is an ongoing struggle to meet patient demand. In particular, patients benefit from a sight test that includes an eye health examination, which is consistent with the wider health policy focus on prevention." ABDO

"The UK has well-functioning, accessible and efficient primary eye care services and at the heart of these is the comprehensive sight test (or eye examination in Scotland), which all patients can access with no or low waiting times. This model of optometrist-led primary eye care has been recognised as one which benefits patients[16], and the current legislation is a key factor in maintaining the safety and integrity of the sight test. This protection for the benefit of the public must continue to ensure all people can see as well as possible, maintain good eye health and avoid preventable sight loss..." The College of Optometrists

"There is no evidence base to suggest that the sight testing legislation needs to change. The sight test, firmly anchored within the safety framework provided by the Opticians Act, has been one of the few healthcare services which has been able to innovate and change over time whilst keeping real terms costs down for patients." FODO

Arguments in favour of changing the duties to be performed on sight testing legislation

123. Some respondents believed the sight testing legislation needed amending in the following areas (although no evidence was presented as to why this should be the case):

[16] Thomas, D., Weegan, L., Walendzik, A., Wasem, J., Jahn, R. (2011), *Comparative Analysis of Delivery of Primary Eye Care in Three European Countries*, IBES Diskussionsbeitrag

- change in terminology from sight test to eye examination – we do not think this is necessary as it has not stopped commissioning bodies from using any terminology that they see fit;
- clarity is required around sight testing for diagnostic purposes in a hospital setting – we think that the Sight Testing (Examination and Prescription) (No. 2) Regulations 1989 are clear with regard to specific exemptions for sight testing "where the testing of sight is carried out by a doctor at a hospital or clinic in the course of diagnosing or treating injury or disease of the eye";
- definition of the sight test needs amending to reflect modern working practices and technology (including autorefraction) and/or to allow for the scope of the sight test to change – it is not clear why this needs to change and respondents did not give evidence as to what the Act restricted from happening;
- allowing for refraction/sight testing and eye health checks to be identified as separate for the purposes of proper funding by the NHS – we believe this is not required as Scotland already has a system in place whereby funding for eye health checks can be provided without the need for the full sight test (called an eye examination in Scotland);
- optometrists being able to deviate from the full sight test if a patient presents with an emergency – it is our interpretation that the Act does not place any requirements on optometrists to carry out a full sight if a patient presents with emergency symptoms, although in some cases they may wish to do so. This is likely to be another matter that relates to funding for those practices that are not registered to provide additional services;
- recognition and use of other healthcare professionals (e.g. orthoptists) – it is not immediately clear how these should be recognised within the Act and it may not be appropriate to do so given the remit of the GOC;
- dispensing opticians being allowed to modify a prescription if they suspect it is wrong and carry out a visual acuity check – no evidence was presented to justify this suggestion; and
- rules for orthoptics, including dispensing opticians being allowed to carry out school vision screening and binocular vision assessment – there was no evidence to support this and it is unlikely to be within the remit of the Act or the GOC.

124. There was some confusion that the sight testing legislation put up regulatory barriers including paying for a sight test up-front, autorefraction, electronic prescriptions and prescriptions being emailed to patients. We do not consider

that the Act either requires or prevents any of these things from happening. We also do not consider that it prevents the scope of the sight test changing if national health services wish to fund this.

125. Many respondents mentioned the sight testing fee for General Ophthalmic Services (GOS). This is a matter for national health services and we know that many of the optical sector professional/representative bodies work with these services to represent the views of the professions on this point.

126. The following themes were identified from the comments received that identified disadvantages and negative impacts of the sight testing legislation remaining as it is currently:

- it restricts the roles of optometrists and dispensing opticians (and other healthcare professionals such as orthoptists) and does not allow for agility and changes in technology;
- optometrists will not be able to fully utilise their skills and/or focus on eye health (although it was recognised there was a lack of funding in this area);
- patients will continue to receive a poor quality service and delayed treatment due to capacity delays within the NHS;
- increasing pressure in hospital eye services, particularly with an ageing population;
- it would cause confusion to the public; and
- workforce shortages of optometrists in some areas of the UK, potentially affecting number of appointments available.

127. A sample of comments is available in the box below.

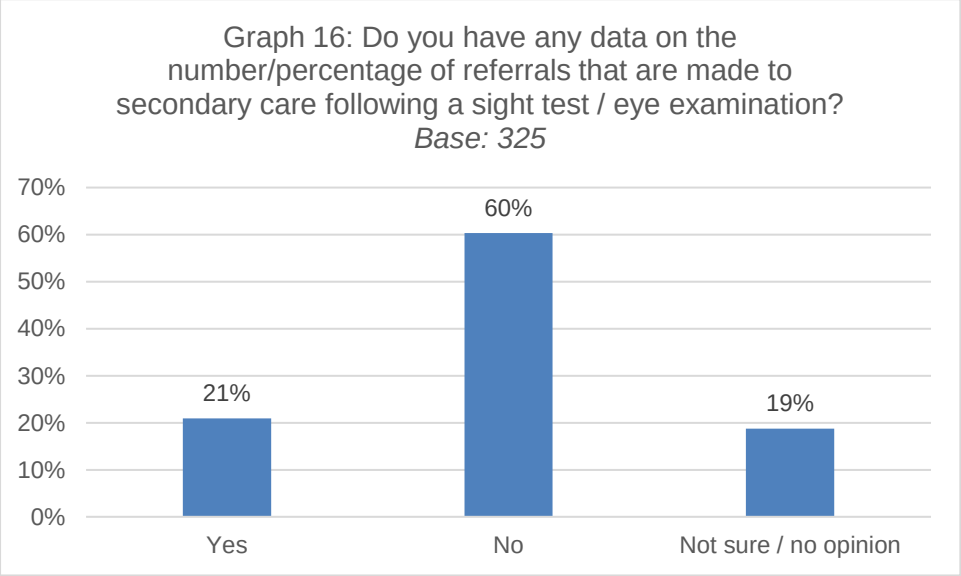
"Optometrists will not be able to utilise their full skills to benefit patients and eye care services, patients will continue to be delayed, harmed, with poor quality service and poor experience due to capacity delays in the NHS services. Optometrists will feel frustrated that they cannot use all their skills with consequent moral, retention and other issues." Consultant Ophthalmologist

"…More thought therefore needs to be given to what regulation may be necessary for technology led sight testing and how this could be managed. It is important that the revision to the Opticians Act does not automatically (and likely inadvertently) prevent such a development. In our view, an ECP [eye care professional] *should be able to use technology where either a) the final decision of treatment or prescription falls to the ECP, or b) where the technology has been clinically validated and regulatory approved.*

Without properly considering and supporting the use of technology, the GOC will both prevent and deter companies from entering the market. As a result, UK eye care patients will not be able to take advantage of new and emerging technologies which potentially could provide them with better or more convenient care." Optical Suppliers' Association

Data on referrals to secondary care

128. We asked stakeholders if they had any data on the number/percentage of referrals that are made to secondary care following a sight test / eye examination. Only 21% of respondents answering the question said that they had data.



129. Estimates from individual comments ranged from 2.5-15% (with an example of around 20% in the over 60s and an extreme example of 90% on some days in a deprived town). Several people commented that the rates varied depending on geographical area (including whether national health services have commissioned any further diagnostic tests in that area, such as a glaucoma referral/refinement pathway) and experience of the optometrist. There were some comments from those who worked in secondary care that a large proportion of referrals were unnecessary. There was also a complaint about having to refer to a GP rather than to secondary care directly.

130. In terms of actual data/studies:

- one optical business said that their patient management system showed 9% onward referrals; another optometrist said 15% from their system; another business said 6% for one large group of practices;

- a study undertaken in England and Scotland[17] showed a 5.1% referral rate to secondary care;
- we were advised that 2019/20 data from Public Health Scotland[18] showed that of just under 2.2 million eye examinations carried out in Scotland (including just under 1.6 million primary eye examinations and just over 586,000 supplementary eye examinations): 4.1% are referred to an eye clinic; 1.4% are referred to a GP; 0.8% are referred to care pathway; and 0.3% are referred to another optometrist; and
- the Welsh Government informed us that 2019/20 data from Wales showed a total of 813,922 GOS sight tests and 201,208 eye health examinations (Eye Health Examination Wales) were performed. Referral to hospital eye care services during the same period totalled 103,627 (10%) of which 23,345 were from GPs and 81,282 referrals were received from non-medical practitioners (optometrists).

131. Some respondents drew our attention to the difficulties in feedback from secondary care back to primary. For example, one study[19] found that in 72.8% of cases the community optometrist remained unaware of the outcome of their referral.

132. Several of the professional/representative bodies were concerned about what the GOC was intending to do with this data. FODO in particular wanted to ensure that any data that we received about false positive glaucoma referrals was not misunderstood – they argued that the referrals are appropriate and are due to lack of diagnostic equipment in optical practices. They also argued that if the NHS wishes to bring down the rate of false positive glaucoma referrals, it would need to fund additional diagnostic procedures, including glaucoma referral refinement pathways. The College of Optometrists also suggested caution about false positive referrals. We were also cautioned by several organisations that many optometrists are able to refer within primary care, particularly if there is a pathway or an independent prescribing optometrist.

133. A sample of associated comments is available in the box below.

"I work in a triage clinic where we see any routine referral coming from primary care instead of them going to HES [hospital eye service]*. We generally discharge 75% of those referrals as they don't need secondary care they just need a*

[17] Shah, R. et al. (2021), Referrals from community optometrists to the hospital eye service in Scotland and England*, Eye* (https://www.nature.com/articles/s41433-021-01728-2#Sec8)
[18] https://www.publichealthscotland.scot/publications/ophthalmic-workload-statistics/ophthalmic-workload-statistics-statistics-as-at-year-ending-31-march-2020/
[19] Harvey, K., Edgar, D.F., Agarwal, R., Benwell, M.J., Evans, B.J.W. (2022), Referrals from community optometrists in England and their replies: a mixed methods study, *Ophthal Physiol Opt.* 42(3), 454-470 (https://onlinelibrary.wiley.com/doi/epdf/10.1111/opo.12948)

competent optom with enough time to fully investigate the issue rather than referring because they don't want to get sued" Optometrist

"I also work secondary care. 60% of referrals are unnecessary" Optometrist

"Why optometrists are not allowed to refer directly to ophthalmology in my area is a mystery to me. Optometrists should be the primary eye care providers and ophthalmology should be treating more complicated cases and in theatre." Optometrist

"Some have in the past claimed that the sight test results in excessive false positive referrals to secondary care, however the evidence does not support this assertation… some stakeholders make assumptions that a high false positive rate following a sight test is evidence itself that the sight test needs reform. This is erroneous logic and no public policy decisions should be based on such assertations…if the NHS wishes to reduce the false positive rate of referrals for glaucoma following a sight test, it simply needs to fund additional diagnostic procedures, including glaucoma referral refinement pathways. The evidence has long shown this would solve the issue of false positive referrals associated with glaucoma." FODO

"There have been many studies evaluating the quality of optometric referrals. Variation in the rate of referral is often confused by varying definitions of how a "false positive" is defined and do not always take account of factors that contribute to a referral decision, such as IT connectivity, local commissioning arrangements and the level of local hospital engagement (specifically whether feedback and discharge information is routinely provided to the referring optometrist). In locations where additional services are not commissioned and funded in primary care, referral following a sight test may be the only option for optometrists whose patient requires further tests or follow up...

We do not feel that the legislation is a barrier to clinical decision-making or referrals, and instead believe that communication, digital connectivity, commissioning and improved pathways are more likely to impact on referral numbers and outcomes." The College of Optometrists

GOC response – duties to be performed on sight testing

134. We have not been presented with any evidence that the sight testing legislation creates unnecessary regulatory barriers. We have responded to points in the main body of the text (see paragraph 123) where we believe that there are misinterpretations about restrictions in the legislation or where they relate to funding issues that we have no control over.

135. We have noted concerns from the professional/representative bodies about what we are going to do with the data that we have asked for in this section. We asked for this data to inform our thinking on refraction and to understand if

there was any information on the levels of referrals to find out how often pathologies were detected in a sight test. We do not intend to take any action in relation to the data provided.

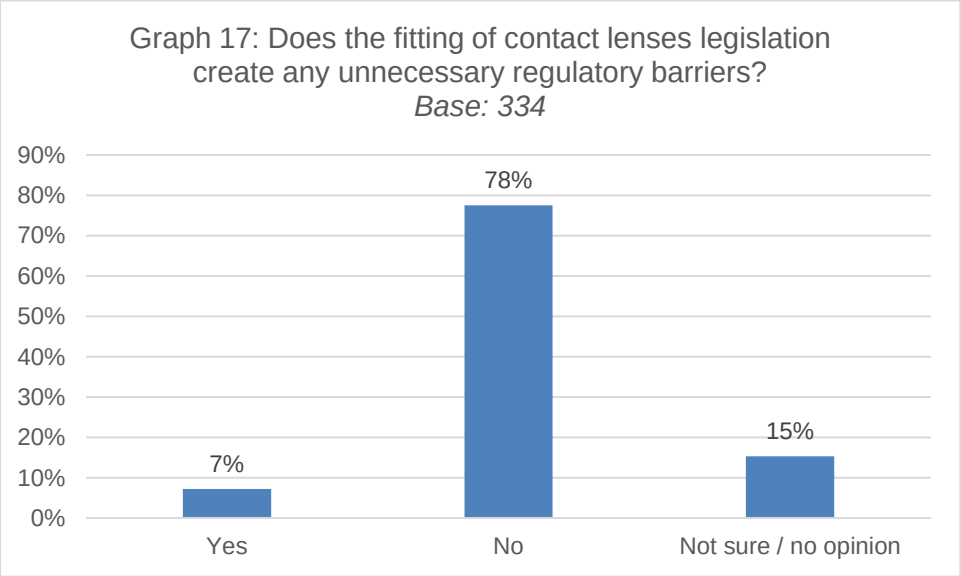
Section 5: Fitting of contact lenses (section 25 of the Act)

136. Section 25 of the Act provides that contact lenses can only be fitted by a dispensing optician[20], optometrist or registered medical practitioner, with special provision for students. Fitting must begin before the re-examination date specified in a valid prescription (dated less than two years ago). For further information please see section 5 of the call for evidence.

Unnecessary regulatory barriers

137. We asked stakeholders whether the fitting of contact lenses legislation creates any unnecessary regulatory barriers.

138. The vast majority of respondents (78%) considered that the fitting of contact lenses legislation did not create any unnecessary regulatory barriers, with only 7% responding that it did and 15% not being sure or having no opinion.



139. Respondents addressed themes considered elsewhere in the call for evidence, which we will not repeat here: the need for fitting of contact lenses to remain a restricted function (see section 2); stronger enforcement of online sales (see section 7); substitution of contact lenses (see section 6); and lack of regulation around the supply of plano/cosmetic/zero powered lenses (see section 6).

140. The overall sentiment was that the current system of contact lens regulation is effective in protecting patients and does not create any unnecessary regulatory barriers. There were very few comments about the ongoing need for specific restrictions required in the Act, for example that fitting must begin before the re-examination date specified in a valid prescription. The implication was that these restrictions should remain due to inherent risks around the fitting of

[20] Dispensing opticians need to have completed an additional contact lens speciality and be on the contact lens speciality register in order to be able to fit contact lenses

contact lenses, i.e. that since they are medical devices there must be proper fitting and aftercare advice to minimise risk of harm to patients.

141. A sample of comments is available in the box below.

> *"Our experience of having fitted millions of patients with contact lenses, in compliance with UK legislation, when compared to our experience in the other markets in which we operate, does not suggest to us that there are unnecessary regulatory barriers in the UK."* Specsavers Optical Group
>
> *"We would support the legislation to remain to ensure optimum patient care. The teaching of insertion and removal lenses using technology to support patients should be included."* BCLA
>
> *"The current system of regulation has meant that over time people have benefited from constant monitoring of eye health, lenses and care regimes being updated in line with advancing technologies, and contact lens complications being addressed in a timely manner, minimising rates of avoidable sight loss. Put simply, the current legislation has helped create a very accessible and safe contact lens market for the public. There is no evidence to support removing existing safeguards which protect the public."* FODO
>
> *"In our opinion the current legislation is there to protect patients and therefore it is beneficial for patient safety that this legislation remains in place."* RNIB
>
> *"Contact lenses fitting is regulated and even now, contact lenses can be bought online without a valid prescription. This is a risk to patients. If deregulated more, more loopholes will appear that will put patients at risk. Deregulation potentially causes more cl* [contact lens] *complications and referrals to secondary care. This is exactly what we are trying to avoid. Keep cl regulation at least as strict as now. Deregulation of this area should not happen."* Optometrist

Advantages, disadvantages and impacts of existing legislation

142. We asked stakeholders what the advantages, disadvantages and impacts (both positive and negative) would be of the fitting of contact lenses legislation remaining as it is currently.

143. The main themes raised in relation to the advantages and positive impacts were:

- the current regulatory framework for contact lenses is effective in protecting patients and should be maintained; and
- de-regulation or easing current restrictions around fitting of contact lenses and aftercare advice would likely increase the risk of harm to patients and

likely result in more referrals to secondary care which would exacerbate the existing burden on hospital eye services.

144. The main theme raised in relation to the disadvantages and negative impacts was that any relaxation of the current regulatory requirements would likely result in increased risk harm to patients, for example, if unqualified and unregulated people were able to fit contact lenses without any training or qualifications.

145. A sample of comments is available in the box below.

> *"…Deregulating the fitting of contact lenses, or allowing this to be done by non-registrants has the potential to increase the incidence of significant contact lens related problems due to inappropriate fitting, advice and aftercare."* Business registrant / employer
>
> *"To ensure patient safety, it is both clinically appropriate and necessary that contact lens fitting can only be legally carried out by registered optometrists or dispensing opticians with a contact lens specialty. Contact lenses are medical devices which carry numerous risks of harm*[21] *including infection, corneal damage and sight loss. Initial fitting, refits and rechecks with registered optical professionals are vital to ensure that patients are protected from these risks of harm... The UK has an accessible network of optical practices which are able to offer fittings and follow-on care to patients who want to wear contact lenses."* AOP
>
> *"We believe it is important to maintain this restriction in the best interests of patients, and to reduce the risks associated with contact lenses that have not been correctly fitted, or supplied without advice on safe handling and wearing schedules. It is important to avoid suggestions that current challenges around enforcement mean that this protection should be abandoned, as that would simply increase risk for millions of people on the basis that a small proportion of contact lens users and companies based abroad today do not comply with UK legalisation."* Optometry Northern Ireland

GOC response – fitting of contact lenses

146. We have heard from stakeholders that the current regulations around the fitting of contact lenses are effective in protecting the public and do not create any unnecessary regulatory barriers. We are therefore not proposing to make any changes to the GOC's regulations around the fitting of contact lenses.

147. We address related issues elsewhere in the document.

[21] Wolffsohn, J. S. et al. (2021), BCLA CLEAR – Evidence-based contact lens practice, *Contact Lens and Anterior Eye*, *44*(2), 368-397

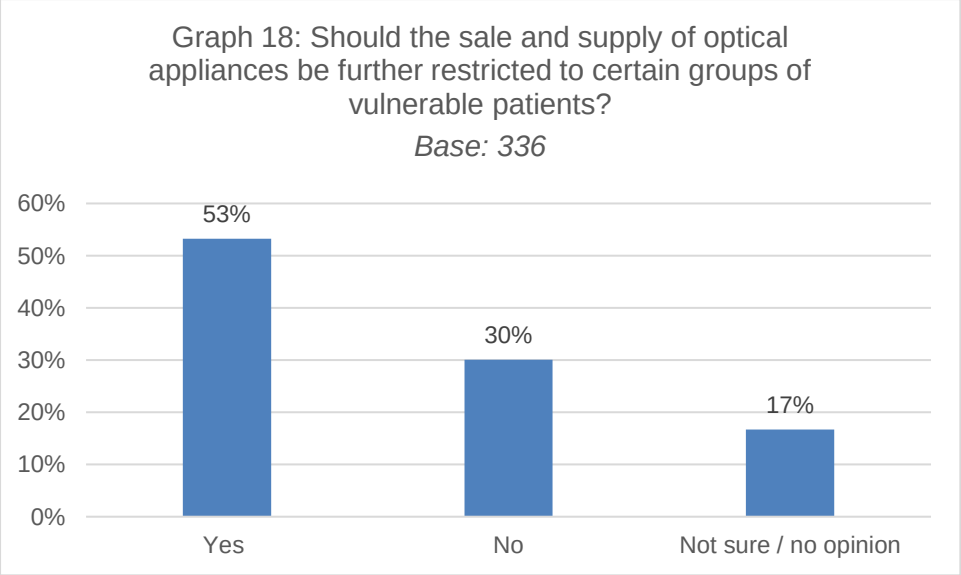
Section 6: Sale and supply of optical appliances (section 27 of the Act)

6.1 Supply to under 16s and those registered visually impaired

148. Under section 27 of the Act, only dispensing opticians, optometrists and registered medical practitioners (or those acting under their supervision) can supply certain optical appliances to children under 16 or those registered visually impaired. We explained on page 17 of the call for evidence that some stakeholders would like these restrictions to be extended to certain groups of vulnerable patients because other professionals do not have the necessary skills and knowledge to understand and address their specific needs.

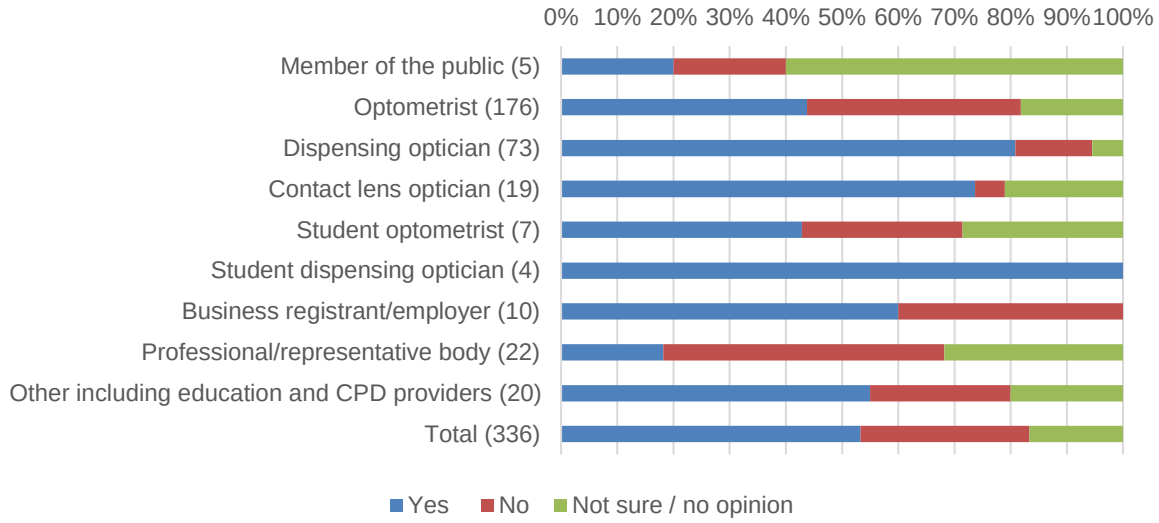
Further restrictions for vulnerable patients

149. We asked stakeholders whether the sale and supply of optical appliances should be further restricted to certain groups of vulnerable patients. Over half of respondents (53%) felt that they should be, 30% answered no and 17% were not sure or had no opinion.



150. Graph 19 shows that opinion was divided among the professional/representative bodies, with this group being much more likely to think that there shouldn't be further restrictions for groups of vulnerable patients than other categories of respondents. Dispensing opticians, contact lens opticians and student dispensing opticians were significantly more likely than other respondents to think that the sale and supply of optical appliances should be further restricted for certain groups of vulnerable patients.

Graph 19: Should the sale and supply of optical appliances be further restricted to certain groups of vulnerable patients?
Base: 336



151. When asked to explain which groups of vulnerable patients the sale and supply of optical appliances should be further restricted to (including reasoning and evidence), the following groups were identified:

- adults with reduced mental capacity or recognised capacity issues;
- children or adults with a mental or physical disability (particularly those patients who have facial disabilities or difficulties with head posture);
- patients with dementia;
- patients with a learning disability;
- patients with difficulties communicating (e.g. autism or dementia);
- older patients;
- patients requiring home visits, such as those in care homes or domiciliary settings;
- patients with complex prescriptions (e.g. a prism or a high prescription);
- patients with high prescriptions (what was considered high varied between +/-3.00, +/-4.00, +/-5.00 and +/-10.00 dioptres), as the prescription may need to be adjusted for back vertex distance;
- patients with low vision (particularly those whose vision isn't 'bad' enough to be registered sight impaired);

- patients requiring safety spectacles for work (to ensure the safety of themselves and others);
- patients who require optical appliances for driving (for the protection of themselves and other road users);
- patients undergoing myopia management interventions;
- patients with strabismus; and
- patients who require sports eyewear (currently only restricted for the under 16s).

152. Many of the responses did not contain reasoning for the suggestions (other than that enhanced skills or knowledge was required) or any evidence to support these.

153. As first referred to in section 2, ABDO was supportive of extending dispensing by a registrant to vulnerable groups, in particular, people with learning disabilities or people diagnosed with dementia. Dispensing to children with learning disabilities is already restricted to dispensing by or under the supervision of a registrant, but ABDO would like to see this restricted to registrants only i.e. not under supervision. They presented evidence that these children were 28 times more likely to have a serious sight problem but that only seven per cent will be able to access a community eye test, resulting in NHS England establishing a Special Schools Eyecare Programme to address this need.

154. ABDO also made a connection between those with dementia and those living in care homes, impaired vision in older people and increased risk of accidents such as falls. As outlined in section 2, they also asked us to carry out further research into the quality of paediatric dispensing and suggested that we may need to consider restricting paediatric dispensing so that it cannot be carried out under supervision.

155. While not related to the question about vulnerable patients, some respondents felt that the fitting of optical appliances to all patients should be restricted to registrants, but did not provide any evidence to support this. Some felt that children should be seen by an optometrist only. There were also suggestions that:

- people who meet the criteria for visual impairment shouldn't have to be certified as visually impaired to fall within the Act (as not all may wish to register for the certification); and

- online dispensing of spectacles should not be permissible for anyone with a prescription of +/-5.00 dioptres because it is not possible to check the fitted vertex distance.

156. A sample of comments is available in the box below.

"According to the GOC Rules on Supply 1984 (and the associated British Standards - specifically British Standard 2738 Note 4 in the introduction) all patients whose Rx is over +/-5.00D require a vertex distance to be measured on the frame they have selected, which must then be compared to the vertex distance of the refraction (trial frame or phoropter) and where there is a difference the prescription recalculated and compensated so that the patient experiences the same effective power at the eye. Currently 99% of non-registered dispensers are incapable of making this calculation and unaware of this requirement. Online sellers are also unable to take this measurement because it would require the frame to be on the patient's face and the measurement needs to be taken from the side - it cannot be done by the patient looking in the mirror, or holding a credit card to their forehead, or even as yet by highly sophisticated 3D scanning apps used on the latest iPhones with 3 cameras built in. Therefore patients whose Rx is over +-5.00D in the highest principal power meridian (and including any reading addition where applicable) should be afforded the protection of being dispensed by or under the direct supervision of a registrant..." CPD provider

"…Sports eyewear, including swimming goggles, sports goggles and diving masks, the visual performance of these appliances is greatly compromised if the prescription is not modified to take into account that many of these appliances fit in a different position to spectacles or the prescriber's trial frame. Sports wear is often used for a variety of very dangerous sports and the consequences of poor vision could be life threatening…" Business registrant/employer

"We believe that there is a case to consider adding patients with learning disabilities, older people in residential care and those with complex conditions which increase the likelihood of eye problems to the list of vulnerable groups who need to have optical appliances supplied to them under the supervision of an optometrist, dispensing optician or medical practitioner. It is accepted that vulnerable patient groups may include:

· Those with a dementia disease such as Alzheimer's
· Adults with a learning disability
· Adults with a complex physical disability
· Older adults in a residential care setting
· Those patients with an existing sight condition such as glaucoma.

These groups have a high prevalence of eye disease[22] [23], which means that they would benefit from having their optical appliances provided under clinical supervision…" AOP

"SeeAbility would like to see greater restrictions on the sale and fitting of glasses to people with learning disabilities so these can only be provided by registrants, in the same way as for children under 16 and those registered visually impaired. This was an agreed position statement by the Vision UK learning disability committee in 2018 and was based on both data and evidence that the vast majority of people with learning disabilities will need glasses – 6 in 10 adults and in our work in special schools over 4 in 10 children.

The committee took on board anecdotal reports from people with learning disabilities and professional bodies of poorly fitting glasses or adherence to glasses wear. The expertise of an optometrist and in particular a dispensing optician is needed to help establish if there are adaptations or styles of glasses that can support individuals, and provide any follow up advice or support.

While we recognise that there may be some commentary that this restricts patient choice, this is not an issue that people with learning disabilities or parent/carers have raised with SeeAbility, conversely many report that they would appreciate more professional support and advice." SeeAbility

"…We also believe that prescription with a power ±5.00 in any meridian should require in-person dispensing. This is because an online retailer cannot verify the dispensed prescription without being able to check the fitted vertex distance and account for the effective power of the lens.

We would also like to see the Act change to recognise those that may not be registered as visually impaired but meet the criteria for visual impairment (Best vision of 6/18). It should not be mandatory to be certified. There are many reasons that a patient may not be registered and we believe those patients still require the same protections under the Act as those that are registered." AIO

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

We note that children with learning disabilities are 28 times more likely to have a serious sight problem and only seven per cent will ever have had a community eye test or be able to access community services. To respond to this need, NHS England established the Special Schools Eyecare Programme and in developing

[22] Purbrick, Robert M.J., John J. Ah-Chan, and Susan M. Downes, Eye disease in older people, *Reviews in Clinical Gerontology* 23.3 (2013): 234-250

[23] Emerson E. and Robertson J. (2011), *The estimated prevalence of Visual Impairment among people with learning disabilities in the UK,* RNIB

the relevant care pathway specified that spectacles should be dispensed by a registrant, recognising the enhanced skills and knowledge required to dispense spectacles to this patient group. More information about this programme is available on the NHS England website: https://www.england.nhs.uk/learning-disabilities/improving-health/eye-care-dental-care-and-hearing-checks/eye-care/" ABDO

157. Of those that did not support further restricting dispensing to certain groups of vulnerable adults, this was mainly because of the difficulties associated in identifying these patients, whether patient outcomes would be improved and/or the lack of evidence supporting the restriction. There were also suggestions that there were already some services in place to help vulnerable patients. Reponses also began to mention unintended consequences which were more relevant to the next question and so have not been dealt with here.

158. A sample of comments is available in the box below.

"We are aware of the debate regarding extending restriction to certain groups but believe the challenges this presents would outweigh any theoretical advantage and comparable benefits could be achieved through expanded professional guidance." Specsavers Optical Group

"Identification of vulnerable groups, especially in marginal cases (e.g. early dementia) would be difficult and onerous" Dudley Local Optical Committee

"We are unaware of any clinical evidence that would necessitate further restrictions. Any change in guidance should be evidence based and premised around the protection of patients and minimise the risk of unintended consequences." LOCSU

"• We are not aware of any clinical evidence that would require the sale and supply of optical appliances to be further restricted to groups of vulnerable patients in paragraph 42 or any other group

• It would be difficult, if not impossible, to enforce protecting supply based on learning disabilities and dementia, without either missing a large proportion of people in these broad groups or inadvertently breaching the Equality Act 2010 – e.g. restricting choice based on a default assumptions about mental capacity etc

• We also believe patients, friends and family might take offence to the suggestion that they are 'all the same', further increasing the risk of such a proposal being seen as discriminatory. This also poses a risk to the relationship between patient and clinician." BBR Optometry Ltd (Business registrant/employer)

"The current regulations for restricted groups are difficult to manage in primary care optometry, for example, many sight impaired and severely sight impaired patients either do not advise you of their registration, or do not wish to share this.

By further expanding the group of vulnerable patients it would lead to complications in primary care, as many disabilities are hidden or cannot be assessed, and therefore could lead to barriers for a group of patients where access to eye care is of utmost importance." Business registrant/employer

"…We also consulted the sector-wide Domiciliary Eyecare Committee (DEC), which includes providers that are more likely to care for people with dementia and learning disabilities relative to practice-based settings. DEC said that suitably trained optometrists and dispensing opticians can already make judgements about capacity and that, beyond this, it would be difficult to justify limiting the human rights to equal treatment and access to health care-based factors such as learning difficulties or mild impairments even if these could be identified in advance." FODO

"…56% of our members who responded to our survey think that the sale and supply of optical appliances should be further restricted to certain groups of vulnerable patients, but a further analysis of their responses showed that they wanted to ensure that these vulnerable groups were looked after, suggesting that service provision models and funding were likely to be more of an issue than the primary legislation.

Instead of legal restrictions, we would recommend that better training is available to all members of staff within an optical practice, so that they can recognise when patients may have additional needs, provide appropriate information and support with using new appliances. These should not require additional qualifications." The College of Optometrists

Advantages, disadvantages and impacts of further restrictions for vulnerable patients

159. We asked stakeholders what the advantages, disadvantages and impacts (both positive and negative) would be of further restricting the sale and supply of optical appliances to certain groups of vulnerable patients.

160. The following themes were identified from the comments received that identified advantages and positive impacts of further restricting the sale and supply of optical appliances to certain groups of vulnerable patients:

- they will benefit from a registrant's expert knowledge and skills and safeguard against poor patient care;
- it would be safer as patients would receive better eye care, more accurate and appropriate/comfortable dispensing and better protection regarding sight related concerns, reducing the risk of harm occurring (such as falls and road traffic accidents) and leading to better quality of life;
- it will protect/enhance the profession and save money for both businesses and patients through less mistakes and 'bad' pairs of spectacles being sold, ultimately leading to less complaints;

- vulnerable patients wouldn't be taken advantage of and would have a course of legal redress; and
- it would promote equality and inclusion.

161. A sample of comments is available in the box below.

> *"It is advantageous that a standard of care that is determined by professional standards established by a regulator is likely to be of a higher level than the unregulated. There is a counter-argument that restriction could reduce access to supply but it is our feeling that there are sufficient sources of supply available from registered outlets to negate this view."* Gloucestershire Local Optical Committee
>
> *"The advantage would be less complaints as well as less remakes."* Education provider
>
> *"Enabling more vulnerable patient groups to benefit from enhanced dispensing skills would promote more equal treatment and increase inclusion.*
>
> *Maintaining the current approach to regulation would have a disproportionately negative impact on vulnerable patient groups, namely children, people with learning disabilities and people with dementia. In particular, where paediatric dispensing is not carried out or supervised by registrants with appropriate expertise, patient groups with facial characteristics that are different to white British children are likely to be even less well protected."* ABDO
>
> *"There are as many advantages and disadvantages of further restricting the sale and supply to certain vulnerable groups…*
>
> *• These vulnerable groups are already at greater risk of eye disease and would benefit from the requirement to see a registered professional to obtain optical appliances.*
>
> *• This would help ensuring that patients' appliances are prescribed and fitted optimally, and their use described clearly, helping keep their vision is at its best to keep their quality of life high.*
>
> *• Optometrists and dispensing opticians have the necessary clinical and communication skills to effectively manage, understand and treat these patients."* The College of Optometrists

162. The following themes were identified from the comments received that identified disadvantages and negative impacts of further restricting the sale and supply of optical appliances to certain groups of vulnerable patients:

- more registered staff would be required and this could lead to cost implications for businesses and patients;

- it may restrict where vulnerable patients are able to purchase optical appliances e.g. they may not be able to purchase online and this may increase their costs;
- it could put registrants and businesses at risk of inadvertently breaking the law as it would be very difficult to identify certain categories of vulnerable patients;
- many people within vulnerable groups may not require additional support, and may not wish to be classified as vulnerable, and this could lead to perceptions of unfairness and barriers to accessing care; and
- not all vulnerable patients might be able to access an appropriate register due to inequality in care at a local level, leading to further inequalities.

163. A sample of comments is available in the box below.

"The disadvantage of not changing the Act to recognise those that are sight impaired but not registered is that there may be patients who encounter barriers to registration due to inequality in care and by removing their protections due to non-registration we would be widening the gap in inequality even further." AIO

"The main disadvantages of adding these groups to the list of vulnerable groups is that many people within these vulnerable groups may not require additional support. This could lead to issues and perceptions of unfairness and barriers to access for them. It may also create an increased cost burden on these groups. Provision of clinical support for people with learning disabilities is likely to work better in areas where targeted eye care and support services have been commissioned, but this varies across the UK.

There would also be practical challenges in how to identify the patients who belong to these vulnerable groups. Registers for people with learning disabilities, living with complex conditions and in residential care do exist, but there is no national register equivalent to that for people with a visual impairment." AOP

"…risks registrants and practices inadvertently breaking the law if they cannot identify an individual from one of the above vulnerable groups or if an individual does not want to disclose information that identifies their vulnerable status…

• This may further limit patients' access to care and add more barriers to a group who already face greater difficulties accessing healthcare equitably

• With a growing number of the population affected by (for example) learning disabilities or dementia, some patients from vulnerable groups may have further limitations on when their appliances can be dispensed and this could cause more barriers to care and increase distress for these patients." The College of Optometrists

GOC response – supply to under 16s and those registered visually impaired

164. We recognise that there are vulnerable patients who would benefit from being dispensed by a registrant. However, we do not consider that adding to the list of restricted activities is the right way forward for reasons including insufficient evidence of harm, difficulties of categorisation of patients and practical implementation, reluctance of patients to be categorised as vulnerable, and risks of unintended consequences relating to costs and access for patients.

165. We recognise that domiciliary care is a particular area of risk and will continue to monitor fitness to practise and OCCS complaints in this area, working with the optical sector, governments and national health services to review the position as research and evidence emerges. As noted in paragraph 54, we will also work with ABDO to understand concerns about paediatric care. The proposed mechanism set out in paragraph 56 for the GOC to recommend changes to the scope of restricted activities could be used to extend protection to specific patient groups should our analysis change in future.

166. Extending regulation to all optical businesses providing restricted activities could help reduce risks to these patient groups, as we could use standards and guidance to support individual registrants and businesses to ensure that these patients are appropriately advised. We will consider this as part of the forthcoming review of our standards.

167. There is a role for public education to encourage vulnerable patients and their carers to use regulated professionals and businesses. We will also discuss with the optical sector and relevant charities how they can show professional leadership in this area and provide registrants, businesses and patients with the information and advice that they need.

168. We note the concern that people who meet the criteria for visual impairment should not have to be certified as visually impaired to fall within the Act. The certificate of visual impairment (CVI) is an indirect requirement under the Act as it restricts dispensing of appliances for use by someone who is registered blind / partially sighted or sight impaired / severely sight impaired. This originally referred to local authority registers of disabled (including blind / partially sighted) people as required under section 29(4)(g) of the National Assistance Act 1948, but now refers to the registers of sight impaired / severely sight impaired people required by section 77 of the Care Act 2014. Under the Care and Support (Sight-impaired and Severely Sight-impaired Adults) Regulations 2014, a person is to be treated as being sight impaired / severely sight impaired if so certified by a consultant ophthalmologist. We will discuss with DHSC whether it would be possible to have regulations that provide a different definition but are concerned that the resulting inconsistency could be complicated.

169. We note that the Sale of Optical Appliances Order 1984 does not reflect the reality of online supplies since it predates internet sales. We will discuss this further with DHSC.

6.2 Prescription contact lenses and verification

170. Prescription contact lenses can be sold:

- by or under the supervision of a dispensing optician, optometrist or registered medical practitioner; or
- (as long as the user is not under 16 or registered visually impaired) under the general direction of a dispensing optician, optometrist or registered medical practitioner, who need not be on the premises at the time, if the supplier first receives the original specification or verifies the specification with the prescriber.

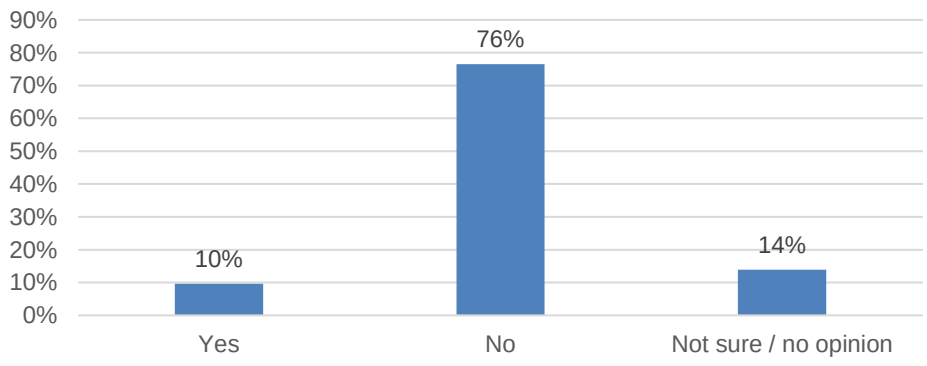
171. In order to be supplied with prescription contact lenses, a patient must have a contact lens specification which has been issued following a contact lens fitting/check and has not expired (i.e. is in-date). Where the sale is being made under the general direction (rather than supervision) of a registrant, and an original of the contact lens specification is not provided, section 27(3)(ii) of the Act requires the specification information (referred to as 'particulars of the specification') or a copy of the specification to be verified with the person who provided the original specification.

Unnecessary regulatory barriers - general direction / supervision

172. We asked stakeholders if the general direction / supervision legislative requirements relating to the sale of prescription contact lenses create any unnecessary regulatory barriers.

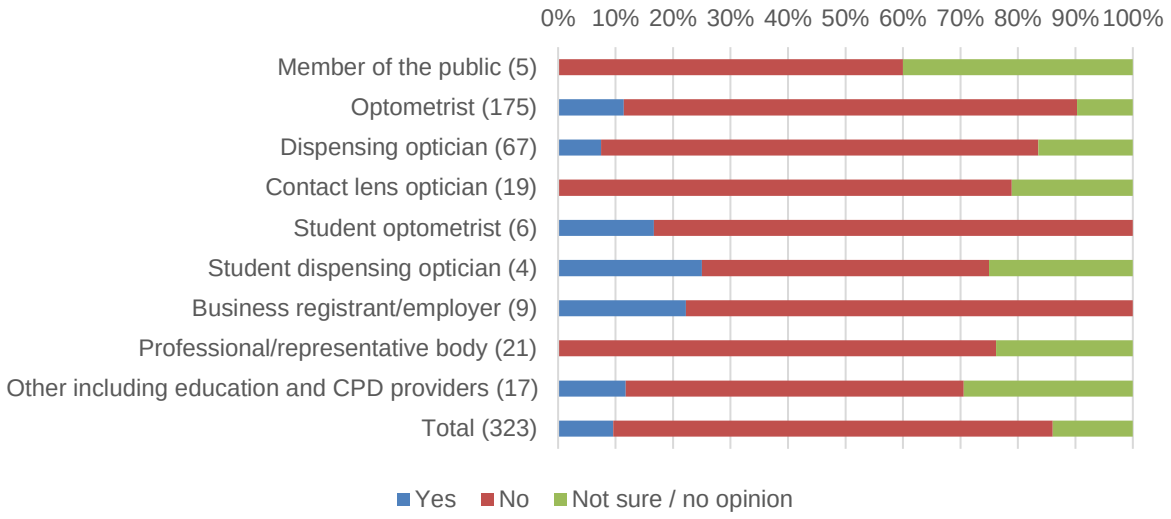
173. Only a small proportion of respondents (10%) thought that they did create unnecessary regulatory barriers, with over three quarters (76%) thinking that they did not and 14% not being sure or having no opinion.

Graph 20: Do the general direction / supervision legislative requirements relating to the sale of prescription contact lenses create any unnecessary regulatory barriers?
Base: 323



174. Graph 21 shows the breakdown by category of respondent. The professional/representative bodies were all in agreement that there were no unnecessary regulatory barriers (or were unsure / had no opinion).

Graph 21: Do the general direction / supervision legislative requirements relating to the sale of prescription contact lenses create any unnecessary regulatory barriers?
By category of respondent
Base: 323



175. The following themes were identified from the comments:

- prescription contact lenses are medical devices and so the regulatory barriers are necessary and there to protect patients from harmful side effects of inappropriate contact lens use;
- the requirement that a contact lens specification must be in date in order for contact lenses to be supplied is an unnecessary barrier and should be left to the professional judgement of the practitioner;
- online suppliers do not comply with the rules (e.g. selling without a specification) – this puts patients at risk, is not fair to individuals and businesses who are observing the law and there should be a level playing field;
- there are loopholes in the law that put patient safety at risk (e.g. being able to supply a different contact lens to that specified on the contact lens specification – we were provided with a link to peer review literature which found that contact lenses should “never be substituted for another lens

type in the absence of a new prescription further to a full finalised fitting, for the simple reason that all soft contact lenses are not created equal"[24]);

- there should be more regulation, for example:
    - for online supply of contact lenses;
    - contact lenses should only be sold by optometrists / qualified professionals;
- assertions that the GOC is not enforcing the rules; and
- recognition that overseas supply cannot be regulated and/or that enforcement of the rules is difficult – ABDO requested us to clarify our approach to enforcing legislation and how it applies to suppliers registered overseas but operating in the UK (please see the GOC response to our consultation on illegal practice strategy and protocol for more information on this point).

176. Many responses mentioned verification of the contact lens specification, but this is dealt with in one of the following questions in this section so not addressed here.

177. A sample of comments is available in the box below.

"No, they do not create any unnecessary barriers, contact lenses are an optical/medical appliance and should be regulated as such… the general public should not be able to acquire contact lenses without a comprehensive fitting as they can pose a risk not only to themselves but others e.g. if their visual acuity is subpar. It's not unusual to see patients in practice who have self prescribed and fall below driving standards despite operating heavy machinery or driving commercially. If it is made any easier for unregulated sellers to operate then these sorts of problems will only increase." Dispensing optician

"The current problem is that the law…is so unclear. Essentially providing the consumer has an in date specification for any old lens they can order a different lens to a completely different specification... I've supervised or been the "generally directing" practitioner for several direct to consumer contact lens businesses since the early 1990s and the only way to make a profit is to ignore the rules on verification - what's the point of verifying if all you are checking is the date and not the lens specification?" CPD provider

"…we think it would be helpful for the GOC to clarify its approach to enforcing the legislation relating to the supply of contact lenses. We appreciate that following the consultation on its revised illegal practice protocol, the GOC will be developing a

[24] Efron, N. et al. (2022), All soft contact lenses are not created equal, *Contact Lens and Anterior Eye* 45 (2022) 101515

wider illegal practice strategy. As part of this work, it would be helpful to clarify how the legislation applies to suppliers who are registered overseas, but operate from the UK." ABDO

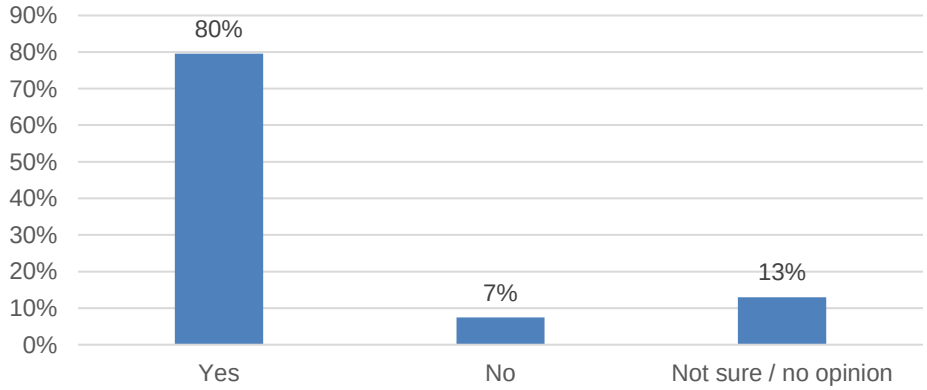
"…the requirement that a contact lens specification must be in date is a barrier to registrants acting in the patients' best interests in exceptional circumstances. During the pandemic, while practices were following the College's and GOC's amber phase guidance and policies, easements enabled registrants to act in their patients' best interests to support an ongoing supply in exceptional circumstances. This discretion helped members of the public safely maintain an ongoing contact lens supply, and for appropriate care to be scheduled as soon as reasonably possible. Continuing this policy of discretion would be of benefit as a permanent change and may reduce the number of people driven to unregulated contact lens supply in exceptional circumstances (for example when they run out of lenses and are waiting for their next appointment). The regulations must be supportive of clinicians using their professional judgment, to ensure members of the public can maintain a safe supply of contact lenses and good vision." The College of Optometrists

Risk of harm – changes to general direction / supervision

178. We asked stakeholders if there would be a risk of harm to patients if the general direction / supervision requirements relating to the sale of prescription contact lenses changed.

179. The vast majority of respondents (80%) felt that there would be a risk of harm to patients, with only 7% saying no to the question and 13% not sure or no opinion.

Graph 22: Would there be a risk of harm to patients if the general direction / supervision requirements relating to the sale of prescription contact lenses changed?
Base: 323



180. The following themes were identified from the comments (if themes were already identified in the previous question, we have not repeated them here):

- if the general direction / supervision requirements for sale of prescription contact lenses were relaxed there would be a risk of harm to patients because:
    - they would not get regular check-ups from professionals to detect any adverse changes and pathology could go undetected, resulting in more hospital attendances;
    - their contact lens compliance is poor and would worsen without education from professionals;
    - they change their contact lens specifications (type and size of contact lenses) with no guidance and reduced regulation could increase this possibility, potentially causing damage to the eyes;
- there would not be any risk of harm if the general direction / supervision requirements for sale of prescription contact lenses were relaxed provided that the patient was an existing wearer and ordered lenses that were in accordance with a valid contact lens specification;
- if the general direction / supervision requirements for sale of prescription contact lenses were tightened there would be less risk of harm to patients because public protection would be increased, ensuring more regular check-ups and compliance with the contact lens specification; and
- the rules around general direction should be removed or tightened because they are not sufficient to protect the public.

181. We were pointed to evidence[25] which found that contact lens wear carries various risks of infection and corneal damage and the importance of teaching an aftercare routine to ensure an appropriate care regimen and cleaning instructions.

182. A sample of comments is available in the box below.

"If the supervision requirements were relaxed suppliers would be free to supply lenses to patients who may need an eye exam or contact lens check, they could supply additional lenses to patients that have been told not to wear lenses by the practitioner for health reasons, change lens type, prescription etc" Optometrist

"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

[25] Wolffsohn et al. (2021), CLEAR - Evidence-based contact lens practice, *Contact Lens and Anterior Eye*, 44(2), 368-397

contact lens patients provided by the contact lens practitioner, particularly in relation to swimming and driving." The Northumberland, Tyne and Wear Local Optical Committee

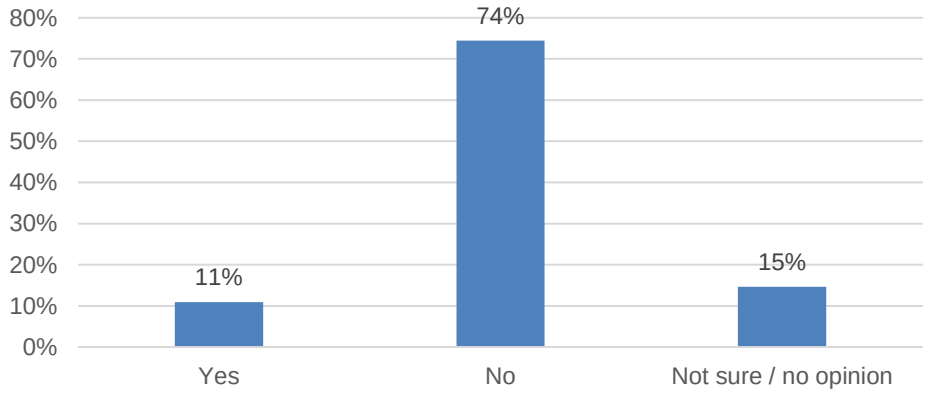
"Removal or relaxation of these supply restrictions could lead to a risk of patients using contact lenses without regular refits and rechecks with an optical professional, or in some cases having never being fitted for them. Contact lens wear carries various risks of infection and corneal damage[26]. …without appropriate advice about how to care for, clean, and store their lenses, there is a significant risk that patients develop unsafe contact lens habits. This may increase the risk of developing sight loss-causing infections[27]." AOP

Unnecessary regulatory barriers – verification of specifications

183. We asked stakeholders if the legislative requirements for verification of contact lens specifications create any unnecessary regulatory barriers.

184. Almost three-quarters of respondents (74%) thought there weren't any unnecessary regulatory barriers, with 11% thinking there were and 15% not being sure or having no opinion.

Graph 23: Do the legislative requirements for verification of contact lens specifications create any unnecessary regulatory barriers?
Base: 321



185. The following themes were identified from the comments from those who did not think that the legislation created any unnecessary regulatory barriers:

- the legislation is necessary as it protects patients; and
- it is largely ignored by online retailers and should be better enforced.

[26] Wolffsohn et al (2021), CLEAR – Evidence-based contact lens practice, *Contact Lens and Anterior Eye*, 44(2), 368-397
[27] Stapleton, F., Keay, L., Jalbert, I., & Cole, N. (2007), The epidemiology of contact lens related infiltrates, *Optometry and vision science*, 84(4), 257-272

186. A sample of comments is available in the box below.

> *"Unfortunately, it seems as though these legislation requirements are seldom conformed to. We have experienced incidences where incorrect lenses have been supplied and clients have not been able to reach driving standards in supplied lenses without follow up. These requirements not only need to be upheld but need to be enforced better"* Business registrant/employer
>
> *"We do not believe the current requirements for verification creates any unnecessary barriers, the guidance during the pandemic was relaxed which was right for the time however this guidance does not need to be carried forward any further."* Business registrant/employer

187. The following themes were identified from the comments from those who thought that the legislation created unnecessary regulatory barriers (themes already identified in previous questions in this section are not repeated here):

- it shouldn't be necessary to verify a copy of a signed and in-date contact lens specification (unless clarification is required) – virtual/scanned copies should be accepted;
- it can be difficult to verify a contact lens specification with the exact person who signed it; and
- verification creates inefficiencies that are then passed on as costs to patients.

188. There was concern from some that although it would be acceptable not to verify an electronic copy of a specification, verification of the particulars of a specification (where a copy had not been provided) should still be required because otherwise this could lead to patients requesting contact lenses without having had a recent fitting. The optical sector professional/representative bodies appeared to be in agreement on this point. FODO believed that this could be clarified in a guidance note rather than a change in legislation being required.

189. The AOP (and others) cautioned us against drawing lessons from the COVID-19 pandemic in this context, advising that contact lens wear decreased during this time[28] and that it is still too early to evaluate the impacts of the changes made during the pandemic as sight loss takes time to develop.

190. A sample of comments is available in the box below.

[28] Morgan, P. B. (2020), Contact lens wear during the COVID-19 pandemic, *Contact Lens and Anterior Eye*, 43(3), 213

"Verification creates confusion and inconvenience for patients who wish to purchase lenses from different suppliers, creating inefficiencies and increasing costs which are then passed onto the patient." Business registrant/employer

"…on balance the current system works. However, we anticipate that while most suppliers will operate within the spirit of the legislative requirements, one aspect, namely verification of a copy "with the person" providing the specification, will be particularly challenging. Clearly the workforce is fairly mobile with an increasing proportion of practitioners choosing to locum, and of course people work part-time, take annual leave and so forth - so while it may be easily possible to verify a specification with someone who has access to the record of fitting, the realistic possibility of confirming directly with 'the person' who provided the specification, may not have been properly considered when the legislation was originally drafted." Specsavers Optical Group

"The…LOC [local optical committee] *believes that the requirements for verification of contact lens specifications creates unnecessary regulatory barriers. Mistakes do happen but in the vast majority of cases there is no need for verification and as such it is not justifiable to follow this protocol."* Local optical committee

"…The need to verify the specification should remain in place where there is doubt about the particulars of the specification, although there is scope safely to update the verification requirement to allow acceptance of electronic specifications…" AOP

"We believe that prescriptions should not need to be verbally validated with practices, but a prescription should be verified to have been written to the correct standards..." AIO

"…it is arguable that a patient should be able to provide an electronic copy of their in-date contact lens specification without the need for this to be separately verified with the supplier of the specification, provided it can be read clearly… However, we do not agree with the GOC's view that the requirement to verify the particulars of a specification should be removed entirely as this would potentially enable contact lenses to be sold without a patient having an in-date specification and therefore without receiving appropriate aftercare." ABDO

"…we believe the current system could be improved by enabling the use of electronic copies of the contact lens specification and removing the need to verify it unless the specification (or duplicate of it) is unclear, contains an obvious error or the registrant believes it has been altered or tampered with…" The College of Optometrists

Advantages, disadvantages and impacts of removing verification requirements

191. We asked stakeholders what the advantages, disadvantages and impacts (both positive and negative) would be of removing the requirement to verify a copy of or the particulars of a contact lens specification.

192. The following themes were identified from the comments around the advantages and positive impacts of removing the requirement to verify a copy of or the particulars of a contact lens specification:

- easier and quicker access to contact lenses for patients (especially in an 'emergency' such as a patient from overseas);
- convenience for patients, the prescriber and supplier; and
- financial benefits for businesses, particularly online businesses.

193. A sample of comments is available in the box below.

> *"Make supply easier as sometimes difficult to verify"* Optometrist
>
> *"…Reduce the time the patient has to wait for the verification to take place…"* Local optical committee
>
> *"Advantages include reducing the burden of time on practice teams and removing barriers to purchase optical appliances for patients."* Optometrist

194. The following themes were identified from the comments around the disadvantages and negative impacts of removing the requirement to verify a copy of or the particulars of a contact lens specification:

- risk to patient safety and the public (leading to accidents, pathology and hospital eye services being even more stretched) due to, for example:
  - inappropriate lenses being supplied due to inaccuracy in type, size and/or strength of contact lenses;
  - improper use of contact lenses through lack of advice;
  - patients being able to order whatever lenses they want without an in-date contact lens specification (including those who have been told that they cannot wear contact lenses and/or those who have never had a contact lens fitting);
  - patients not getting regular check-ups;
- patients would be more likely to order online;

- the change would make no difference as so many patients order online anyway from website that do not request and/or verify specifications; and
- it would destroy/downgrade the profession.

195. A sample of comments is available in the box below.

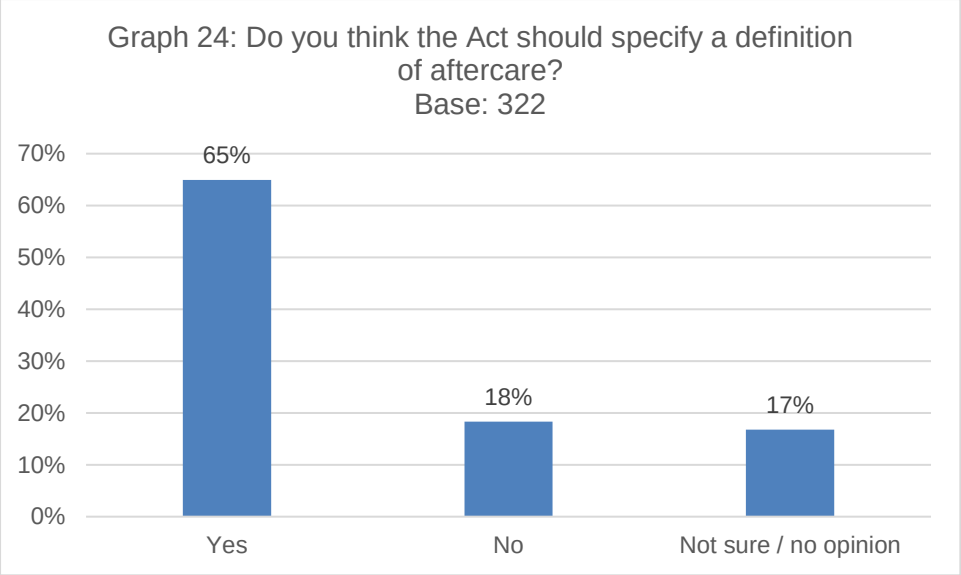
> *"Removing the verification procedure would give the patient freedom to order whatever they want online and this may have a potential harm to their ocular health and promote misuse of contact lenses."* Optometrist
>
> *"Anyone could write in any specifications and therefore contact lens associated pathology would increase, sight loss would increase and people may be wearing inappropriate prescriptions for driving etc leading to potential death"* Optometrist
>
> *"…Supply of contact lenses without verification/validation puts the consumer at risk and perpetuates this damaging notion that you can stick anything in your eye without ramification. As a CLO I too often see patients who have fallen victim to companies…who have been lured in by a cheap deal and a marketing ploy and end up with corneal events, poor VA* [visual acuity]*, poor comfort/lens tolerance all due to lack of proper fitting and aftercare. Not the mention that many who fall victim to this only attend for AC* [aftercare] *every 3-4 years as the casual nature of the purchase leads them to believe regular AC is unnecessary…"* Dispensing optician
>
> *"…a recent study of patients buying contact lenses on the internet found a growing number who initiated lens wear independently without professional care and advice[29]. Less frequent contact lens care and advice from optical professionals will increase the risk of patients developing poor contact lens hygiene habits and increasing the risk of developing harmful infections that could lead to sight loss…"* AOP

Aftercare

196. Section 27(3B) of the Act requires the seller of contact lenses to make arrangements for the user to receive reasonable 'aftercare' in so far as, and for as long as, may be reasonable in that individual's case. We asked stakeholders if they thought the Act should specify a definition of aftercare.

197. Almost two-thirds of respondents (65%) thought the Act should specify a definition of aftercare, 18% did not, and 17% weren't sure or had no opinion.

[29] Mingo-Botín, D., Zamora, J., Arnalich-Montiel, F., & Muñoz-Negrete, F. J. (2020), Characteristics, behaviors, and awareness of contact lens wearers purchasing lenses over the internet, *Eye & Contact Lens*, 46(4), 208-213



198. We asked stakeholders who had responded positively to whether the Act should specify a definition of aftercare to say what they thought that should be. The following themes were identified:

- history taking and symptoms;
- checking the fit of the lenses;
- health checks (examination of the anterior eye both with and without contact lenses);
- visual acuity and prescription checks;
- suggestion of a maximum time between appointments (12 and 24 months were most frequently suggested);
- requirement to provide a contact lens specification after the aftercare appointment with an expiry date;
- discussion and advice around the cleaning regime, handling and compliance with wearing time; and
- in line with recommendations from the professional bodies.

199. A sample of comments is available in the box below.

"Practices use the term aftercare to refer to what professional associations commonly call a check or fit/re-fit. It is important that the GOC defines the differences between both of these otherwise there is the potential that practitioners will be caught out. This was highlighted by the GOC Covid-19 statements which called out the perceived differences from a GOC perspective." Optometrist

"We suggest the Act should stipulate an aftercare must include an assessment of ocular health as it relates to contact lens wear. It should be the GOC's responsibility to define the aftercare and we suggest that the GOC should adopt the definition supplied by the College of Optometrists." AIO

"…as the online market for contact lenses grows, there has been and is likely to be an increasing separation of fitting from supply. This makes the sellers' duty of aftercare even more important to protect patients. Providing a definition of aftercare could help to ensure that patients who purchase from online suppliers are given suitable advice on how to safely use their lenses and what to do if they experience problems with them. Our suggested definition for aftercare would be:

'To ensure that those who sell or supply contact lenses to patients are mandated to ensure follow-on arrangements for care are in place, which provides the patient with a reasonable means to safely use the supplied contact lenses, identify signs of infection or other harm and to obtain suitable care or advice if problems occur.…' " AOP

200. Although the question did not ask for this information, numerous stakeholders commented on why it was not necessary to provide a definition of aftercare in the Act, including the following themes:

- the issue is with supply, not aftercare;
- it should be dealt with in professional guidance (or a GOC position statement) rather than legislation;
- it should be for the professional judgement of the registrant; and
- it would be difficult to future-proof a definition.

GOC response – prescription contact lenses and verification

201. We have heard that verification of a copy of a contact lens specification is no longer necessary, provided that the specification is clear, does not contain any obvious errors and has not obviously been tampered with. We therefore intend to seek legislative change to allow us to set out more detailed requirements in rules/guidance but in the meantime, we will consider issuing a position statement to say we will not enforce the requirement to verify a copy of a specification, with the provisos outlined in the previous sentence. We will also consider extending this statement to prescriptions for spectacles. If we decide to issue a statement, we will carry out further consultation on these areas to further understand the impacts and ensure that there are no unintended consequences of a change in policy and/or legislation.

202. We have been persuaded by arguments to continue to require verification of the particulars of a specification and therefore do not propose to make any changes in this area.

203. We note concerns regarding suppliers who supply contact lenses that are not the exact type of contact lenses specified on the contact lens specification. We have considered recent peer reviewed evidence which suggests that the decision to substitute a contact lens should usually only be made on the advice of a qualified eye care practitioner due to the potential risk of adverse clinical events. The paper states that there is currently no direct evidence to show clinical harm resulting from substitution (in part because harm is likely to take time to occur and underreporting[30]). Currently, we do not propose introducing a specific legal requirement to supply contact lenses only in accordance with the contact lens specification since the evidence suggests that professionals exercising their clinical judgement can substitute safely. We will continue to keep this situation under review as research progresses.

204. With regard to whether a definition of aftercare is required in the Act, we note the confusion between the use of the term aftercare provided by registrants under s25(5)(b) (which is essentially part of the appointment to assess the fit of contact lenses, sometimes referred to as a contact lens check-up) and aftercare within the meaning of section 27(3B) of the Act which relates to a seller (whether or not GOC registered) of contact lenses being obliged to make arrangements for the patient to receive aftercare in so far as and for as long as may be reasonable in the particular case – our consultation question was in relation to the latter point. We consider that the current drafting of the legislation allows for a broad interpretation which would allow for change over time. However, we will consider whether it would be helpful to provide a definition of aftercare in a GOC position statement so that it is clear what sellers of contact lenses are obliged to do in order to meet their legal obligations.

205. We do not propose to give detailed advice about what aftercare appointments undertaken by registrants should involve, as this is a matter for clinical judgement. Any GOC guidance in this area would likely consider the current guidance issued by The College of Optometrists and ABDO, and will require further consultation to understand the impacts and ensure that there are no unintended consequences of a change in policy and/or legislation.

[30] Efron, N. et al. (2022), All soft contact lenses are not created equal, *Contact Lens and Anterior Eye* 45 (2022) 101515

6.3 Zero powered contact lenses

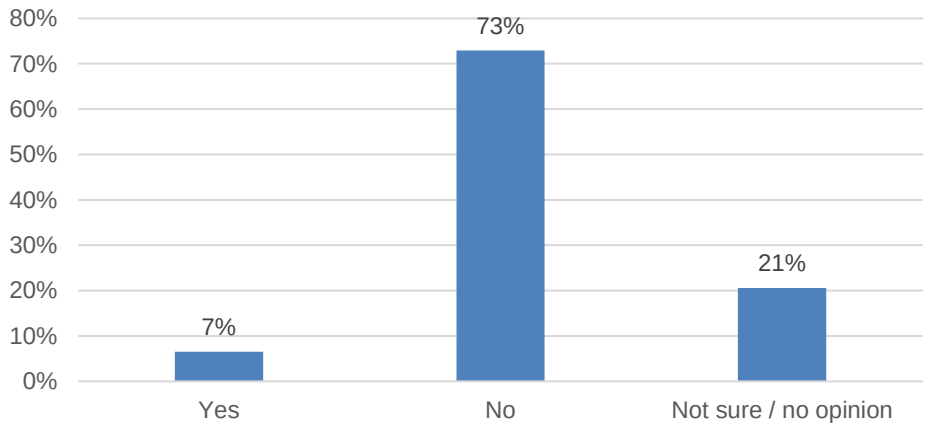
206. Section 27(1)(b) of the Act provides that zero powered contact lenses can be sold only by or under the supervision of a dispensing optician, optometrist or registered medical practitioner. Case law and our standards require that the supervisor must be on the premises at the time of the sale, exercising their professional judgement as a clinician and in a position to intervene in the patient's interests.

Unnecessary regulatory barriers – zero powered contact lenses

207. We asked stakeholders whether the zero powered contact lenses legislation creates any unnecessary regulatory barriers.

208. Of the 321 respondents who answered the question, 73% thought that the legislation didn't create any unnecessary regulatory barriers, 7% thought that it did and 21% were not sure or had no opinion.

Graph 25: Does the zero powered contact lenses legislation create any unnecessary regulatory barriers?
Base: 321



209. The comments indicated overwhelmingly that the zero powered contact lenses legislation did not create any unnecessary regulatory barriers. The BCLA and The College of Optometrists provided links to articles about the ocular complications associated with the use of cosmetic contact lenses, with one article concluding that "uninformed lens wearers are experiencing acute, vision-threatening infections and inflammation"[31].

[31] Steinemann, T.L., Pinninti, U., Szczotka, L.B., Eiferman, R.A., Price Jr, F.W. (2003), Ocular Complications Associated with the Use of Cosmetic Contact Lenses from Unlicensed Vendors, *Eye & Contact Lens* 29(4): 196–200

210. The following themes were identified from the comments:

- non-registrants are not aware of the legislation and there are many unregulated sales where the legislation is not enforced;
- sale of zero powered contact lenses online should be against the law;
- contact lenses are the same regardless of whether they are powered or zero powered;
- zero powered contact lenses have a higher risk factor as they are:
  - often not fitted, therefore wearers do not receive proper advice on insertion, removal and infection prevention; and
  - not usually worn by people who are used to wearing contact lenses;
- the Medicines and Healthcare products Regulatory Agency (MHRA) has agreed to re-classify zero powered contact lenses as medical devices[32].

211. A sample of comments is available in the box below.

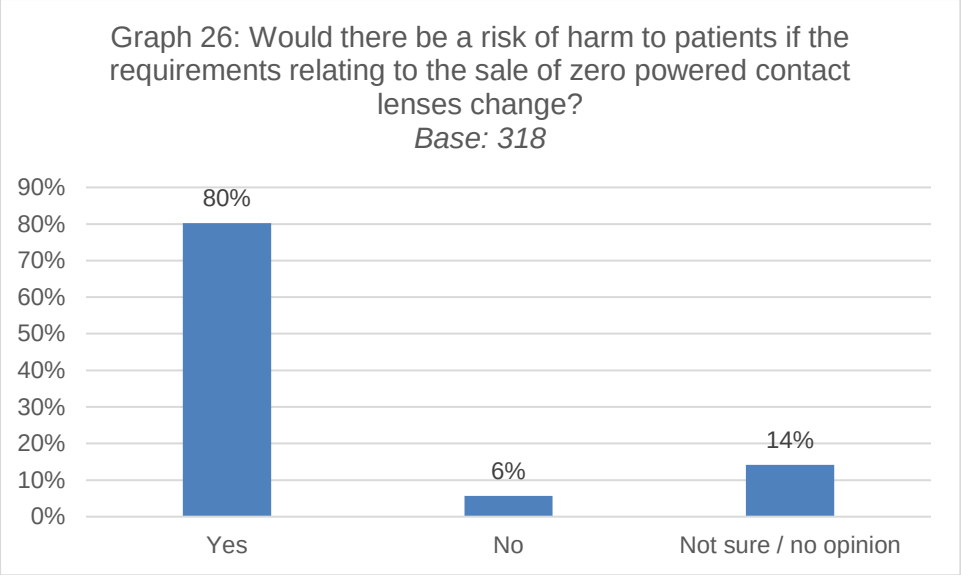
> *"The risk of harm from zero power contact lenses is if anything greater than powered contact lenses due to the attitude of a fashion item rather than a medical device. The GOC must protect the public"* Dudley Local Optical Committee
>
> *"Zero powered are lenses not for correction of vision (e.g. therapeutic, cosmetic, bandage etc). Older technology and materials and cosmetic use makes them more prone to abuse and the potential for higher risk of contact lens adverse effects."* BCLA
>
> *"The zero powered contact lenses legislation provides sensible protections for casual purchasers who would not otherwise be contact lens wearers, and who may be unaware of risks associated with contact lens use. These requirements were introduced due to issues with over-the-counter contact lenses being purchased with no instruction, guidance or aftercare…"* FODO

Changes to zero powered contact lens legislation

212. We asked stakeholders whether there would be a risk of harm to patients if the requirements relating to the sale of zero powered contact lenses changed.

213. Of the 318 respondents that answered the question, 80% thought there would be a risk of harm, 6% that there would not be and 14% were not sure or had no opinion.

[32] https://www.gov.uk/government/consultations/consultation-on-the-future-regulation-of-medical-devices-in-the-united-kingdom



214. Many of the themes from the comments to this question had already been identified in the previous question (particularly those related to the risk profile of prescription and zero powered contact lenses being the same, if not greater for zero powered contact lenses) and are therefore not repeated here. The remaining themes from the comments, most of which relate to the risk of harm of buying zero powered contact lenses online, are as follows:

- risk of delayed identification of pathology and risk of complications (e.g. corneal ulcers and infections, microbial keratitis) leading to sight loss;
- increased burden on optometrists, contact lens opticians and/or hospital eye services;
- concern that patients would not even be fitted for lenses;
- concern about the quality of some zero powered contact lenses;
- those who purchase online are less likely to attend eye examinations and more likely to forget aftercare advice (evidence was provided to support these points); and
- a suggestion for the GOC to tackle the problems with online suppliers through the contact lens manufacturers.

215. We were pointed to a large number of articles about the risks associated with the wearing of contact lenses, particularly those who buy online and those who are not advised about the proper handling of contact lenses around water.

216. A sample of comments is available in the box below.

"Contact lens wear is distinct from wearing spectacles due to the interaction of the lens with the ocular surface, tear film and surrounding structures. This is irrespective of the prescription involved and as such involves health risks to the wearer." Welsh Government

"There is evidence that contact lens users who buy their lenses through alternative supply routes may be more susceptible to poor hygiene procedures and to an increased risk of infection[33].

A US study found that consumers who bought contact lenses from sources other than their eye care practitioner were less likely to comply with good eye care health practices and have reported cases of serious corneal ulcers and infections associated with wear of zero powered contact lenses[34]. Corneal ulcers can progress rapidly, leading to internal ocular infection if left untreated. Uncontrolled infection can lead to corneal scarring and vision impairment. In extreme cases, this condition can result in blindness and eye loss." The College of Optometrists

"…'Patients who acquire [Cosmetic contact lens] are less likely to be instructed on appropriate lenses use and basic hygiene rules. Consequently, [Cosmetic contact lens] wearers are experiencing acute vision-threatening infections.'[35]

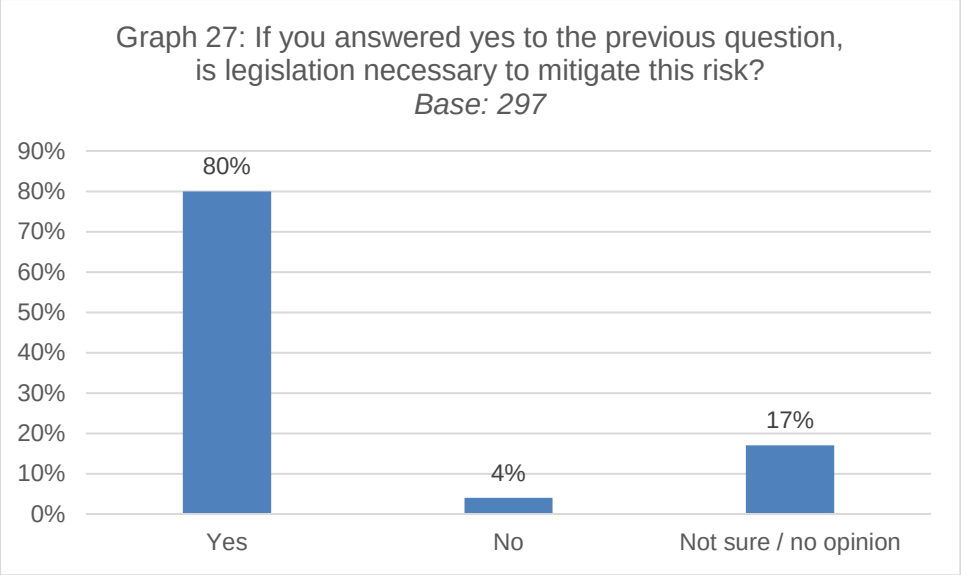
We believe that removing restrictions on the sale of zero-powered contact lens will make access to these lenses more widely available, whilst reducing contact with a qualified practitioner who can properly instruct them. In turn, this will increase the prevalence of cases of microbial keratitis and increase the burden on primary and secondary care." AIO

Mitigation of risk

217. If they answered yes to the previous question (whether there is a risk of harm to patients if the requirements relating to the sale of zero powered contact lenses changed), we asked stakeholders whether legislation is necessary to mitigate this risk.

218. Of the 297 respondents who answered the question, 80% thought that legislation was necessary to mitigate this risk, 4% did not and 17% were not sure or had no opinion.

[33] Steinman, T.L. et al. (2005), Over-the-counter decorative contact lenses: cosmetic or medical devices? A case series, *Eye & Contact Lens* 31; 5: 194-200
[34] Snyder, R.W. et al. (1991), Microbial keratitis associated with plano tinted contact lenses, *CLAO J* 17; 4: 252-5
[35] Sauer, A. and Bourcier, T. (2011), Microbial keratitis as a foreseeable complication of cosmetic contact lenses: a prospective study. *Acta Ophthalmologica* 2011: 89: 439-442



219. Themes identified from the comments were already identified in previous questions in this section and so have not been repeated here. The overwhelming response from the comments was in support of legislation being required to mitigate the risk and that legislation in this area needed to be better enforced.

220. The AOP recommended non-legislative approaches, as well as arguing for the legislative restrictions to remain in place. These included public education (although they argued that the younger age group who may never have had a contact lens fitting are heard to reach) and prominent warnings on contact lens packaging. ABDO argued that legislation is necessary because GOC statements would not cover non-registered businesses.

221. A sample of comments is available in the box below.

"Only legislation could ensure that these lenses are sold by a registrant to ensure patient safety." Local optical committee

"We believe that the current legislation protects users of zero-powered lenses and is necessary. There would be a significant risk of increased harm to wearers of cosmetic lenses if current restrictions on the sale of zero-powered lenses are relaxed or removed… Legislative restrictions reduce the risks of harm, but sellers are likely to continue to operate outside the legal framework and zero powered lens users will need additional messages about how to reduce their risks of harm from lens wear." AOP

"Legislation on its own will not and has not solved the issue. It also needs effective policing of the legislation." Business registrant/employer

"Yes, legislation is necessary to mitigate the risk of patient harm as in the absence of such legislation, zero-powered contact lenses could be supplied by businesses,

such as hairdressers or market stalls, that would not be registered with the GOC and therefore, not required to follow GOC policy statements." ABDO

Advantages, disadvantages and impacts of current zero powered contact lenses legislation

222. We asked stakeholders what the advantages, disadvantages and impacts (both positive and negative) would be of zero powered contact lenses legislation remaining as it is currently.

223. The following themes were identified from the comments around the advantages and positive impacts of the zero powered contact lens legislation remaining as it is:

- it would protect eye health as patients will be fitted and educated by a healthcare professional, will have better fitting lenses, will be better monitored, and hospital eye services are less likely to be required as there are less likely to be problems; and
- it avoids zero powered contact lenses being bought online.

224. A sample of comments is available in the box below.

"…There are advantages that patients will be properly cared for in optical practices. The correct advice will be given. This means they are less likely to have an eye infection and end up in hospital costing the NHS money." Dispensing optician

"Reduce the risk of harm if customers never used lenses before. Avoid the use of coloured lenses bought in internet" Member of the public

"…the current legislation reduces the risk of harm, including sight threatening conditions that can result when contact lenses are poorly fitted or patients are not aware of the risks involved in handling and storing of lenses, and do not act on signs and symptoms as a result." FODO

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

225. Many stakeholders commented that there were no disadvantages of the legislation remaining as it is.

226. The following themes were identified from the comments around the disadvantages and negative impacts of the zero powered contact lens legislation remaining as it is:

- it is difficult to enforce against non-UK based companies;
- companies are already abusing / not complying with the legislation;
- the legislation is confusing for the public; and
- it is more costly and harder to access for the public.

227. A sample of comments is available in the box below.

> *"Will increase the cost to the general public."* Business registrant/employer
>
> *"…The potential disadvantages of retaining the current restrictions centre around challenges in enforcing the current regulations and dealing with the risks associated with online sales:*
>
> - *The GOC may lack appropriate resources of enforcements to tackle all UK websites and retail outlets selling cosmetic lenses without oversight from an optical professional*
> - *The GOC may find it particularly challenging to mitigate the risks to the public from non-UK sales of cosmetic lenses, as consumers increasingly switch to online purchasing habits – again there is likely to be a disproportionate risk of harm to young people who have not had a contact lens fitting…"* AOP
>
> *"…People may continue to buy contact lenses online from unregistered professionals or suppliers based on lower costs. This could lead to an increased risk of harm occurring to the consumer. Strengthening the GOC's power…would help mitigate this."* The College of Optometrists

GOC response – zero powered contact lenses

228. There was no evidence raised during the consultation to suggest that the zero powered contact lenses legislation creates any unnecessary regulatory barriers. However, it is our understanding that very few registrants sell zero powered contact lenses and therefore there may be a risk that the current legislation drives zero powered contact lens wearers to unregulated sources, thereby increasing the potential risk of harm to the public. At the current time we do not propose to make any changes to legislation in this area but we may return to the issue in the future.

229. We note comments in this section that the legislation could be better enforced. Our core statutory functions relate to the regulation of our registrants. We do not have statutory powers in relation to the activities of non-registrants, and it may not be practical or proportionate to take formal action in response to every complaint. We take a risk-focused approach when considering whether it is necessary to act to protect the public under our Illegal practice protocol, which

includes considering criteria such as whether zero powered contact lenses are being sold to children or vulnerable adults, or whether there is potential for serious harm or there has been actual harm. Where a case does not meet our criteria for action, we may refer to and support other agencies, including Trading Standards, in acting where a retailer may be trading illegally.

230. We noted one comment that sale of zero powered contact lenses online should be against the law. Zero powered contact lenses can only be sold by or under the supervision of a registrant and, based on case law, we consider that the supervision requirement (of a non-registrant) cannot be met in relation to online sales. However, there is no specific prohibition in the legislation against an online sale by a registrant. We do not consider that it would be appropriate to restrict registrants' professional discretion by preventing them from directly supplying zero powered contact lenses online. This should be a matter for professional judgement in the same way as it is for distance supply of spectacles for users under 16 or sight impaired.

6.4 Offences under the Act

231. The Act creates the following criminal offences:

- illegally conducting sight tests (section 24);
- illegally fitting contact lenses (section 25);
- illegally supplying spectacles (section 27);
- illegally supplying prescription contact lenses (section 27);
- illegally supplying zero powered contact lenses (section 27); and
- misuse of protected title or misrepresentation of registration status with the GOC (section 28).

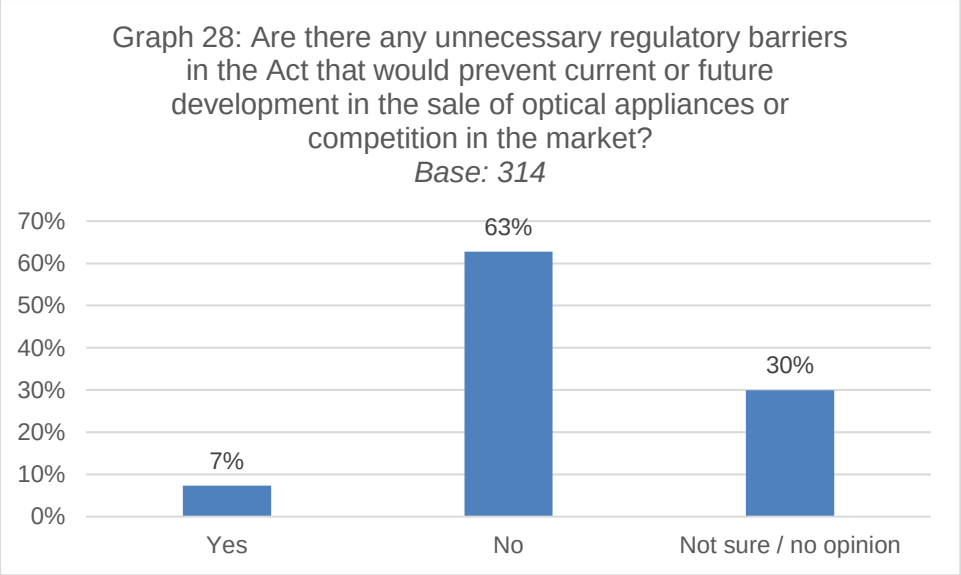
232. We noted in our call for evidence that professional bodies and registrants have said in responses to our recent illegal practice strategy review consultation that we should do more to protect the public from illegal online sales, both UK and non-UK, and that the Act requires reform to address the consumer shift to online purchases. Responses have also levelled criticism that in failing to tackle illegal online sellers we are allowing an unlevel playing field.

233. We also said that the reality is that the enforcement of our legislation relating to sales – bringing a private prosecution in the magistrates' court – is not practicable for an organisation the size of the GOC or in relation to sales in a global online market. Moreover, it is not realistic to expect the GOC to achieve legislative reform that enables us to routinely act against non-UK sellers. We suggested that de-regulation could be a way to achieve a level playing field if transferring the onus of compliance to the consumer, except for restricted categories, does not expose the consumer to a level of risk that is necessary to be mitigated by legislation.

Unnecessary regulatory barriers – prevention of development or competition

234. We asked stakeholders if there were 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.

235. Of the 314 respondents who answered the question, 63% didn't think there were any unnecessary regulatory barriers, 7% thought that there were and 30% were not sure or had no opinion.



236. Respondents were asked to comment if they said 'yes' to the question above. The main theme from these comments was that the legislation around sight testing and contact lens fitting would not allow for changes in technology which might mean that safe care is possible remotely (both in terms of refraction and eye health checks). Digital screening by non-registrants was also mentioned, with the argument that it would increase access to eye care.

237. A sample of comments is available in the box below.

"…re-issue of a specification to an asymptomatic established wearer must be done in a face to face setting. It is likely that technology will make it possible to check the health of the anterior eye remotely in the future but since this is considered a fit, if the legislation does not change, to use such technology would be considered unlawfully fitting. It would be useful to consider this to make the legislation fit for the future." Contact lens manufacturer

"The Act does not foresee or allow for advances in technology which will change the way in which sight tests are delivered and spectacles are supplied. As it currently stands it would prevent changes to provide digital and/or online eye care which would be safe and for many patients would be their preferred option." Optical Suppliers' Association

"…Digital remote screening of elderly (for instance by a home care nurse) has a proven effect on the identification of poor sightedness in a home care population. These patients can be referred for visual aids or optical appliances. A lower entry to the identification of these cases, will improve general wellbeing." Business registrant/employer

238. The majority of comments received in this section were from stakeholders who were arguing that there were *no* unnecessary regulatory barriers and that

regulation should be increased (e.g. particularly in relation to all online businesses having to register with the GOC to create a level playing field).

Risks on consumer if barriers removed

239. If they answered yes to the previous question, we asked stakeholders what the risk would be on the consumer if these barriers were removed. The following points were identified:

- there would be no risk on the consumer if barriers were removed;
- small risk of over sales / upselling of optical appliances;
- less risk of a monopoly by particular businesses and more choice for patients; and
- patients would be more likely to receive eye health care if they could attend appointments remotely.

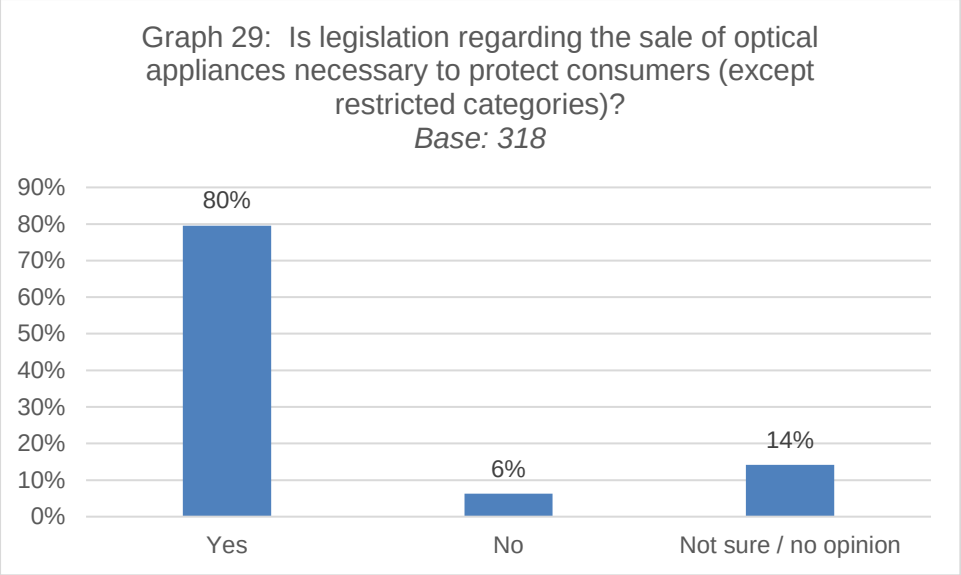
240. A sample of comments is available in the box below.

> *"small risk of over sales of optical appliances. No serious patient safety impact."* Consultant Ophthalmologist
>
> *"Insights suggest that one of the factors influencing online contact lens purchase (potentially from non-regulated sellers) is the avoidance of opticians appointments. By allowing easier access to clinical care remotely, practices would be able to free up chair time and provide care and advice to more patients..."* Contact lens manufacturer

Necessity of sale of optical appliances legislation

241. We asked stakeholders if legislation regarding the sale of optical appliances is necessary to protect consumers (except restricted categories).

242. Of the 318 respondents who answered the question, 80% said that legislation was necessary, 6% that it wasn't and 14% were not sure or had no opinion.



243. The following themes were identified from the comments:

- legislation regarding the sale of optical appliances is necessary to:
  - reduce pressure on hospital eye services;
  - protect patients from ordering the wrong optical appliances or delaying sight tests;
  - maintain high standards and give the public confidence in the professions;
- online retail presents a threat and risks the consumer not having properly fitted optical appliances;
- the GOC needs to enforce the sale of optical appliances legislation and should do more to prevent online illegal sales in the UK, particularly from overseas suppliers; and
- suggestions to work with sector bodies to explore how the GOC standards could be used to apply to other areas that are not directly covered by the legislation.

244. The College of Optometrists wanted the GOC to run regular public education campaigns about the risks of contact lenses and to have powers to address two main future areas of what it perceived to be harm, including the “growing online sales of optical products” and the “emergence of unregulated online refraction and optical services” which they argued were “threats to public protection”.

245. A sample of comments is available in the box below.

"The Sale of Optical Appliances Order of Council 1984 is sensible legislation that strikes a good balance between removing unnecessary restrictions on supply and protecting patients from poor quality spectacles made by unscrupulous businesses… The removal of these standards could lead to spectacles being made outwith specifications causing poor vision, eyestrain and potentially accidents." Business registrant/employer

"It is clear from the substantial evidence of risk of harm to patients that can result from sale and supply regulations not being followed that continued GOC enforcement of this legislation is necessary to protect the public. The current restrictions fundamentally help protect the public…" AOP

"Optical appliances are medical devices and current legislation works well and proportionately with higher levels of safeguards for spectacles and goggles for children, visually impaired and severely visually impaired adults and for contact lenses which sit on the surface of the eye. There is no evidence that this needs to change or that new legislation is necessary… there might be value in the GOC collaborating with sector bodies – e.g. College of Optometrists – to explore how existing GOC standards apply to areas such as myopia control and innovative appliances, but new legislation is unlikely to be a proportionate response or necessary." FODO

"The current legislation is vital to protect the public, both through safeguards to the supply of appliances and because of the impact of article 3 of The Sale of Optical Appliances Order 1984, which effectively ensures members of the public using optical appliances are encouraged to have regular sight tests. The definition of optical appliance as defined within the Act should not be changed. 89% of our members who responded to our survey think that legislation regarding the sale of optical appliances is necessary to protect consumers..." The College of Optometrists

GOC response – offences under the Act

246. We have not been presented with any arguments to suggest that there are any unnecessary regulatory barriers to this part of the legislation. In relation to technology, some of the comments suggest that the Act requires face to face care. However, we consider that the Act leaves this to the professional judgement of the registrant.

247. We also note the request for us to run public education programmes about the risks of contact lenses. We acknowledge that there is a role for public education programmes and where there is a regulatory dimension to this we might consider contributing to an initiative led by the sector. However, we consider that professional bodies and others are best placed to lead public education campaigns, and this should not be a core regulatory function for the GOC.

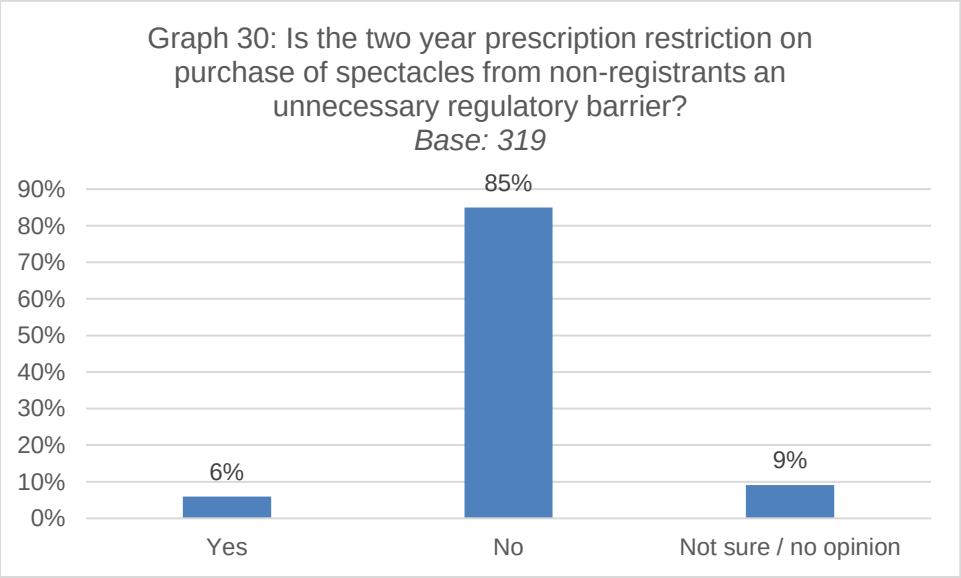
248. There were suggestions that we should have additional powers to address the public protection threats of growing online sales and optical services delivered online. We have addressed this matter in section 7.

6.5 Sale and supply of spectacles by non-registrants

249. Currently the Act does not restrict the supply of spectacles by (or under the supervision of) optometrists and dispensing opticians, including for users aged under 16 or registered visually impaired. However, article 3 of The Sale of Optical Appliances Order 1984 requires (among other matters) that non-registrants may supply spectacles only in accordance with a written prescription issued within the previous two years.

250. We asked stakeholders if the two-year prescription restriction on purchase of spectacles from non-registrants was an unnecessary regulatory barrier.

251. Of the 319 respondents who answered the question, 85% said that the restriction did not create an unnecessary regulatory barrier, 6% said that it did and 9% were not sure or had no opinion.



Arguments in favour of the two-year prescription restriction remaining as it is

252. The vast majority of respondents considered that the two-year prescription restriction on purchase of spectacles from non-registrants was *not* an unnecessary regulatory barrier. The following themes were identified:

- two years is a reasonable barrier to protect the public by ensuring patients are wearing the correct prescription, by increasing the likelihood that patients are receiving regular eye health checks, enabling early detection and treatment of eye diseases (particularly those that are asymptomatic) and preventing sight loss, falls and accidents;
- patients will have the right visual acuity, especially in relation to the legal limits for driving;

- patients will receive advice and guidance from a healthcare professional to enable them to make the right decisions about their spectacles and eye health;
- hospital eye services are not over-used under the current system of ensuring regular eye health checks through a sight test;
- registrants can use their professional judgement to provide spectacles without a prescription where it is appropriate to do so;
- current legislation has prevented an increase in health inequalities by ensuring everyone is encouraged to attend regular sight tests;
- some questioned whether the frequency should be lowered to a one year prescription;
- changing the legislation might lead to:
    - a reduction in uptake of regular sight tests resulting in health conditions, eye disease and sight loss (and the ability to detect these early will be decreased) and a potential increase in inequalities in eye health among different groups of the population;
    - spectacles of an inappropriate strength resulting in poor vision for patients – this could increase the risk of falls and would be particularly problematic for drivers who might not pass the visual driving standard, which would pose a risk to the public by increasing the possibility of road traffic accidents;
    - financial loss to:
        - practices and registrants from lack of sight tests, with the potential for some practices to be put out of business;
        - national health services due to undetected pathology;
        - patients when they have to purchase additional spectacles because of an out of date prescription;
    - public harm as non-registrants do not have the same level of knowledge as registrants and cannot advise where a sight test might be necessary;
    - liability being unclear if spectacles are made up to inaccurate prescriptions;
    - public health messaging to have a sight test every two years being obscured; and

- more businesses being encouraged to enter the UK market that are unqualified, unregistered and inadequately trained.

253. A sample of comments is available in the box below.

"Without this many of the patients who have their eye health checked as part of our current comprehensive eye care model would not have this done, this would lead to more undetected pathology and an ever more increasing burden of poor eye health on the NHS which is already struggling." Optometrist

"In my clinics the highest level of preventable sight loss is amongst adult patients who buy glasses without a prescription (and therefore eye care as well) and only seek professional advice by the time they have a significant loss of vision..." Optometrist

"With approximately 25% of the patients we refer being asymptomatic, this would undoubtedly result in pathology being missed and sight being lost unnecessarily." Business registrant/employer

"If consumers wish to purchase spectacles made to a prescription that is older than two years, there is wide access to registrants who are able to advise and facilitate such a request as appropriate. This maintains the important safeguard that, where it would be inappropriate to do so without first seeking a further sight test, the registrant can guide accordingly. 70% of patients in the UK (and 100% in Scotland) have access to a sight test paid for by the NHS every two years, or more frequently if this is clinically indicated, so this in itself is not a barrier. The inclusion of the 2 year limit was introduced in 1984, since which time there will have been in the order of 400 million prescriptions issued, so in this context we would be surprised if the current restriction has an impact on a substantive group of patients, and removing a restriction intended to provide public protection, in order to meet the request of such a small minority would not be in line with the stated objectives for legislative reform." Specsavers Optical Group

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

"…Allowing non-registrants to dispense spectacles without a prescription dated in the previous two years will inevitably encourage unqualified, unregistered, inadequately trained and potentially non-UK based businesses to enter the UK market. These entrants will have little or no incentive to dispense safely and appropriately, lack accountability or transparency, and, in many cases, will be beyond the reach of GOC regulation…" LOCSU

"…The risks associated with removing the requirement for an in-date spectacle prescription are likely to exacerbate health inequalities as patients who are less

health literate will be most likely to delay sight tests, and severe disease such as glaucoma disproportionately impacts some ethnic groups more than others. It could also delay the detection of systemic conditions through case findings during the sight test, such as cardiovascular disease in groups who are otherwise unlikely to engage with healthcare professionals…" AOP

"The disadvantage and impact of removing the two-year requirement, would be to effectively separate supply of ocular appliances from ensuring a regular ocular health assessment… This would result in higher rates of preventable sight loss and conditions such as glaucoma not being detected in the early asymptomatic stages..." The College of Optometrists

"…The Opticians Act does not present barriers to care, and in fact (as stated in our responses above) has helped provide one of the most advanced and accessible primary eye care services in the world. As a result, the Opticians Act, as it currently stands, has improved equity in access overall." FODO

Arguments in favour of the two-year prescription restriction being removed

254. A very small minority of respondents that thought the two-year prescription restriction on purchase of spectacles from non-registrants was an unnecessary regulatory barrier. The following themes were identified:

- people have the right to take ownership of their health and make their own judgements (with one comment that they should be made aware of the risks) – the public perceives the current approach as unnecessary and against personal choice, resulting in a negative image of optometry;
- a challenge as to whether a sight test is required every two years and what the clinical evidence for this is, especially for the under 60s (except those with diabetes), and/or if a vision check (whether by a person or an auto-refractor) is carried out to double-check the prescription;
- inconvenience for the consumer who may have to wait longer for spectacles if they cannot be seen quickly by an optometrist;
- costs to the patient; and
- changing the legislation would promote consumer choice, be cheaper and more convenient for patients, save unnecessary sight tests and increase revenue for online businesses.

255. A sample of comments is available in the box below.

"All citizens should have the right to take full ownership of their health (including eye health), I believe that prescriptions and other similar restrictions should be

discarded as they only help companies to profit and take away people's freedom of choice!" Patient

"Inconvenient to the consumer to impose it, leading to the delay in supply of glasses, and in any event, any qualified DO/OO has the ability to use a prescription of any date provided they can justify it's in the consumers best interests, so it's easy to circumvent this legislation, therefore it's unnecessary." Dispensing optician

"…If a patient/client rates the quality of vision with [h]is prescription as good/excellent, and a vision screener identifies that the visual acuity is on par/unchanged, why should one then be referred to an optometrist to redo the measurement. The chances that this investigation will create added value is small, while the costs are almost the same for a new prescription, or a complex prescription…" Business registrant/employer

"There is no clinical evidence to support a new Rx [prescription] *every two years -- nothing. People know if they see clearly -- another reason to be rid of the two year validity."* Business registrant/employer

"…if restricted groups were extended to include all voucher patients and all patients requiring a vertex distance according to the 1984 GOC Rules then I think this restriction could be removed for everyone else except possibly the over 60s since they are at greatly increased risk of sight threatening eye disease…" CPD provider

"It should be for the consumer to have the right to make that decision." Optical Suppliers' Association

GOC response – sale and supply of spectacles by non-registrants

256. We have considered the personal responsibility vs public health debate in the responses. We consider that the regulatory barriers that prevent non-registrants from supplying spectacles without an in-date prescription is in line with national health services' objectives for preventative healthcare (preventable sight loss which would have an impact on national health services) and necessary to protect the public. We have not been presented with any evidence to suggest that the legislation is significantly detrimental to patients and note that it is possible for patients to approach a registrant for spectacles who can advise them about whether it is necessary for them to have a further sight test and discuss the risks and benefits with them.

257. We have not been presented with persuasive arguments that the two-year limit should either be extended or reduced.

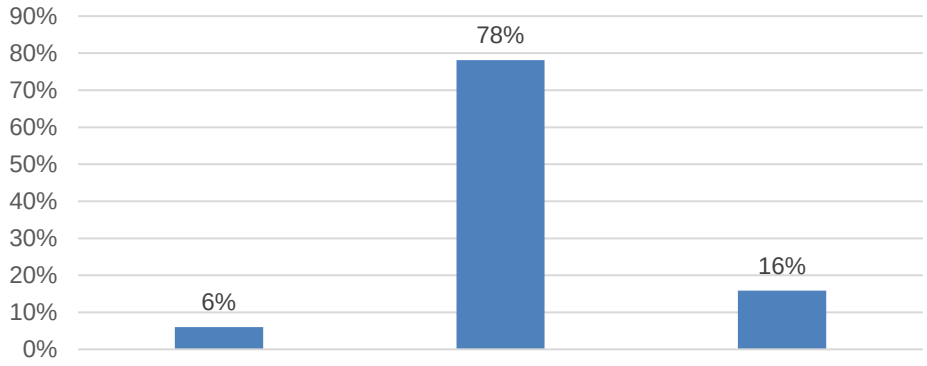
6.6 Supply of sportswear optical appliances to children under 16

258. The restrictions under the Act relating to supply of optical appliances to children under 16 apply to sportswear prescription optical appliances (such as prescription swimming goggles and dive masks), not just spectacles and contact lenses. This means that this type of sportswear cannot be provided over the internet by non-registrants.

259. We asked stakeholders if the legislation in relation to the sale and supply of sportswear optical appliances for children under 16 created any unnecessary regulatory barriers.

260. Of the 315 respondents who answered the question, 78% did not think the legislation created any unnecessary regulatory barriers, 6% thought that it did and 16% were not sure or had no opinion.

Graph 31: Does the legislation in relation to the sale and supply of sportswear optical appliances for children under 16 create any unnecessary regulatory barriers?
Base: 315



Arguments in favour of sportswear optical appliances legislation remaining as it is

261. The following themes were identified from the comments where respondents thought that the regulatory barriers were necessary and saw advantages and positive impacts of the legislation remaining as it is:

- there is no evidence that the legislation is a problem for children or their parents or that the legislation needs to change;
- the current restrictions protect children – under 16s should always be fitted properly regardless of the appliance, as poor optical appliances can harm their eye development and lead to reduced vision in the longer term;
- fitting requirements for sportswear optical appliances are more complex than ordinary optical appliances;

- continued protection of children under 16 through well-fitted, correct and safe use of optical appliances, with appropriate advice – it gives an opportunity to safeguard children's sight and supply will be subject to GOC regulation;

- changing the legislation might lead to:

    - it being unsafe for children if they were incorrectly fitted with sportswear optical appliances, as this could have a negative impact on the development of children's eyes and/or facial growth/features, and lead to eye strain, blurred vision, muscle imbalance, binocular vision problems, amblyopia (a lazy eye) and/or a change in prescription;

    - patients ending up with the wrong prescription which could lead to damage to the eyes longer term – this is a particular issue because children are less likely to be able to tell if they have problems with their vision;

    - the appliances being unsafe, with the potential to cause injury to the eyes or another person when playing impact sports;

    - patients being more likely to buy incorrect sportswear optical appliances online; and

    - risk of inappropriate advice by non-registrants.

262. While being supportive of the legislation remaining as it is, some respondents suggested that it depended on the type of sportswear optical appliance (e.g. impact sports create a higher risk than swimming and the regulations could be separated out) and/or the environment in which it is used – (e.g. the risks are greater with some sportswear optical appliances because of the higher risk environment in some cases – poorly fitting appliances have the potential to obstruct vision and the restrictions therefore protect others who the wearer might come into contact with).

263. A sample of comments is available in the box below.

"…Many children opting for sports eyewear only do so because they are of moderate-high ametropia [refractive error] as often those with low ametropia will attempt to cope without. With moderate-high ametropia it is of course more imperative that the frames and lenses are dispensed appropriately so as to provide adequate vision. In addition, poorly fitted sports eyewear could lead to injury and so it only makes sense that a qualified registrant with both the capacity and enthusiasm determine suitability should dispense such an appliance…" Dispensing optician

"…It would be worth separating out swimming googles (where vision is compromised anyway by being underwater, best correction is adequate, and the PD [pupillary distance] *can be altered by adjusting the bridge) and sports specs with high wrap and impact resistant requirements as these are complex appliances and require additional in person measurements. In fast paced sports like squash, badminton, football, cricket it is not good enough to allow approximate prescriptions as it puts the player, and other players at risk of serious injury."* CPD provider

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

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

"…Children under 16 need to be fitted by suitably trained and qualified professionals, in particular children with squints and binocular problems. Where children are undergoing treatment for squint or lazy eye, it is important to ensure they wear sportswear with their accurate prescription incorporated, to continue the beneficial effect of their treatment… Correct fitting of optical appliances, including sportwear, is therefore imperative for optimum vision. A failure to do so can lead to lifelong impacts on children's vision and risks harm in the short and long term…" The College of Optometrists

"Unsupervised sales of optical appliances to children are a significant area of risk. This is because children's eyes are still developing, and poorly fitting and inappropriate prescription eyewear, provided without appropriate clinical oversight, can lead to discomfort[36]. There is also a risk that the incorrect impact protection may be provided if the process is not overseen by registrants. The call for evidence says that risks associated with sports eyewear may be less because the appliances are being worn infrequently. However, the problem of children having inappropriate vision correction leading to harm are made more significant because

[36] Powell, C., Wedner, S., Hatt, S.R. (2009), Vision screening for correctable visual acuity deficits in school-age children and adolescents, *The Cochrane Collaboration*

they will be engaging in higher risk activities such as swimming, sports, and outdoor pursuits." AOP

"If unqualified professionals are able to sell sportwear optical appliances there is a risk that the products might not fit, have unnecessary coatings, inappropriate frames or that safety considerations are not taken into account. As children's eyes are not yet fully developed it's essential they have the correct prescription which can only come from a qualified and registered professional." RNIB

Arguments in favour of sportswear optical appliances legislation restrictions being removed

264. The following themes were identified from the small number of comments where respondents thought that the regulatory barriers were unnecessary and from comments about the disadvantages and negative impacts of the legislation remaining as it is:

- the risk for sportswear is lower because they are not worn permanently;
- fitting requirements for most sportswear is not as complex as other eyewear;
- greater cost for patients; and
- changing the legislation would result in greater access to the appliances and financial benefit to the purchaser.

265. A sample of comments is available in the box below.

"…the risk is negligible and the restrictions are simply not warranted." Consultant Ophthalmologist

"OTC [over the counter] *devices such as rx* [prescription] *swim goggles are not permanent corrections so should be able to be sold as an accessory."* Optical manager

"Cost can be impact on inclusion." Dispensing optician

"The cost of sportwear optical appliances would be more expensive." Local optical committee

"Financial benefit would be present because without having to fund a professional salary the retail price could be reduced." Business registrant/employer

GOC response – supply of sportswear optical appliances to children under 16

266. We have considered the arguments for and against a change in legislation and are not convinced that there is sufficient evidence to justify a change. We are

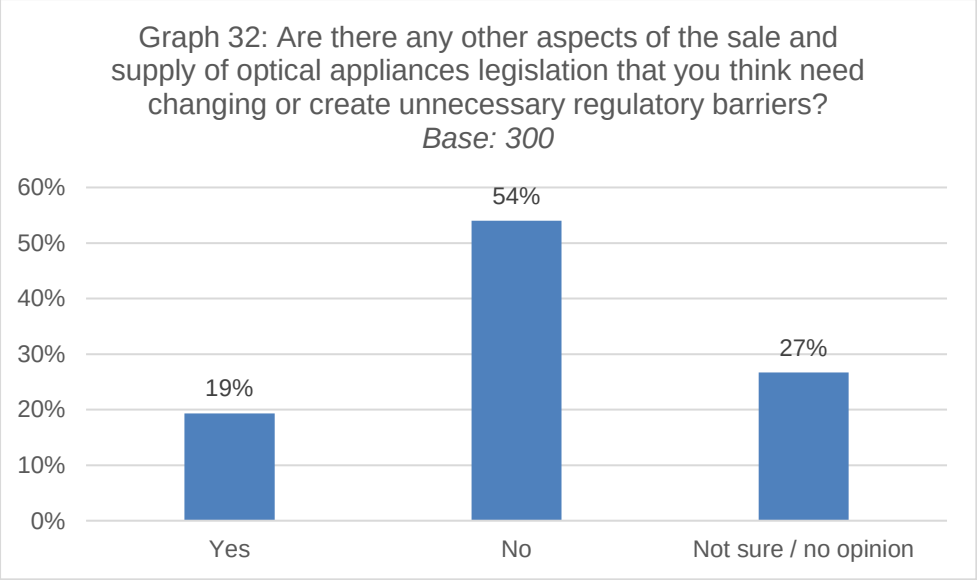
persuaded by public protection arguments that sportswear prescription optical appliances for children should only be supplied by or under the supervision of a registrant (or registered medical practitioner) due to the extended length of time that some sportswear optical appliances are worn and the risk of injury to others, not just self, particularly in impact sports.

6.7 Other

Sale and supply of optical legislation that requires changing or creates unnecessary regulatory barriers

267. We asked stakeholders if there were any other aspects of the sale and supply of optical appliances legislation that they thought needed changing or created unnecessary regulatory barriers.

268. Of the 300 respondents who answered the question, 54% thought that there weren't any other aspects of the legislation that needed changing or that created unnecessary regulatory barriers, 19% thought that there were and 27% were not sure or had opinion.



269. The following themes were identified from the comments (we have not included themes already identified in other parts of this consultation):

- the legislation around low vision aids should be clearer, including what are considered low vision aids, and opening up the restrictions for low vision specialists;
- it should be clear that the responsibility for the product lies with the seller, not the optometrist that performed the sight test;
- either abolishing the sale of ready readers or restricting them to +2.5, as there is concern that anything above this could be correcting latent (hidden) hypermetropia[37]; and
- a prescription should include the tested visual acuities for any prescribed working distances.

[37] https://www.nhs.uk/conditions/long-sightedness/

270. We asked stakeholders what the advantages, disadvantages and impacts (both positive and negative) would be of the sale and supply of optical appliances legislation remaining as it is currently. The main themes related to patient safety and public protection.

271. A sample of comments is available in the box below.

> *"Need to make it clearer regarding low vision aids"* Optometrist
>
> *"…We also believe that a valid prescription must also include the tested visual acuities for any prescribed working distances."* AIO
>
> *"Enhanced patient safety measures for the current vulnerable groups"* Local optical committee
>
> *"We feel the current legislation works well as it protects patients and the public from harm. As previously stated above, the legislation should remain in order to continue to maintain a risk-based approach. This will also help in enabling ICSs* [integrated care systems] *to better commission and deliver consistent and equitable care."* AOP

GOC response – other

272. We have reviewed the definition of low vision appliances in the legislation[38] and agree that it could be clearer. We produced a position statement on low vision aids in 2012. We will review the legislation in the context of our statement and consult on any changes as part of future consultation on any new draft legislation for the GOC as part of the DHSC's legislative reform programme. At the time of writing, it is not clear how much of part IV of the Act will be repealed to allow us to deal with issues such as these in position statements and standards/guidance which do not require legislative change. This is something that we will continue to discuss with DHSC as it consults on its legislative reform programme. Our preference would be to deal with these issues in standards/guidance as it allows for a more flexible approach.

273. It was suggested that the legislation should make it clear that responsibility for the product lies with the seller, not the optometrist that performed the sight test. We infer that this relates to situations where, for example, spectacles are made up to a prescription, but the patient is not content with the spectacles. It would not be appropriate to make any changes to the Act because this is a matter of

[38] Regulation 1(2)(d)(b) of the Sale of Optical Appliances Order 1984: "any appliance sold or to be sold in pursuance of a prescription which identifies the appliance to be sold as being a low vision aid (whether by means of the words "low vision aid" or some other similar words), and includes frames or mounts which are intended for use as part of eyeglasses so designed and are sold or supplied without lenses and lenses so intended which are sold or supplied without frames or mounts"

general consumer law. However, we fund the Optical Consumer Complaints Service (OCCS) which can assist consumers and businesses in these cases.

274. We have considered comments related to ready readers. There would need to be a high evidence bar to reverse this matter which was debated extensively in Parliament in the 1980s when the change was introduced. We have not been presented with evidence of public harm that would justify a change in legislation in this area.

275. We have considered the suggestion that the Sight Testing (Examination and Prescription) (No. 2) Regulations 1989 should be changed so that a prescription should include the tested visual acuities for any prescribed working distances. We will discuss this further with the professional bodies to understand the case for change.

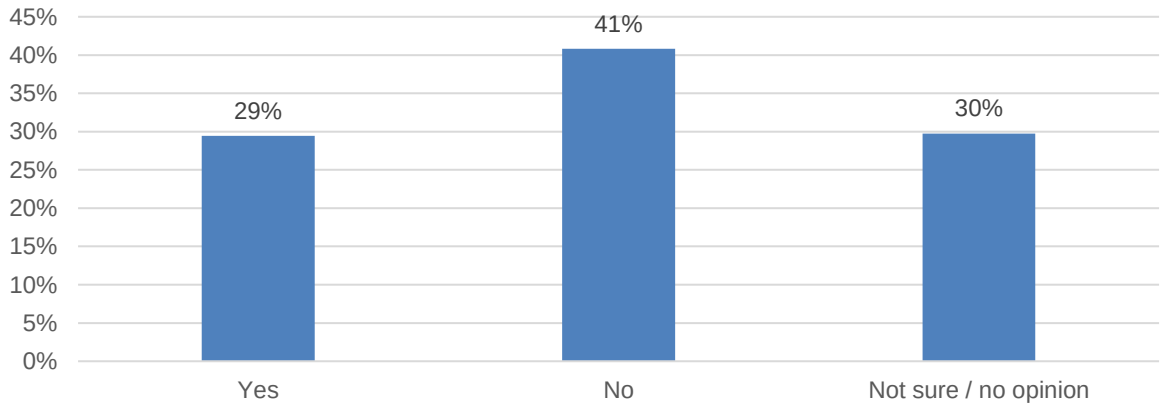
Section 7: Delivery of remote care and technology

Technological development

276. We asked stakeholders if they had any knowledge or experience of areas of technological development that the GOC should be aware of when considering changes to the Act.

277. Of the 316 respondents who answered the question, 41% said that they didn't have any knowledge or experience, 29% said that they had and 30% were not sure or had no opinion.

Graph 33: 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?
Base: 316



278. The following themes were identified from the comments:

- there were no areas of the Act that had restricted innovation in technology or prevented artificial intelligence (AI) developments, as these developments have happened despite the Act being in place;
- some examples given of developments and advancements in optics are:
    - remote delivery of services such as sight tests, refraction, triage and healthcare professionals sharing virtual diagnostic information;
    - remote testing and diagnostic tools such as home visual acuity monitoring apps, digital imaging, remotely operable slit lamp and iPhone ophthalmoscopes;
    - optical coherence tomography (OCT) and use of AI;
    - clear-lens extraction;
    - free-form lenses; and

    - online purchasing of spectacles and contact lenses;

- the GOC must clarify and distinguish between words and terms such as ‘technology’, ‘remote care’, ‘remote refraction’ and ‘AI’. These are all very different terms with different policy implications. Moreover, terms such as technology and AI are umbrella terms that encompass a wide range of developments, all with different levels of risks and benefits to patients;

- COVID-19 accelerated the provision of remote care and remote consultations which was beneficial to patients (some good examples are Minor Eye Conditions Service (MECS) or Community Urgent Eyecare Services or COVID-19 Urgent Eyecare Service (CUES)) and helped to reduce the burden in secondary care);

- the GOC should distinguish between, for example, remote care done under the supervision of a GOC registrant and care delivered remotely unsupervised;

- there are many benefits in relation to remote care such as: increasing access for some groups of patients as it is easier to dial in than attending in person; reducing patient waiting times; freeing up services for more complicated cases; and reducing the burden in secondary care. However, remote care is not beneficial for all types of patients, and could exacerbate health inequalities within some groups. Some patients may not be digitally literate or have access to smart phones and digital devices, so it is important that patients can access care in a method suitable for them;

- there may be financial barriers that could prevent some businesses (for example, smaller businesses) from being able to afford new technology and offer this to patients, or patients having to pay more, for example, for a sight test with OCT. Both these situations could exacerbate health inequalities as some patients either won’t have access to or will not be able to afford to pay extra to access new technologies;

- while technological developments and AI have the potential to benefit patients, there are also risks associated with these developments, for example, the availability of online sight tests is seen as a risk to patients as it is unclear how this method of testing could offer the same quality and data as an in person test, and could result in conditions going undetected. Online sight testing and online refractions provided by companies based outside the UK were also seen as a risk as they did not fall within the GOC’s regulatory remit;

- to mitigate against potential risks, competent and registered healthcare professionals must remain at the centre of clinical decision making; and

- the Act should not restrict innovation but equally it must protect the public.

279. A sample of comments is available in the box below.

"We do not see anything in the current Act precluding the utilisation of technological developments. It is important to note as well that Remote care, technology and AI are not the same things. They will also mean different things to different eyecare providers and patients. Definition of what is meant by these terms is necessary." LOCSU

"We have seen the huge benefits in the sector and for the patient in the optometrist-led remote care which was delivered during the COVID pandemic. Remote care was an advantageous tool especially for patients who couldn't attend a face-to-face appointment for health risks or who were unable to travel." AOP

"I work with low vision patients and people with learning disabilities and I have seen the use of telemedicine during the lock down be almost totally inaccessible to these groups with very little options offered." Optometrist

"Smart phone apps and other remote technology is developing constantly and is a risk to patient safety if not managed and regulated correctly. Technology advancement can be positive as seen during the pandemic but needs consideration and caution." Bexley, Bromley & Greenwich Local Optical Committee

"The central principle for optical regulation and practice should be that registered, competent optical professionals must remain in control of clinical decision-making as new technologies and innovations are deployed. The Opticians Act should not unduly restrict innovation, but should also maintain its current fundamental principles to ensure the public benefits from safe care and regular and complete sight tests." The College of Optometrists

"There are a huge range of technological developments that are changing how ophthalmic care is being delivered, across the whole patient pathway from primary to secondary care. These include AI, video consultations, home visual acuity monitoring apps, virtual diagnostics and shared electronic patient referral systems." Royal College of Ophthalmologists

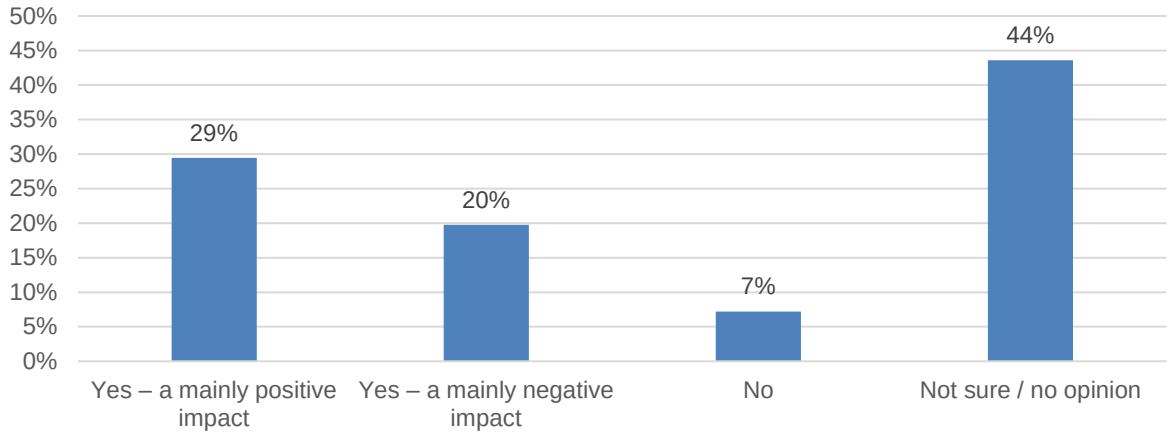
Impact on patient safety/care

280. We asked stakeholders whether there was any evidence that increased use of technology or remote care may have an impact on patient safety or care in the future.

281. Of the 319 respondents who answered the question, 29% said that the evidence suggested a mainly positive impact, 20% said that the evidence

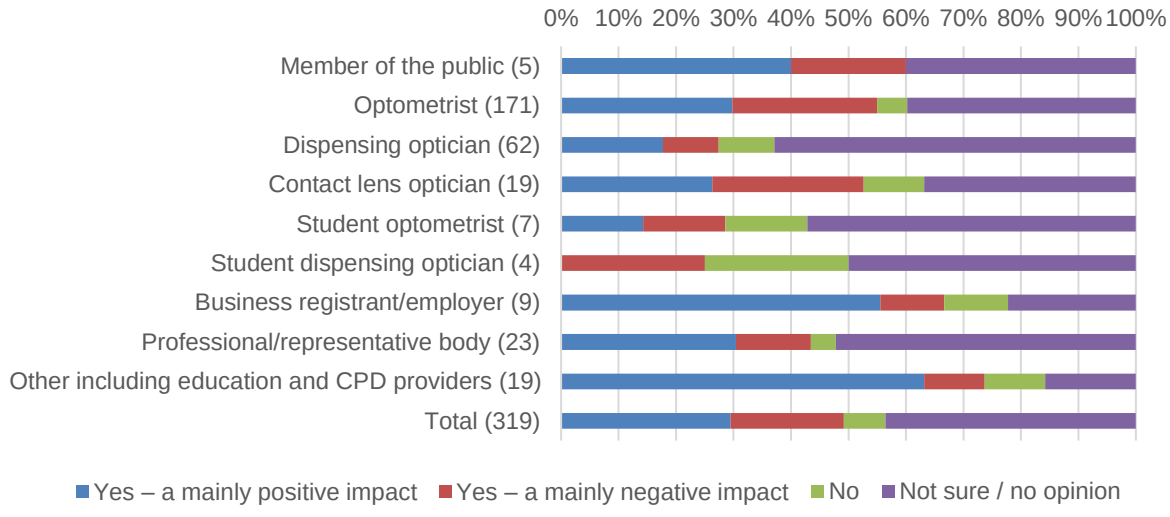
suggested a mainly negative impact, 7% thought there wasn't any evidence and 44% were not sure or had no opinion.

Graph 34: Is there any evidence that increased use of technology or remote care may have an impact on patient safety or care in the future?
Base: 319



282. Graph 35 shows that members of the public, business registrants/employers and other including education and CPD providers were more likely than other categories of respondent to think that the evidence showed a mainly positive impact on patient safety or care in the future.

Graph 35: Is there any evidence that increased use of technology or remote care may have an impact on patient safety or care in the future?
By category of respondent
Base: 319



283. The following themes were identified from the comments (where not covered in responses to the previous question):

- there was support for both use of technology and remote care but only under the right conditions i.e. if it's in the best interests of that particular patient and works as well as a face to face interaction;
- increased accessibility is one of the main advantages of remote care and this could help with patient compliance with treatments as they have more access to healthcare professionals. On the other hand, a risk is that details about a patient could be missed from a remote care appointment that might have been picked up by an in person appointment;
- technology has helped with record sharing between patients and healthcare professionals, and also between primary and secondary care;
- robust evidence and further research is needed when evaluating the impacts of remote care / technology / AI;
- compliance with GOC standards is key in protecting patients, and risks should be addressed via standards rather than changes to the Act;
- the risk is with companies based outside of the UK who are not bound by GOC standards and legislation; and
- telemedicine worked well during COVID, but the sight test must not be done remotely.

284. A sample of comments is available in the box below.

"Remote care can give greater access to services when an in person visit is not possible however I feel that in the majority of cases an in person examination is more appropriate." Dispensing optician

"I am incredibly concerned about the concept of remote refractions and their accuracy. The potential to miss pathologies, send customers (not pxs [patients]*) out to drive or operate machinery in spectacles prescribed in this way is frightening."* Optometrist

"It has the potential to impact on the patient safety of people who have barriers to accessing the internet… However, there is no clear-cut answer to this question, technology can bring a lot of positive elements but it relies heavily on how it is implemented and put to use. Technology for example has improved communication between primary and secondary care, but remote care can risk excluding some patients who are not digitally literate, especially if remote care is the only easily available option." RNIB

"Technology and remote care are two different topics that should be addressed separately. The GOC should not combine the two when considering the outcomes of this Call for Evidence … there have been many advances in eye care-related technology, which create both opportunities and risks. There needs to be robust analyses of these impacts on patient and public health. There is not yet a robust evidence base on the overall impact of the increased use of technology or remote care on future patient safety or care, although individual studies are being published and adding to our growing knowledge." The College of Optometrists

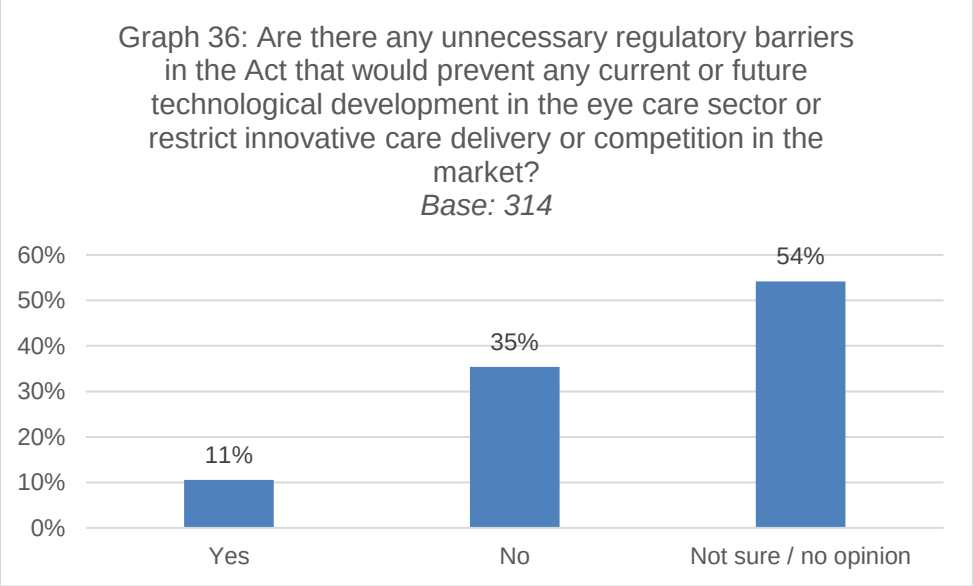
"The use of technology in optical practice raises different issues to the application of remote care so this is a difficult question to answer and there would be value in breaking it down further. The use of technology in practice in line with legislative requirements and GOC standards is likely to continue to enhance patient care by, for example, improving the diagnosis of eye disease and wider health issues. The use of remote care has the potential to increase the risk to patients if it is carried out by offshore business that are not bound by UK legislation and without the involvement of GOC registrants." ABDO

"The answer is more complicated than the options allow. Both technology and remote care will have an impact on patient care but, whether this is positive or negative, will depend in large part on the robustness and clarity of the GOC's standards. FODO and our members support all clinical and service innovations that advance safety, effectiveness, and patient and public benefit. We also support choice and innovations in optical technologies that improve outcomes for patients and advance eye care provision for populations." FODO

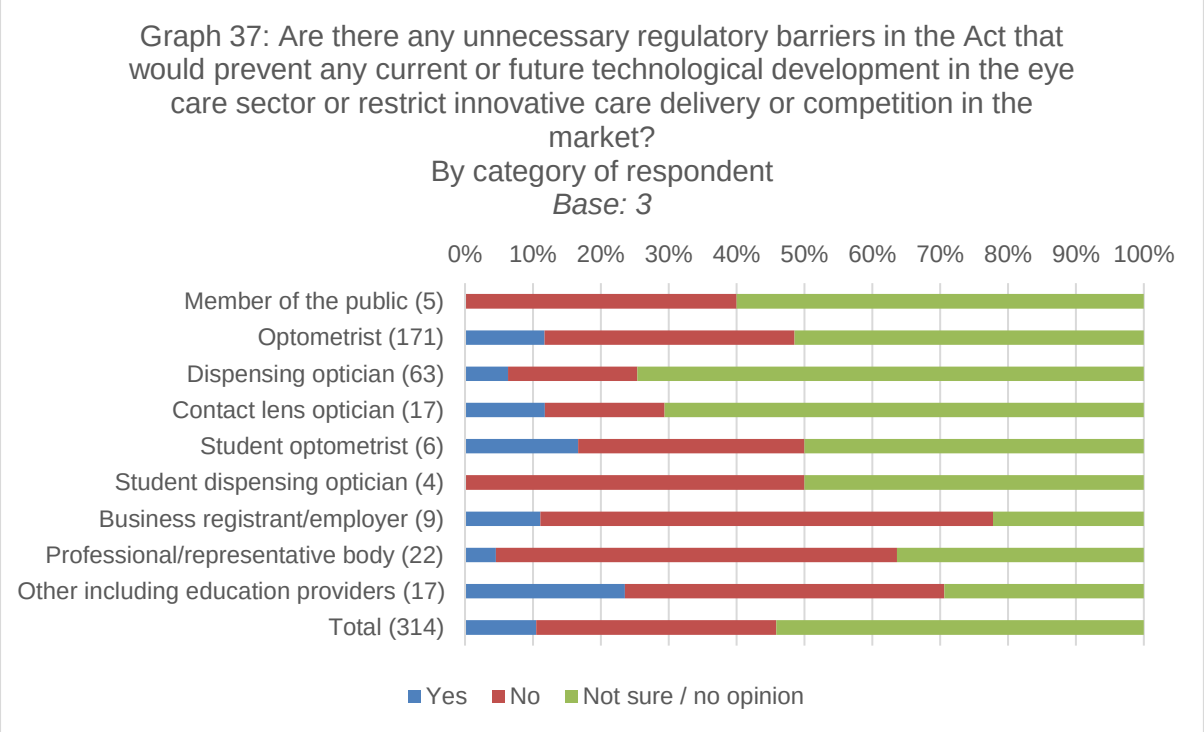
Unnecessary regulatory barriers – preventing technological development

285. We asked stakeholders whether there were 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.

286. Of the 314 respondents who answered the question, 35% didn't think there were any unnecessary regulatory barriers, 11% thought that there were and 54% were not sure or had no opinion.



287. Graph 37 shows that student optometrists and other including education providers were more likely than other categories of stakeholder to think that there were unnecessary regulatory barriers.



288. The following themes were identified from the comments that had not already been raised previously:

- the Act doesn't take account of remote care or remote consultations as it pre-dates these developments; and

- there should be more guidance for registrants from the GOC on technological developments to help them better understand how to deliver this in a safe and efficient way to benefit patient care.

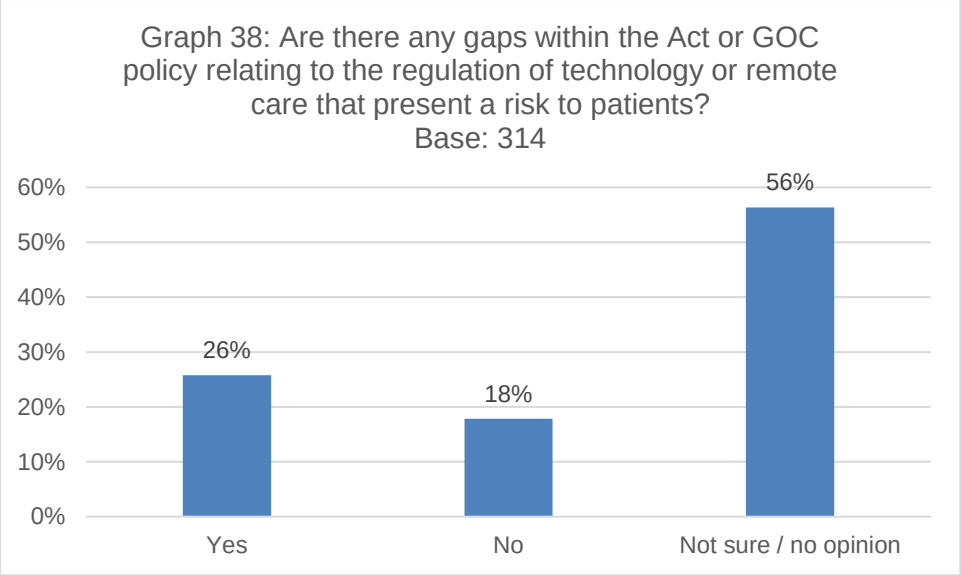
289. A sample of comments is available in the box below.

> *"Thus far it has proven possible to adopt the use of chosen technologies without finding that current legislation creates a barrier. Rather, by using technology to work within current legislation assures the patient protections the legislation intended, and provides guiding principles for how the technology is used and further developed."* Optometry Northern Ireland
>
> *"Although most technological developments that are currently and commonly used in practice did not exist or envisaged when the Opticians Act came into effect or was amended in 1989, the Act does not restrict the type of equipment, products or technology that can be used by registrants."* The College of Optometrists
>
> *"No, the longstanding adoption of latest diagnostic testing equipment and changing therapeutics by the optical sector is clear evidence of this. It may be the case that some stakeholders might perceive barriers when a technology is advertised but not actually available. This however is in fact because new advertised technologies are not supported by good evidence and registrants rightly do therefore not deploy them. Hence, rather than a barrier, such examples are evidence of the Act working well to protect patients and the public. This is achieved via GOC standards for protecting patients and securing high quality care."* FODO

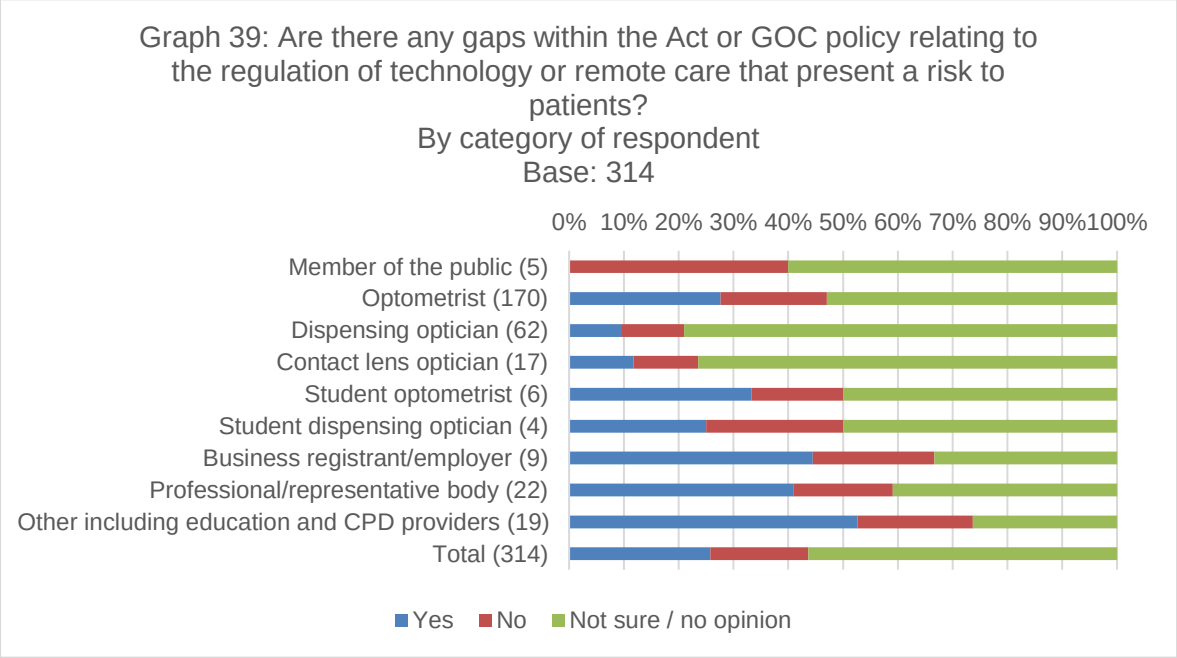
Gaps in regulation of technology or remote care

290. We asked stakeholders whether there were any gaps within the Act or GOC policy relating to the regulation of technology or remote care that present a risk to patients.

291. Of the 314 respondents who answered the question, 26% thought that there were gaps, 18% didn't think there were gaps and 56% were not sure or had no opinion.



292. Graph 39 shows that student optometrists, business registrants/employers, professional/representative bodies and other including education and CPD providers were more likely than other categories of respondents to think that there were gaps within the Act of GOC policy.



293. Respondents returned to the same themes as in their answers to previous questions in this section, for example, that the legislation has not held back innovation and use of technology, the role of GOC standards and guidance in supporting registrants, the merits of sight tests conducted remotely and regulation of online sales by overseas providers.

294. Respondents challenged us to evolve our regulatory approach to meet the challenges posed by technological developments and remote care.

295. A sample of comments is available in the box below.

> *"I'd like to see the GOC working with tech developers/suppliers to better understand the direction of travel. Any use of technology is, I think, down to the registrant to decide whether it's appropriate, which could prove problematic, so some regulation, or at least changes to policy/guidance, working with ABDO, College of Optometrists, is needed to protect registrants and the public."* Dispensing optician
>
> *"We are concerned that the GOC has not evolved its regulatory approach to meet these challenges and protect patients from companies offering components of online/remote optical care without appropriate registrant involvement and/or standards of care. Regulatory oversight needs to adapt to maintain public protection. We note with interest (and support) that the Medicines and Healthcare products Regulatory Agency (MHRA) has announced plans to strengthen regulation of medical devices including medical devices that involve AI. Appropriate regulatory mechanisms should be used to manage the risks that arise from new technologies, such as AI and remote care. This includes standards for individuals and businesses, including GOC regulatory action where care is being delivered in novel ways that pose risks to patients."* AOP

Suggestions for addressing gaps in regulation of technology or remote care

296. If they answered yes to the previous question, we asked stakeholders whether they had any suggestions about how these gaps in the regulation of technology or remote care could be addressed.

297. The following themes were identified from the comments:

- any gaps in regulation should be addressed via GOC standards and guidance rather than amendments to the Act, for example, there was support for the GOC providing guidance on remote care;
- there must be clear lines of accountability for registrants with the advancement of new technologies, AI and remote care. Technological and AI innovations will likely challenge the traditional roles of GOC registrants and blur the lines of accountability and responsibility for decision making;
- GOC registrants must continue to have oversight and responsibility for clinical decision making if remote care is delivered to patients;
- regulation must evolve and be agile and flexible so as not to hinder technological developments but at the same time patient protection must remain at the forefront of any developments in technology and AI;

- the GOC should look at what the MHRA is doing, for example, some AI developments are being treated as medical devices and therefore subject to greater regulation; and
- new risks will emerge as technology and AI develop, and it is not always easy to foresee what these might be in future.

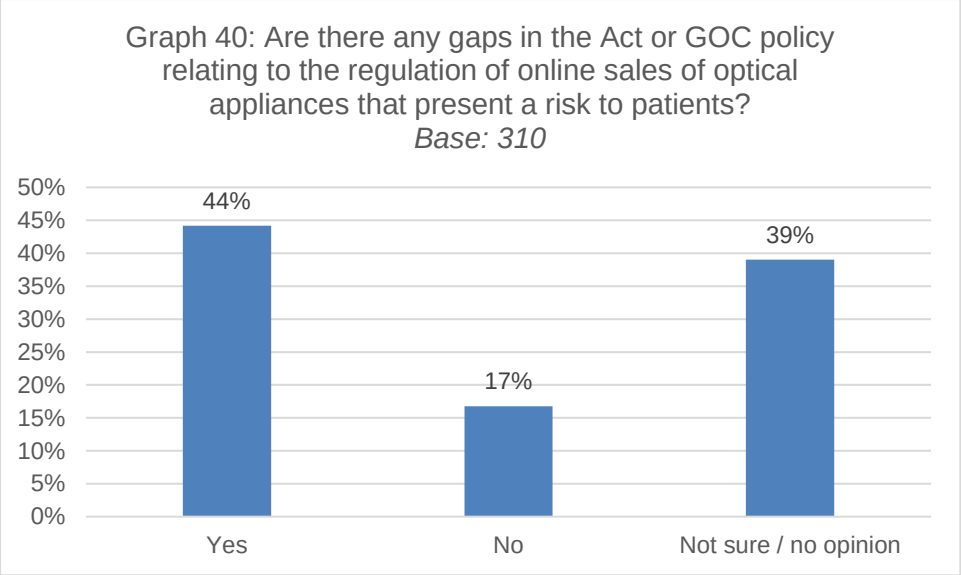
298. A sample of comments is available in the box below.

> *"The GOC should review its policy statement on supervision to reflect developments in the delivery of eye care, including hybrid models. It should also ensure this is enforced effectively. The GOC should consider further how it might promote technological literacy through, for example, its education requirements, standards of practice, business standards and CPD scheme."* ABDO
>
> *"Regulation should ensure that appropriately skilled optical professionals remain responsible for decision making around eye care, and that their role for patient care is not adversely affected by the use of new technology or remote care. Good regulation in this sphere would help in managing the implications of new technology. The growth of the use of artificial intelligence to support diagnostic decision-making and screening raises questions about the interaction between regulation of individual practitioners and the regulation of devices. The increasing delivery of services and sales of medical devices via the internet is challenging the traditional limits of regulation. Regulation must evolve to maintain public protection."* AOP
>
> *"We recommend that all regulators, including the GOC, review how they will determine lines of accountability for new technologies. It will be important for regulators to collaborate both with other regulators and other stakeholders with involvement in this area to ensure a consistent approach which will be necessary to ensure clarity for professionals, patients and service users."* PSA

Gaps in regulation of online sales

299. We asked stakeholders if there were any gaps in the Act or GOC policy relating to the regulation of online sales of optical appliances that present a risk to patients.

300. Of the 310 respondents who answered the question, 44% said that there were gaps that presented a risk to patients, 17% said that there weren't any gaps and 39% were not sure or had no opinion.



301. The following themes were identified from the comments:

- there is frustration that the GOC is not able to do more to deal with the online supply of spectacles and contact lenses from companies based outside of the UK;
- there are risks of remote care being delivered outside of the UK without supervision or oversight from a GOC registrant including:
    - risks that patients are unaware that the company providing the service is not subject to UK regulation and do not have to abide by regulatory standards; and
    - risks that if something goes wrong there is no remedy for the patient as the company is based outside of UK jurisdiction;
- the lack of regulatory oversight presents risks to patients, for example, as many online companies based outside the UK:
    - do not require an up to date sight test and prescription before dispensing spectacles and contact lenses;
    - do not verify the dispensing measurements which can result in badly and incorrectly fitting spectacles and contact lenses;
    - can substitute the contact lenses prescribed by a GOC registrant with an alternative[39]; and
    - put profits before patient care;

[39] NB It should be noted that there is no specific legal requirement in the Act to supply contact lenses only in accordance with the contact lens specification.

- patients may be unaware of these and other types of risks;
- there is a burden on registrants and the NHS as they have to deal with eye care issues that patients have had from buying online;
- online supply should be restricted to exclude those with more complex needs, for example, patients under 16 years old, patients with high prescriptions (for example, +5.00), bifocal, multifocal; and
- there is a risk that patients buying online will go less regularly for sight tests and potentially put their eye health at risk, for example, as asymptomatic conditions like glaucoma are not picked up early.

302. A sample of comments is available in the box below.

"Online businesses should not be claiming it's ok to buy glasses online and to simply "pop along to your local optician for an adjustment", they shouldn't be selling/supplying contact lenses without any evidence of a valid specification and they shouldn't be villainising the optician as a marketing ploy. We have all had the experience of a patient buying random contact lenses online, only to end up with terrible vision, ulcers, a lens "stuck" in their eye etc since they've had no appropriate instruction or care provided." Dispensing optician

"Online sales need to be regulated. It is not safe for people to be able to purchase online without a registrant who has examined the patient verifying the prescription and specifications." Optometrist

"The inability to regulate non-UK online sellers is the greatest risk to patients. Inevitably, a non-regulated seller is less likely to adhere to GOC standards which are in place to protect the public." Business registrant/employer

"In terms of remote care - there is very little evidence around this area in eyecare so clearly defined scope of practice underpinned with regulations is needed." Education provider

"There is nothing to restrict the testing of sight of a patient by an unregulated professional that is situated in another country via remote care technology. They would fall outside the jurisdiction of the GOC. The risk to patients is that they are unregulated and could cause harm. There is also risk in the GOC not being able to enforce the Act on the individual as it will continue to happen. We know this to be true from the sale of contact lenses by overseas sellers. Over the years the GOC has not been able to enforce rules on these sellers." AIO

Suggestions for addressing gaps in regulation of online sales

303. If they answered yes to the previous question, we asked stakeholders if they had any suggestions about how these gaps in the regulation of online sales of optical appliances could be addressed.

304. The following themes were identified from the comments:

- require all optical business to register with the GOC;
- all businesses providing optical appliances into the UK must be required to register with the GOC even if the company is based outside of the UK;
- the GOC should be given more regulatory powers to investigate and prosecute illegal sales. Also, the GOC should work more with overseas regulators and enforcement agencies to notify them when companies are supplying optical appliances into the UK;
- there should be more public awareness raising by the GOC about the risks of buying online and the harm that patients might face from poorly and incorrectly fitting spectacles and contact lenses;
- there must be oversight by a GOC registrant when selling online to patients;
- introducing a GOC kitemark could show the public that the business is registered with the GOC; and
- specific regulatory safeguards, including:
    - online sellers must be required to verify that the patient has an up to date sight test and prescription;
    - restrict the supply of certain lenses online, for example, prescriptions not exceeding +5.00, bifocal and multifocal; and
    - ensure that online companies are providing aftercare advice after selling contact lenses to patients.

305. A sample of comments is available in the box below.

"Ensure all websites with a .co.uk domain are registered with the GOC and following UK rules. Making sure spectacles and contact lenses are treated as medical devices and ensure that personal importation of them follows the same rules as other medical devices." Business registrant/employer

"Awareness to the public about who does and doesn't conform to GOC standards. A bit like ATOL protection for holidays where holiday goers can be reassured. A

GOC stamp of approval for optical sales where patients know they have some protection in terms of the supplier can be held to account." Business registrant/employer

"The verification of dispensing measurement by a registrant is missing. Currently patients can take their own measurements and submit them online and this can create errors in the spectacles that the patient receives meaning that patient cannot use them safely." Education provider

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

"We would like to see full consideration given to these questions as part of the Government's regulatory reform programme. This should include a full review of all regulatory powers and whether they are sufficient to address current and future challenges and protect the public." PSA

GOC response – delivery of remote care and technology

306. Respondents argued persuasively that the Act has not impeded or restricted advancements in technology and remote care. In our view, the optical sector would benefit from a shared understanding of the latest developments and a mechanism to keep this knowledge up to date. We will discuss with stakeholders how best to achieve this .

307. If the existing legislation is not impeding innovation or harming patients, we recognise our own responsibility to ensure that the GOC's regulatory arrangements are proportionate and that we help to foster innovation that maintains public trust. Regulation needs to strike the right balance between protecting patients and fostering innovations in the sector which would benefit patient care.

308. We have heard from stakeholders that the use of technology and AI can cause uncertainty for registrants, for example, as the boundaries of decision-making and accountability become blurred. It was suggested that we should review our standards and guidance to reflect developments in this area and provide more advice for registrants. We will take on board these comments as part of the review of our Standards of Practice for Optometrists and Dispensing Opticians, Standards for Optical Businesses, Standards for Optical Students and guidance documents that is already in progress.

309. Issues concerning lines of accountability for decision-making are challenging all healthcare regulators, and indeed regulators across the economy and public services. It is possible that the law will evolve over time and the GOC will continue to engage with these developments. Indeed, we would welcome collaboration and cross-sector working between government departments and healthcare regulators to help develop shared approaches.

310. Other regulatory changes we are proposing, such as expanding the scope of business regulation, will also assist in managing risks that may develop. All businesses within the scope of the legislation will be subject to our standards whether they operate physically or online. Similarly, these standards require registrants to provide safe and effective care whatever tools they use.

311. The GOC's ability to act against online providers is limited by geography. This applies to providers based outside of the UK operating lawfully but providing poor quality goods and services, as well as to providers operating illegally. In its 'Safer care for all' report[40], the PSA used examples from the pharmacy, dentistry and care sectors, as well as optical services, to demonstrate this is a cross-cutting issue that has accelerated following the COVID-19 pandemic. In its report the PSA challenges governments to "ensure regulators have the agility to address the challenges brought about by new approaches to funding and delivering care, including the introduction of new technologies". We welcome the PSA's challenge and will work with relevant healthcare regulators, the PSA and governments to explore possible solutions in these areas.

312. In our GOC response to our consultation on illegal practice strategy and protocol we said:

    "The Opticians Act applies only in the UK. It is difficult to use UK law to prosecute an overseas company even where the purchaser is in the UK. There would be practical problems in presenting a hearing without the power to compel the defendant to attend a UK court. It would also be extremely hard to enforce any conviction or order.

    In addition, the criminal offences relating to supply do not arise at distribution stage - they arise at the point of sale. The Act does not provide the GOC with any legislative basis on which to act against distribution centres and we consider that to do so would be beyond our statutory remit.

    We note the comments seeking reform of the Act including additional powers for the GOC to act against illegal practice. An extension of our remit through legislative reform will require a clear evidence base linking illegal online supply and risk of harm, or risk of potential harm, to the public. The GOC encourages

[40] Professional Standards Authority for Health and Social Care (2022), *Safer care for all: Solutions from professional regulation and beyond*

the sector to provide evidence of harm caused by illegal online supply as part of our call for evidence on the Opticians Act and consultation on associated GOC policies and explain how the evidence base necessitates additional offences and enforcement powers in order for the GOC to protect the public."

313. [Placeholder for paragraph regarding PSA report once published.]

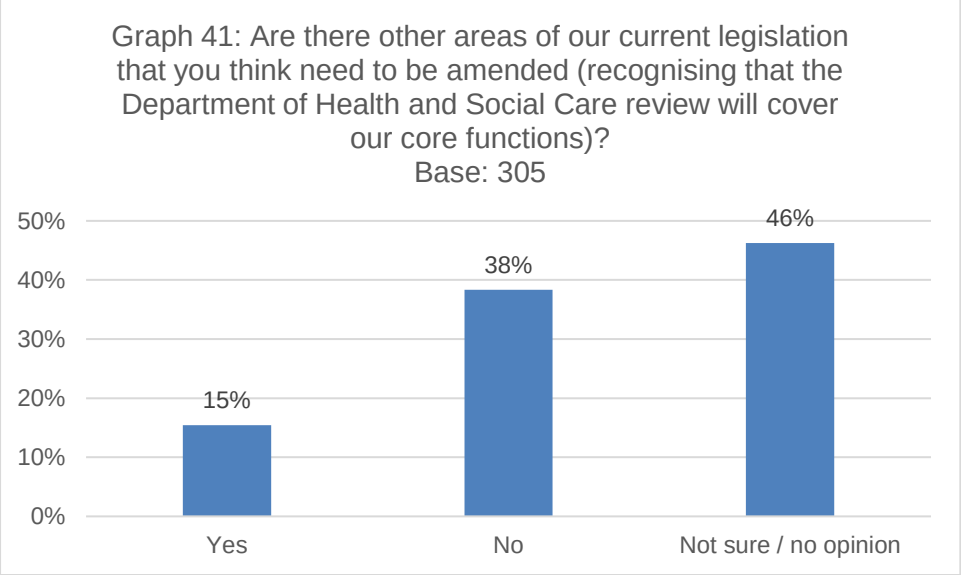
314. In summary, we recognise this is a rapidly changing area and that patient safety concerns are widely held, but that the current evidence base is weak. The GOC will continue to keep these matters under review and discuss future approaches with DHSC, the PSA and regulators facing similar challenges.

Section 8: Any other areas

Any other areas of current legislation requiring amendment and gaps in regulation requiring legislative change

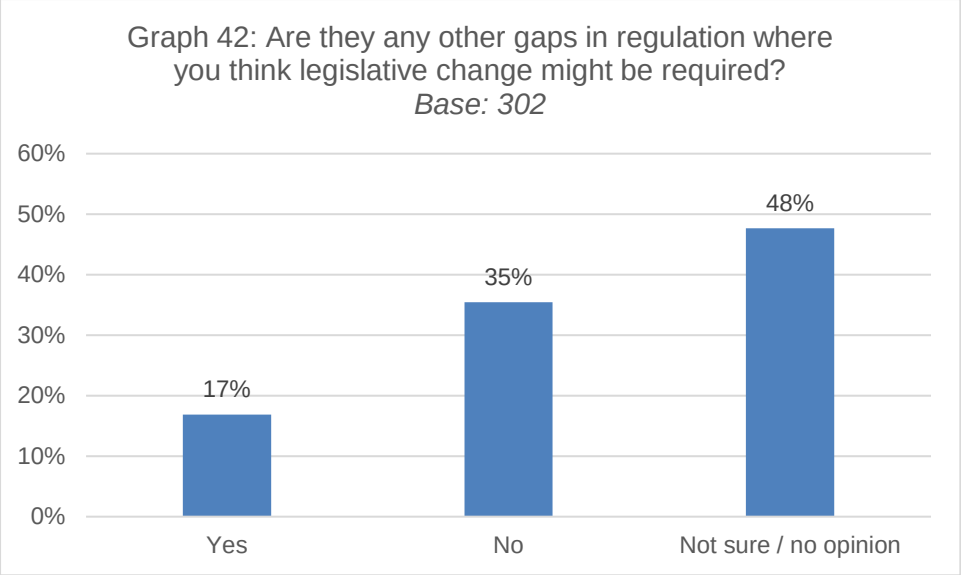
315. We asked stakeholders if there were any other areas of our current legislation that they thought needed to be amended (recognising that the Department of Health and Social Care review will cover our core functions).

316. Of the 305 respondents who answered the question, 38% did not think that there were any other areas of legislation that needed to be amended, 15% thought that there were and 46% were not sure or had no opinion.



317. We asked stakeholders if there were any other gaps in regulation where they thought legislative change might be required.

318. Of the 302 respondents who answered the question, 35% did not think that there were any other gaps in relation where legislative change might be required, 17% thought that there were and 48% were not sure or had no opinion.



319. Most of the comments in response to the previous two questions had already been mentioned in previous sections of the consultation and/or were not relevant to Act. The following themes were identified from the comments:

- the Act should specify a minimum length of time for the sight test – we have previously advised that it is not appropriate for the GOC to specify minimum appointment times and this extends to the Act. These can vary for a number of reasons (e.g. history of patient or size of premises) and is a matter of professional judgement. Safeguards are in place through our standards which ensure safe and effective care, and it is open to anyone to complain about a registrant putting patients at risk through inappropriate testing times;
- optometrists should be able to prescribe – optometrists can already prescribe a specific list of medicines specified in the Human Medicines Regulations 2012 and it is not clear what further amendments the respondents had in mind or the evidence for it;
- removal of student registration – this is expected to happen as part of the DHSC's legislative reform programme; and
- it should be possible to take a deposit prior to a sight test – see GOC response at the end of this section.

320. There were some specific suggestions including:

- that general practitioners (GPs) should have their right to prescribe removed – the reason and evidence basis for this was not clear and this would be a matter for other legislation, not the GOC's;
- the sections of the Act related to exemption of 'Ministers of the Crown of Government department' (sections 27(4) and 27(5)) should be removed –

we have reviewed these sections and our view is that the exemptions appear to be reasonable, for example, there should be stricter processes for supplies to individual users than supplies to a government department, NHS body and GOC registrants. We are not aware of any public protection risks associated with supplies to government bodies and it would seem inappropriate for Parliament to bind itself by preventing a "Minister of the Crown or Government department" from purchasing optical appliances;

- '…title of registered optometrist' should be replaced with 'title of optometrist' in section 28(1)(c) of the Act – we do not consider this amendment to be necessary as using the title of 'optometrist' alone is already covered in section 28(1)(a) of the Act, however, we will review the ordering of the wording in this section as we think it could be made clearer in any new legislation as part of the DHSC's legislative reform programme; and

- section 26(1)(b)(i) of the Act should be more than an optometrist confirming that he has carried out 'the examinations that the regulations require' – the reasons for this requested change were not clear and we do not consider that any changes are necessary.

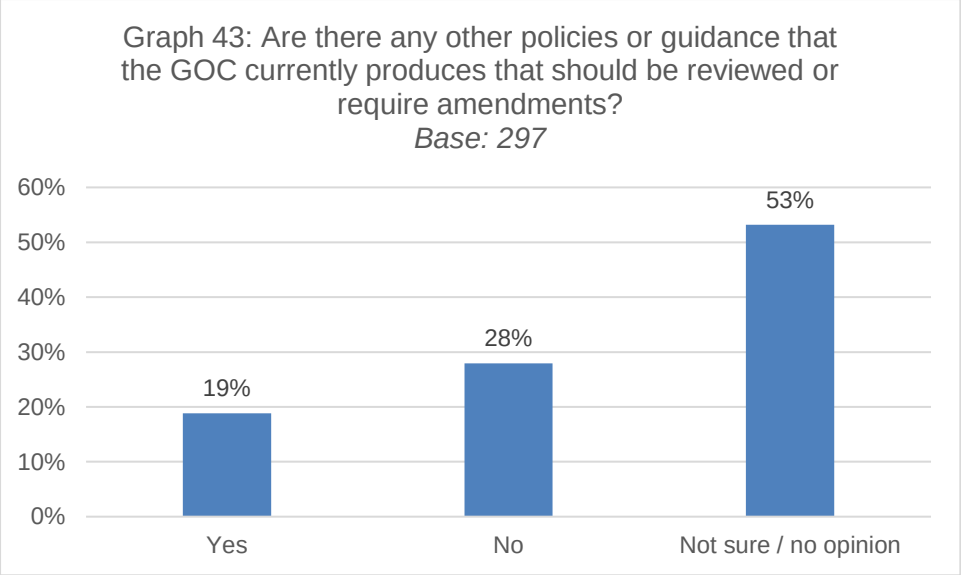
321. A sample of comments is available in the box below.

> *"…I feel a minimum testing time of 30 minutes should be enforced in all stores…"* Optometrist
>
> *"all optometrists should be able to prescribe eye medication"* Student optometrist
>
> *"The part where is says that the patient is not allowed to pay before the appointment. We should be able to take a deposit for bookings in order to protect our business as why should we have to lose out if patients do not turn up for their appointments. Other healthcare businesses are allowed to charge, why not opticians?..."* Optometrist

Policies or guidance requiring review or amendment

322. We asked stakeholders if there were any other policies or guidance that the GOC currently produces that should be reviewed or required amendments.

323. Of the 297 respondents who answered the question, 28% didn't think there were any other policies or guidance that should be reviewed or required amendments, 19% thought that there were and 53% were not sure or had no opinion.



324. The following themes were identified from the comments:

- minimum sight testing times (this had already been mentioned in the context of legislation but some thought that GOC policy or guidance was a more appropriate place to address it) – as outlined in paragraph 319 we have previously advised that it is not appropriate for the GOC to specify minimum appointment times;
- further guidance on supervision of students and trainees, including how employers can support supervisors – we will keep this under review with education providers and professional bodies. It may be that it is more appropriate for providers of approved qualifications to issue this guidance to those employers or placement providers offering periods of professional and clinical experience or other forms of experiential learning; and
- if student registration is not removed, further guidance on the responsibility of students to register with the GOC – under current handbooks, providers have a responsibility to ensure that students are registered with us and we carry out student roadshows / welcome events to raise awareness of the need to register and retain. In the new education and training requirements we have two related standards: S1.1 emphasises that there must be policies and systems in place to ensure students understand and adhere to GOC standards; and S1.4 emphasises the providers' role in informing students that they must be registered with the GOC at all times whilst studying on a programme. We are not prescriptive about what the policies and systems need to be but draw attention to the requirement to have robust systems in place. This could include a system to ensure that the GOC is appropriately and regularly informed regarding any changes to class lists and having policies in place to deal with any individuals who are not registered with the GOC during their studies.

325. The AOP raised concerns about the "appropriateness and quality of the GOC's framing of allegations in FtP cases", arguing that improvement was needed in our policies, processes and training in this area. Further training on allegation drafting has taken place and we have introduced lawyers into our investigations process which we consider will improve the end-to-end approach to investigations, including the drafting of allegations.

326. The AOP also raised the need to review our declarations guidance, as they often receive queries from members on this process related to health declarations. We are planning a review of this guidance and will take the AOP's comments into consideration as part of the review.

327. There were some suggestions from individuals or organisations where the Standards of Practice for Optometrists and Dispensing Opticians and Standards for Optical Businesses could be made clearer and we will consider these as part of our review of the standards.

328. A sample of comments is available in the box below.

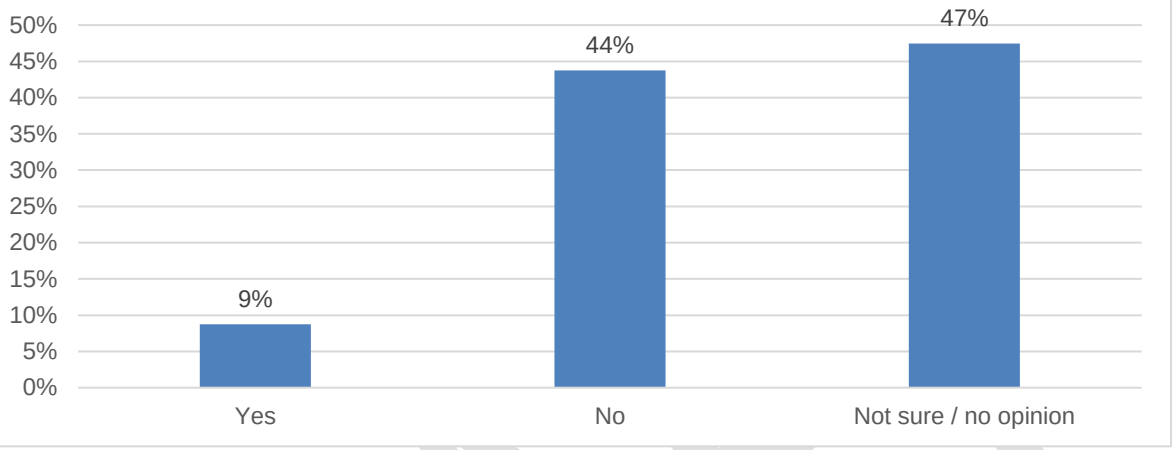
> *"Supervision of trainees and how employers can support supervisors so that they can train the future workforce safely without the commercial pressures of selling/productivity, etc."* Optometrist
>
> *"…If student registration is maintained, we suggest that the GOC make responsibility for registration 'sit' with the individual trainee, rather than making policing each student's registration part of the educator's responsibility. Monitoring of student registration by the GOC and HEIs* [higher education institutions] *at the present time is resource heavy and inefficient when individual students should be tasked with taking responsibility for their registration and the consequences of not being registered. The consequence of an individual trainee's lack of registration should not endanger a programme's accreditation status."* Optometry Schools Council
>
> *"…If student registration is maintained, we feel it is unreasonable to pass on the responsibility to check student registration on to the training provider, but this should sit with the individual registrant as it will do once they are qualified."* Aston University

Impacts of legislation

329. We asked stakeholders if there were any other impacts of our legislation that they 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).

330. Of the 297 respondents who answered the question, 44% did not have anything to tell us about in relation to impacts of our legislation, 9% did and 47% were not sure or had no opinion.

Graph 44: 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?
Base: 297



331. The following areas were identified from the comments:

- legislation should protect the most vulnerable, particularly those who are seen in domiciliary settings, with concern that the current legislation doesn't protect those with learning disabilities – this will be taken into consideration when we carry out impact assessments on any changes that we are proposing to make, which will then be consulted upon to allow for further views on impact;
- the language in the Act should be gender neutralised – we agree that gender neutral language should be used and that would be our expectation for any new Act; and
- any changes to legislation might impact on other healthcare professionals and disciplines (e.g. workforce needs and multidisciplinary teams) or cause unwanted financial burden for the optical sector – this will be taken into consideration when we carry out impact assessments on any changes that we are proposing to make, which will then be consulted upon to allow for further views on impact.

332. A sample of comments is available in the box below.

"…The vulnerable need greater protection through greater sanction of the use of registrants by businesses particularly when the patient is dispensed, or the optical appliance delivered to them for fitting, in their own home…" CPD provider

"…It is our opinion that regulation and associated guidance should be predicated on ensuring equality of access and that any patient is not disadvantaged because of a protected characteristic or at any point over their life course.

Some patients with a protected characteristic are more susceptible/at risk of eye disease or sight loss for reasons including:

- *Eye disease is more prevalent in some groups, for example Asian and Black ethnic groups are at greater risk of eye disease such as glaucoma and diabetic retinopathy*[41]
- *Contributing factors, for example pregnancy or fertility treatment can cause blurred vision or cause refractive change*[42]
- *Some people can be excluded or disadvantaged from accessing healthcare, for example black communities in the UK are less likely to attend primary eye care appointments despite the increased risk of sight loss*[43]*"* AOP

"Please see elements of our response elsewhere with relation to people with learning difficulties, in its current form the legislation puts them at greater risk of sight loss." RNIB

GOC response – any other areas

333. We have considered the suggestions in this section. The one area that we agree where a change in the Act may be required is in relation to enabling a deposit to be taken prior to a sight test – our initial view is that it seems reasonable to be able to take a deposit for a sight test given that other healthcare professionals may charge cancellation fees. If we consider that we do wish to pursue a change in this area, we will carry out further consultation to further understand the impacts and ensure that there are no unintended consequences of a change in policy and/or legislation.

[41] Scase, M.O. and Johnson, M.R. (2005), Visual impairment in ethnic minorities in the UK, *International Congress Series* 1282 (2005) 438-442
[42] https://www.aop.org.uk/advice-and-support/for-patients/eye-care-blogs/2020/09/17/how-your-eyesight-changes-during-pregnancy
[43] Elam, A.R. and Lee, P.P. (2013), High-risk populations for vision loss and eye care underutilization: a review of the literature and ideas on moving forward, *Surv Ophthalmol*, 2013 Jul-Aug; 58(4): 348-58

Annex 2

Analysis of arguments for and against refraction by dispensing opticians for the purposes of the sight test

What is refraction?

A sight test consists of a series of elements to measure how well a patient can see and to look for any problems that might be affecting the overall health of the eyes. Refraction is performed as part of the sight test where the eye care practitioner determines what, if any, optical prescription (or change to the current optical prescription) is required. There are two methods of performing refraction:

- Objective refraction: This is done using tests which do not require responses from the patient. The objective assessment can be done using an autorefractor (automated and often operated by optical assistants) or using retinoscopy (performed by the eye care practitioner using a handheld instrument called a retinoscope which shines a light into the eyes).
- Subjective refraction: This part of the examination requires responses from the patient to questions asked by the optometrist (e.g., “Do the black rings appear darker and bolder on the red or green background?”, “Which is clearer, lens one or lens two?”, etc).

The objective assessment is usually done first, to give the optometrist an estimate of the refractive error. The results from this test are usually fine-tuned using a subjective refraction.

The role of refraction in the sight test

The clinical research we commissioned identified the main components of the sight test and differences in patient journeys. It found significant use of optical assistants in elements of the sight test, especially in larger practices. In the research nearly all participants agreed that presenting vision, fundus photographs/scans, tonometry, and visual fields can be safely carried out by personnel other than the optometrist.

Autorefractor machines are commonly used in the pre-screening stages, i.e. before the patient sees the optometrist. This test is fully automated – the patient puts their chin on a rest and looks into the machine, which takes all the measurements. These technologies, which we understand are very common, are gradually replacing retinoscopy, although will not be suitable in all circumstances.

We understand that further advances in technology may soon assist with other elements of refraction, such as binocular vision. The general trend in the sight test is a move away from using manual tools to reviewing images.

Arguments in favour of dispensing opticians (DOs) refracting for the purposes of the sight test

Below is an analysis of the strength of the arguments put forward during the call for evidence on the Opticians Act 1989 in favour of DOs performing refraction for the purposes of the sight test.

For brevity we refer to permitting DOs to refract without also saying 'for the purposes of the sight test', but it is understood that DOs already perform refraction as part of the patient journey, for example when rechecking a prescription during the dispensing process.

Argument	Analysis
It could free up optometrists to deliver more clinical care (and relieve pressures on hospital eye services)	The argument participants found most persuasive was that it would relieve pressures on the NHS. However, there is no evidence that community optometrists are unable to take on enhanced services currently performed by ophthalmologists due to work pressures. Changes to service commissioning models and fee scales are likely to be more powerful drivers of change. Refraction is just one element of the sight test, so the merits of this argument depend on the cumulative minutes saved to free up optometrists for higher-skill work. We heard that a typical refraction takes 5-7 minutes. It was also suggested that the optometrist may wish to check the refraction, which would limit the time savings. Further, pre-screening and triage tasks that have already been delegated take 15-20 minutes. The level of time savings depends on how many businesses adopt models where the DOs perform refraction. If policy change leads to negative health outcomes, e.g. missed pathologies during the sight test that lead to more serious problems later, this would increase pressures on secondary care and ultimately defeat one of the key objectives of reform.
DOs could have additional training	The Association of British Dispensing Opticians (ABDO) has acknowledged the need for more training, but it is unclear whether this would give DOs sufficient clinical underpinning to identify subtle clues of eye health problems. Additional training may result in adjustments to GOC pre-registration requirements for approved qualifications leading to entry to the register as a DO (i.e the 2021 'Outcomes for Registration'), or as a post-registration GOC approved qualification, or as required continuing professional development (CPD) under domain 5. These options would require further analysis should Council decide in principle that DOs should be permitted to refract.

Argument	Analysis
	Another factor is whether there is sufficient interest among DOs to justify putting the training and qualification infrastructure in place (and the regulatory arrangements to support this). ABDO member surveys suggest there is sufficient interest, and ABDO (and other qualification providers) would need to take the commercial risk to develop training provision. Should the GOC consider DOs could safely refract with additional training/and or qualifications, commercial factors are not sufficient reason alone to maintain the restrictions. A wider factor is that change could boost dispensing optics as a profession at a time when student numbers have been declining and technology is reducing the scope of their role. While DOs can undertake a one-year GOC approved conversion course to become an optometrist, completing the necessary additional training to perform refraction may not take this long. In addition, DOs have a strong sense of professional identity and may not wish to become optometrists. The alternative is that the additional training is included within the GOC approved DO pre-registration qualification through an adjustment to the 'Outcomes for Registration.') If DOs are not permitted to refract, there may be other avenues, such as low vision services, which would represent a logical extension to their existing scope of practice.
DOs already learn to refract	Under the education and training requirements (ETR) there is some overlap between the knowledge, skills and behaviours (KSBs) that DOs and optometrists must demonstrate. DOs already learn the theory of refraction in their pre-registration qualifications, but the practical application and assessment of refraction within the context of the sight test is not required. They also perform subjective refraction in re-checks, but this does not involve clinical skills where eye health issues are detected. The clinical research suggests that retinoscopy is a skill that students find difficult to learn. As in the previous row of this table, ABDO accepts that DOs would need to undergo additional training, but the size and nature of the training gap and it's relevant RQF/FHEQ level is unclear at present.
Refraction tests could be done in between full sight tests	A significant minority of respondents were attracted to the idea that refraction tests could be done between full sight tests. Refraction only tests were strongly opposed in the clinical research and call for evidence submissions, including by ABDO. It was considered that people would mistakenly believe they had received a full sight test, or they would decide not to have the eye health check and pathologies would be missed. There

Argument	Analysis
	was also concern that businesses would abuse the rules by separating the different parts of the sight test. While acknowledging strength of clinical opinion on this issue, it is a good discipline to consider counterarguments. This is not least since refraction only tests are available in other countries. Since untreated refractive error can cause sight loss, refraction only tests are better than people having no sight test altogether. Enabling such services may benefit younger age groups who our data shows are less likely to have regular sight tests. From a clinical perspective, there is less risk of this age group having undiagnosed asymptomatic eye health issues. Similarly, since refraction only tests would be cheaper this could benefit people on lower incomes who fall below the threshold for free NHS sight tests. In the context of the cost-of-living crisis, insisting that people have a full sight test risks fewer people getting any form of sight test and could lead to more missed pathologies. Another factor is the growth of DIY in-home refraction tests, which fall outside the scope of GOC regulation. If DOs could perform refraction only tests in a regulated environment this would be preferable to consumers using unregulated providers. Conditions could be introduced to mitigate risks of missed pathologies, as in British Columbia where refraction only tests can only be performed on patients who have had an eye health test within the period recommended by the health authorities. While there is some logic to these arguments, any benefits from refraction only tests would need to be weighed against the risks. The universal sentiment among stakeholders is that the UK sight test represents the 'gold standard' and that risks of missed pathologies would outweigh any benefits of change.
It could reduce costs for patients	As above, many people struggle to afford sight tests but fall below the eligibility threshold for free NHS tests. AOP research suggests the cost-of-living crisis is leading people to put off eye care. In this context, the prospect of cheaper sight tests helping to reduce health inequalities is a relevant factor. Since DOs are cheaper to employ, in a competitive market, economic theory suggests that providers would pass on the savings to consumers by lowering prices. However, the savings from allowing DOs to perform refraction may be marginal (assuming that refraction only tests would not be permitted). The optical services market has not been subject to a competition review. However, there is likely to be less 'shopping around' compared to many other markets due to the nature of

Argument	Analysis
	the services provided (maintaining good eyesight is greatly valued and people develop a trusted relationship with their optometrist). The Europe Economics research for the business regulation part of the call for evidence suggests low levels of price transparency on sight tests. While the cost of the sight test may present barriers for some, the cost of vision correction is likely to be a higher barrier.
It could improve access to eye care in under-served areas	If refraction only tests were permitted this could enable mobile clinics to serve rural areas. We are aware of emerging models involving elements of remote sight testing in geographic areas where businesses are struggling to recruit optometrists.
It could widen patient choices and enable more flexible care	The core insight from the public and patient research was that with appropriate training and safeguards, most of the public supports DOs being able to perform refraction. The research suggests people are confused by different professional roles and do not mind who performs the various tests if they are qualified. The clinical research revealed there is already a variety of business models and anecdotal evidence suggests a wide range of prices for different service models. Patients, subject to their budget, can already choose between seeing an optometrist for the whole appointment or being seen by multiple individuals including optical assistants. Again, permitting refraction only tests would offer a different service delivery model. However, the paper assumes this option will not be progressed (and if it was, it is unclear whether any of the major providers would offer such services).

Arguments against DOs refracting for the purposes of the sight test

Below is an analysis of the strength of the arguments put forward during the call for evidence against DOs performing refraction.

Argument	Analysis
DOs lack qualifications, training and experience	See analysis in earlier section.
The sight test could be split in two and fewer people may have eye health checks	See analysis of refraction only tests in earlier section. Further, the GOC could specify in its standards and guidance that the sight test cannot be split. This is different to the GOC's position that the law does not prevent the sight test being separated by place or time. Instead, we could state that the sight test must

Argument	Analysis
	consist of different procedures (including eye health checks) and businesses cannot opt to offer only parts of the test.
The two main parts of the sight tests are connected and cannot be done by different people	In the call for evidence there was support for a multidisciplinary team approach to patient care where healthcare professionals work together under the oversight of an optometrist or registered medical practitioner in a safe and effective manner. This was positioned in the context of the evolution of professional roles, new delivery models including developments in technology and challenges around ensuring access to a wide range of services in all geographical areas. Denying DOs the ability to perform refraction would seem to go against the grain. The argument runs, if the GOC is supporting optometrists to work to their full professional capabilities, then why shouldn't DOs be afforded the same opportunities? The Welsh Government argued as follows: "to enable this clinical shift in services, and reduce the demand for secondary care services, the roles of all members of the primary care MDT [multi-disciplinary team] will need to evolve to ensure that demand for primary care services can continue to be met." The clinical research suggests that retinoscopy gives clues about the patient's ability to focus (accommodation), presence/absence of ocular pathology such as keratoconus, corneal diseases, and lens opacities (cataract). Further, there may be subtle clues present during refraction, and further clues during ophthalmoscopy. If one person conducts both sight test components, it is reasonable to expect them to combine these subtle cues so that the threshold for referral is reached. But, if different professionals conduct the sight test components, there is a greater likelihood that these clues would be missed. Similarly, a response to the call for evidence suggested that "There are many occasions where a refraction needs to be tailored due to ocular health or patient history and this can only be done effectively if this is all done by one individual". The GOC clinical advisors highlighted that: "Refracting and prescribing are different but intrinsically linked. That is to say, the final prescription is not necessarily what was found in refraction but other factors such as eye health, binocular vision status, lifestyle etc would need to be taken into account and this would require all the functions of a sight test." This may be the strongest argument in favour of not permitting DOs to refract since it risks pathologies going undetected. We have seen data showing that sight tests result in significant

Argument	Analysis
	volumes of referrals, although we cannot say how many of these would be missed if the sight test was split.
Patients with additional needs may struggle seeing two different people	There are good arguments why some patients should see a single professional during their sight test. As well as reducing anxiety, there are other clinical factors to consider. One form of objective refraction is cycloplegic retinoscopy, which uses drops to temporarily paralyse the eye muscles. This is often used for more vulnerable patients, including younger children and those with significant learning difficulties. Where patients in vulnerable circumstances are identified, optical practices can manage these situations by ensuring the optometrist performs the full test. The GOC should be able to address this issue through standards and guidance. As above, if proportionate safeguards can be introduced to protect patients presenting with additional needs, this should not prevent change that could benefit the average patient. There is also a consumer choice element: people can choose between different models involving one or more professionals.
Optometrists could have less time to conduct the eye health check	There is concern that any supervision requirement could increase workload. However, the same is true of functions carried out by optical assistants, plus businesses would not voluntarily introduce more inefficient models of care. It is more likely that policy change would free up optometrists' time than make more demands on their time. Permitting DOs to refract would not alter GOC expectations of the quality of the eye health check enforceable via the standards of practice. There was concern in responses to the call for evidence about commercial incentives leading to fast refractions and eye health issues being missed. Autorefractors are already common and phasing out retinoscopy, so fast refractions are already here. Meanwhile, increased use of optical coherence tomography (OCT) and other technologies are continually improving diagnostic capabilities. The overall effect of change in optical services is improved eye health checks.
Part of the refraction may be duplicated, increasing appointment length	There is concern that sight tests would be cheaper for optical businesses to perform but patient appointments would take longer. The effect of change is impossible for the GOC to predict, but businesses risk patients changing provider if they receive an unsatisfactory customer experience. This argument should be seen in the context of high customer satisfaction in successive waves of the GOC's public perceptions survey.

Safeguards

The patient and public research tested a range of possible safeguards, and below is an analysis of the merits of these.

Any new safeguards would supplement existing features of GOC regulation, for example DOs would need to obtain adequate insurance.

Safeguard	Analysis
Additional training	See analysis above. ABDO has already identified the need for DOs to undergo additional training. The extent of the training gap and costs are unclear, with ABDO highlighting that refraction already forms part of training for DOs. There are a series of second order questions relating to the training gap: What Regulated Qualifications Framework (RQF) level would this qualification be? What qualification type? Credit size? Pre- or post- registration? Leading to register annotation or included in a revised Outcomes for Registration for approved qualifications in dispensing optics?
Anyone who wanted could see an optometrist for the whole sight test	This is a matter of consumer choice reflecting existing differences in patient journeys already available in the market. Giving consumers the option of insisting they are seen by an optometrist for the whole sight test could be an unreasonable constraint on businesses. The effectiveness of this safeguard depends on consumers being aware of such a right, which is unlikely. Enforcement is also likely to be practically difficult.
The vision quality check and eye health check would have to happen at the same visit	See analysis above on refraction only tests. A revised policy statement could include this provision and is likely to be widely supported by industry stakeholders.
People would need to be informed which type of healthcare professional would be conducting the sight test	Consumers may not be aware how the sight test will be carried out before arriving for their appointment. The research suggests that some members of the public may be unlikely to notice if a DO conducted the refraction element of the sight test. An information remedy that supports consumers to make informed choices could include requiring a description on the website during the booking stage or in a telephone booking. However, the research also reveals confusion over job titles and that people do not mind who conducts certain tests if they are properly trained. Information remedies may be ineffective and suffer wide non-compliance and may lead to a worse customer experience. There is no current requirement to disclose when

Safeguard	Analysis
	optical assistants are used, and the GOC would need to justify imposing a requirement for the purposes of refraction by DOs.
People with additional needs would be able to see an optometrist for the full sight test	See analysis above – where such patients are identified, optical practices can manage these situations by ensuring the optometrist performs the full test. The GOC should be able to address this issue through standards and guidance. Submissions to the call for evidence highlighted difficulties around businesses identifying people with additional needs and people's reluctance to disclose their needs, which would make enforcement of any specific requirement challenging.
DOs would only be able to perform refraction if supervised by an optometrist	A supervision requirement is supported by ABDO, was a feature of the clinical research and would fit with the GOC's regulatory approach in other areas. There are issues around liability to consider given that two types of registrant are involved. These issues may make optometrists reluctant to delegate refraction to DOs. Further, the Optical Consumer Complaints Service (OCCS) would need to resolve complaints where it is unclear where the responsibility lies. This is also likely to be a feature of fitness to practise cases. Against these concerns, this is an inevitable aspect of multi-disciplinary models of care which are already common in optical services and the relevant agencies are experienced in untangling such cases.

Discussion

The central issue: should DOs be able to refract?

The GOC's 2013 policy statement is a decade old and optical practice has changed considerably since it was published. Therefore, it is timely for the GOC to review this issue. As a starting principle, the onus is on those seeking to introduce or maintain restrictions on someone's freedom to practise to justify these.

There seems no justifiable reason to prevent DOs from operating autorefractors provided this is not done as part of the sight test. Our view is that the law already permits DOs to operate autorefractors just as optical assistants can do so, but the GOC could clarify this by updating the 2013 statement or in another document.

Patient safety is the GOC's overriding consideration. Participants in the clinical research identified refraction as one of the core sight test components that differ from non-core components in that they are most important for patient safety and require clinical decision-making during the test procedure. A principal concern is undetected pathologies, including subtle clues during refraction and ophthalmoscopy

that may be missed if different professionals conduct these sight test components. Except for standardised pre-screening questions and sight test processes that are automated, where the optometrist will see all the necessary results, the clinical advice is that patient safety demands a single professional perform the sight test.

The argument that participants in the public and patient research found most persuasive was that allowing DOs to perform refraction would relieve pressures on the NHS. However, there was scepticism about this argument in both the clinical research and stakeholder responses to the call for evidence. The GOC has not seen evidence that community optometrists are unable to take on enhanced services due to work pressures. Developments in service commissioning models and fee scales are likely to be more powerful drivers of change than permitting DOs to refract.

Based on the information collected during the call for evidence and findings from the subsequent research, at this point in time, the Executive is not satisfied that DOs should be permitted to refract for the purposes of the sight test.

However, should Council decide to permit refraction by DOs it could introduce safeguards to mitigate some of the concerns identified. ABDO already accepts the need for DOs to have additional training and accreditation. Similarly, it accepts that DOs could only perform refraction under supervision by an optometrist, although there are some issues of liability to work through. The GOC's revised policy statement and/or standards and guidance could specify that the refraction and eye health check happen at the same visit. Similarly, it could specify that patients presenting with additional needs are seen by the optometrist throughout their appointment. Introducing new information remedies, such as explaining to prospective patients at the booking stage how the sight test works, are likely to be ineffective and are harder to justify since this is not a requirement for processes using optical assistants now.

Refraction by Non-Optometrists - Advice from GOC Clinical Advisors
22 February 2023

Denise Voon & Roma Malik

1. We were asked to comment on our overall reflections on the 'Clinical advice on refraction in the sight test' report (2023, Evans et al), for views on what the pathologies are that risk being missed in the refraction part of the sight test if not undertaken in other parts of the sight test, and what training might be required if dispensing opticians were to perform refraction for the purposes of the sight test. We were also asked to comment on whether two optometrists could perform different parts of the sight test safely, whether eye health problems can be identified during subjective refraction, as well as how autorefraction is used during the sight test and what it can identify.

Interlinked components of the sight test

2. The autorefractor reading is only used as a starting point for refraction. The optometrist then conducts a subjective refraction and refines the prescription, taking into account other factors such as the patient's binocular vision status, occupational and lifestyle needs etc.

3. Whilst a dispensing optician could potentially flag some binocular vision issues with the optometrist, some binocular vision issues can be corrected or exacerbated by a prescription. Therefore, a binocular vision check and refraction need to go hand in hand as they may need to be assessed concurrently. For example, a patient requiring the incorporation of prism into their prescription to relieve symptoms of double vision would require a binocular vision assessment (ocular muscle balance, convergence etc) before a prescription could be finalised. Another example is where modification of a prescription may alleviate the need for prism.

4. Furthermore, it will not always be clear from a refraction alone whether a slight change in prescription is normal or indicative of underlying pathology. For example, a hyperopic shift could be due to wet age-related macular degeneration (AMD) or a normal change.

5. The sight test components are intrinsically linked. Over time optometrists have become extremely efficient at collating a large amount of information that they draw out of history and symptoms, refraction, binocular vision assessment, eye health check and supplementary tests. In our opinion, separating out the refraction from the eye health check would be detrimental to the patient and could lead to missed pathology and avoidable sight loss.

6. It is difficult to find a similar scenario, but a sight test can be thought of as a painting which is divided up into different sections. Allowing different parts to be performed by different people would make it much more difficult to form a cohesive picture and can lead to mistakes. If an optometrist were to retain

oversight on the full sight test it would likely mean duplication of work as the optometrist may choose to redo the refraction.

7. Refracting and prescribing are different but intrinsically linked. That is to say, the final prescription is not necessarily what was found in refraction but other factors such as eye health, binocular vision status, lifestyle etc would need to be taken into account and this would require all the functions of a sight test. While it is beneficial to have a baseline refraction, the wide availability of autorefractors and the speed and repeatability of measurements that they provide negates whether this is necessary and whether there would be much benefit of a dispensing optician undergoing extensive training to be able to perform this function.

8. In summary, the sight test components are intrinsically linked and therefore two different professionals doing different parts of the sight test would be problematic. It would be much more difficult to see the full clinical picture if parts of the sight test are separated.

What are the pathologies that risk being missed in the refraction part of the sight test if not undertaken in other parts of the sight test?

9. There are a lot of unspoken signals that an optometrist picks up during a subjective refraction that again adds to the full clinical picture. Some unspoken or indirect signals could include:

    - a patient mentioning that part of the testing chart is missing (this could be indicative of misalignment of the patient's chair or for example a stroke)
    - a patient reporting the letters are distorted (this could be a case of further refinement being needed but it could also be indicative of a macular problem)
    - non-verbal ways of communicating including body language, position, facial expressions etc. For example, when asking someone if they can see a row of letters clearly, they may say ‘yes’ and continue to read the line correctly, but a wrinkled brow or the speed and fluency of their reading often provides an idea of how easy it is for the patient to actually see that row of letters

10. The pathologies that risk being missed during the refraction include (but are not limited to):

    - Keratoconus (early detection, which can often only be seen on a ret reflex, is essential to allow for early intervention and treatment to prevent sight loss)
    - Macular oedema from wet AMD, central serous retinopathy (CSR), post-surgery etc causing hyperopic shift
    - Poorly controlled diabetes, nuclear cataract etc causing myopic shift
    - Any pathology seen on retro-illumination
    - Certain types of glaucoma – transillumination from pigment dispersion, pseudoexfoliation
    - Binocular vision issues – accommodative spasm, squints, determining the need and amount of prism

- Raised intra-ocular pressures (IOPs) causing corneal changes in the absence of other clinical signs

11. Separation of refraction from the rest of the sight test raises serious concerns, particularly as some patients may not return for the eye health check or know that the two are different. This would create the risk of avoidable sight loss from disease progression that would normally be detected in a sight test.

Orthoptists

12. Orthoptists are not currently prescribing, but instead refracting as a delegated function by an ophthalmologist who retains responsibility. Any change in legislation allowing orthoptists to refract and prescribe would raise the question as to who would be responsible for the refraction and whether orthoptists would require additional indemnity insurance to cover this new role.

13. Whilst it is convenient to have fewer appointments for paediatric patients, joint orthoptic and optometry clinics (where a patient sees an orthoptist and optometrist in the same visit) can be utilised and this would reduce the demand on the ophthalmologists as optometrists will be able to do an eye health check on those patients who are not expected to have eye problems, freeing up capacity for those patients who need to be seen by a doctor.

14. In addition, if a paediatric patient requires a cycloplegic refraction, having the orthoptist instilling the eye drops and the optometrist refracting can lead to better compliance as young patients can often be less co-operative with the person instilling the drops.

Useful links

Cheloni, R., Swystun, A. G., Frisani, M., & Davey, C. J. (2021), Referral in a routine Italian optometric examination: towards an evidence-based model*, Scandinavian Journal of Optometry and Visual Science*, 14(1), 1–11

Michaud, L. and Forcier, P. (2014), Prevalence of asymptomatic ocular conditions in subjects with refractive-based symptoms, *Journal of Optometry*, Vol 7, Issue 3, pages 153-160

Annex 4 – Autorefraction vs retinoscopy

Council members asked for further information about autorefraction and retinoscopy, both types of objective refraction (tests which do not require responses from the patient).

Autorefraction or an automated refractor is a machine that measures the ability of the eyes to focus and automatically determines a lens prescription.

Retinoscopy is performed using a handheld instrument called a retinoscope which shines a light into the eyes to determine the refractive error of the eye.

We have found several articles which compare the two and provided links and conclusions below.

We could not find any information on the proportion of businesses using autorefractors.

Articles

- Retinoscopy/autorefraction: which is the best starting point for a noncycloplegic refraction? - PubMed (nih.gov)

"Conclusions: The present results confirm that when performed by an experienced clinician, retinoscopy is more accurate than automatic refraction, giving a better starting point to noncycloplegic refraction."

- A comparison between retinoscopy and autorefraction in acceptance of subjective correction in school age children - IJCEO

"Conclusion: Conventional retinoscopy is still the most accurate objective method to estimate the refractive status in children and can be considered a reliable starting point for subjective refraction, however, autorefraction has comparable accuracy and can be a valuable aid to prescribe cylindrical correction."

- A comparison of cycloplegic autorefraction and retinoscopy in Indian children - PubMed (nih.gov)

"Conclusion: Autorefraction with Topcon KR-8900 can be used reliably in Indian children older than six years, if conducted under cycloplegia. In mixed astigmatism and children less than six years, it should be corroborated with retinoscopy."

NB Cycloplegic refraction is "a procedure used to determine a person's complete refractive error by temporarily paralyzing the muscles that aid in focusing the eye"[1]. It is usually used in young children or patients who are non-verbal.

[1] Cycloplegic Refraction: Top 5 Q&As - Optometrists.org

- Accuracy of Noncycloplegic Retinoscopy, Retinomax Autorefractor, and SureSight Vision Screener for Detecting Significant Refractive Errors | IOVS | ARVO Journals

“Conclusions: Each test had a very high discriminatory power for detecting children with any significant RE [refractive error].”

Annex 5 – Extract from Advisory Panel minutes on refraction (meeting held 10 March 2023)

There was a range of views expressed, with a broad consensus around the following:

- the capability of dispensing opticians to provide refraction was not disputed, subject to additional training (which might be pre- or post-registration), and the option to pursue a professional pathway to become an optometrist was already well-established;
- the intentions behind the proposal to allow dispensing opticians to refract for the purposes of the sight was not clear and in particular, it was felt that there was an absence of compelling evidence that this would benefit the patient or protect the public, or that it would be safe to do so. The Panel also noted the technology to auto-refract was already available and queried what additional benefits would be provided by a dispensing optician refracting for the purposes of the sight test;
- there was concern regarding the risk of missed pathologies and health issues only being identified at a late stage. This was particularly if refraction only tests were permitted, but also should the refraction and eye health checks not be carried out by the same professional in a single visit. Should dispensing opticians be permitted to refract, training requirements should equip them to determine the final refraction result taking into account binocular vision and any pathology the patient had;
- the arguments around freeing up the time of optometrists to enable them to deliver more clinical care were not considered persuasive, given that refraction took approximately five minutes and would likely need to be repeated by the optometrist supervising a dispensing optician;
- the arguments around the reallocation of cost savings to the NHS hospital eye services were not considered persuasive;
- there was concern around continuity of care and making the pathway for patients more complex, particularly those in vulnerable circumstances, such as children with special educational needs and disabilities or adults in domiciliary care settings;
- there was concern that even if patients were given the choice to see one or more healthcare professionals during their appointment, they may not understand the options they are being presented with (and therefore unable to make an informed choice);
- concerns that the dispensing optician workforce might not wish to take on this work or that there might not be the numbers to do this in the future; and
- in relation to autonomous decision-making by dispensing opticians, there were concerns around governance arrangements, for example, how dispensing opticians would be supervised to ensure ongoing competence in refraction. The governance arrangements in hospitals were different to community settings.

The view was expressed that allowing pre-screening to be undertaken by staff other than the optometrist was already in effect splitting up the sight test, which in itself could present a risk. However, it was also acknowledged that pre-screening was well-established and common practice, especially in larger businesses.

Annex 6 – Extract from Companies Committee minutes on business regulation (meeting held 10 March 2023)

The Director of Regulatory Strategy introduced Deborah Drury, an external consultant from Europe Economics. Deborah presented the findings of the research into mapping of optical businesses. Committee members were asked to note that the report was confidential. The presentation was recorded.

The Committee discussed the presentation in the consultant's presence where the following points were noted:

- that while the report looked at ownership models overall it did not segment small husband/wife holdings, such organisations may want to be on the business register but under the current wording of the Act, cannot register;
- the nature of risk had changed since the report was last undertaken in 2013, with more issues to do with clinical eye care issues, online practice and technology than ten years ago;
- in relation to option 1 in the paper, the price per registrant increase was limited to new registrants;
- preparation time had not been factored into the estimated cost to business of inspection, although Europe Economics clarified they had assumed preparation would be done outside of office hours.

The Committee were asked to comment on whether they thought business regulation should be extended to all businesses. They agreed with the proposal on the basis that it would be proportionate and applied consistently. In discussion it was suggested that option five, the consumer redress scheme was disproportionate and that there was no evidence that mandating engagement with the Optical Consumer Complaints Service (OCCS) was necessary. It was noted that business regulation was not widespread across all other healthcare regulators. It was suggested that the GOC should take some learnings from the process of business regulation as carried out in the pharmacy industry. It was noted that while optical businesses in Northern Ireland were subject to regular NHS inspection, this was not the case in England and it was only optical businesses with NHS contracts that had to undergo an inspection every three years.

The Committee discussed the need for registrant directors within optical businesses and agreed that there should be individuals with clinical experience making key decisions within a given business, particularly in the context of legal accountability. It was noted that if the proposals went ahead and in order to create a level playing field, sole trader businesses would need to be registered as their activities carried the same level of risk from a public safety perspective.

The Committee were informed that the framework to extend business regulation would take at least six to nine months to develop. It was noted that if business regulation extension went ahead the policy work would be brought back to the Committee before being presented to Council for final approval (post-consultation).

Annex 7

Impact Assessment Screening Tool

Name of policy or process:	Refraction by dispensing opticians for the purposes of the sight test (as set out in our 2013 statement on testing of sight)
Purpose of policy or process:	To set out the GOC's position on whether dispensing opticians should be able to carry out refraction for the purposes of the sight test
Team/Department:	Policy
Date:	13/3/23
Screen undertaken by:	Marie Bunby
Approved by:	Steve Brooker
Date approved:	14/3/23
Instructions:	• Circle or colour in the current status of the project or policy for each row. • **Do not miss out any rows**. If it is not applicable – put N/A, if you do not know put a question mark in that column. • This is a live tool, you will be able to update it further as you have completed more actions. • Make sure your selections are accurate at the time of completion. • Decide whether you think a **full** impact assessment is required to list the risks and the mitigating/strengthening actions. • If you think that a full impact assessment is **not** required, put your reasoning in the blank spaces under each section. • You can include comments in the boxes or in the space below. • Submit the completed form to the Compliance Manager for approval.

A) Impacts	High risk	Medium risk		Low risk	? or N/A
1. Reserves	It is likely that reserves may be required	It is possible that reserves may be required		No impact on the reserves / not used	
2. Budget	No budget has been allocated or agreed, but will be required.	Budget has not been allocated, but is agreed to be transferred shortly	Budget has been allocated, but more may be required (including in future years)	No budget is required OR budget has been allocated and it is unlikely more will be required	
3. Legislation, Guidelines or Regulations	Not sure of the relevant legislation	Aware of all the legislation but not yet included within project/process	Aware of the legislation, it is included in the process/project, but we are not yet compliant	Aware of all the legislation, it is included in the project/process, and we are compliant	
4. Future legislation changes	Legislation is due to be changed within the next 12 months	Legislation is due to be changed within the next 24 months	Legislation may be changed at some point in the near future	There are no plans for legislation to be changed	
5. Reputation and media	This topic has high media focus at present or in last 12 months	This topic has growing focus in the media in the last 12 months	This topic has little focus in the media in the last 12 months	This topic has very little or no focus in the media in the last 12 months	
6. Resources (people and equipment)	Requires new resource	Likely to complete with current resource, or by sharing resource	Likely to complete with current resource	Able to complete with current resource	
7. Sustainability	Less than 5 people are aware of the process/project, and it is not recorded centrally nor fully	Less than 5 people are aware of the project/process, but it is recorded centrally and fully	More than 5 people are aware of the process/project, but it is not fully recorded and/or centrally	More than 5 people are aware of the process/ project and it is clearly recorded centrally	N/A
	No plans are in place for training, and/or no date set for completion of training	Training material not created, but training plan and owner identified and completion dates set	Training material and plan created, owner identified and completion dates set	Training completed and recorded with HR	N/A
8. Communication (Comms) / raising awareness	No comms plan is in place, and no owner or timeline identified	External comms plan is in place (including all relevant stakeholders) but not completed, an owner and completion dates are identified	Internal comms plan is in place (for all relevant levels and departments) but not completed, and owner and completion dates are identified	Both internal and external comms plan is in place and completed, owner and completion dates are identified	
	Not sure if needs to be published in Welsh	Must be published in Welsh; Comms Team aware		Does not need to be published in Welsh	

Please put commentary below about your impacts ratings above:
4. Future legislation changes: The Opticians Act is due to be updated as part of the Department of Health and Social Care's legislative reform programme. 5. Reputation and media: This issue has prominent in the optical trade press during the last 12 months.

B) Information governance	High risk	Medium risk		Low risk	? or N/A
1. What data is involved?	Sensitive personal data	Personal data	Private / closed business data	Confidential / open business data	N/A
2. Will the data be anonymised?	No	Sometimes, in shared documents	Yes, immediately, and the original retained	Yes, immediately, and the original deleted	N/A
3. Will someone be identifiable from the data?	Yes	Yes, but their name is already in the public domain(SMT/Council)	Not from this data alone, but possibly when data is merged with other source	No – all anonymised and cannot be merged with other information	N/A
4. Is **all** of the data collected going to be used?	No, maybe in future	Yes, but this is the first time we collect and use it	Yes, but it hasn't previously been used in full before	Yes, already being used in full	N/A
5. What is the volume of data handled per year?	Large – over 4,000 records	Medium – between 1,000-3,999 records		Less than 1,000 records	N/A
6. Do you have consent from data subjects?	No	Possibly, it is explained on our website (About Us)	Yes, explicitly obtained, not always recorded	Yes, explicitly obtained and recorded/or part of statutory duty/contractual	N/A
7. Do you know how long the data will be held?	No – it is not yet on retention schedule	Yes – it is on retention schedule	Yes – but it is not on the retention schedule	On retention schedule **and** the relevant employees are aware	N/A
8. Where and in what format would the data be held? (delete as appropriate)	Paper; at home/off site; new IT system or provider; Survey Monkey; personal laptop	Paper; archive room; office storage (locked)	GOC shared drive; personal drive	other IT system (in use); online portal; CRM; Scanned in & held on H: drive team/dept folder	N/A
9. Is it on the information asset register?	No	Not yet, I've submitted to Information Asset Owner (IAO)	Yes, but it has not been reviewed by IAO	Yes, and has been reviewed by IAO **and** approved by Gov. dept.	N/A
10. Will data be shared or disclosed with third parties?	Yes, but no agreements are in place	Yes, agreement in place	Possibly under Freedom of Information Act	No, all internal use	N/A
11. Will data be handled by anyone outside the EU?	Yes	-	-	No	N/A
12. Will personal or identifiable data be published?	Yes – not yet approved by Compliance	Yes- been agreed with Compliance	No, personal and identifiable data will be redacted	None - no personal or identifiable data will be published	N/A

B) Information governance	High risk	Medium risk		Low risk	? or N/A
13. Individuals handling the data have been appropriately trained	Some people have never trained by GOC in IG	All trained in IG but over 12 months ago		Yes, all trained in IG in the last 12 months	N/A

Please put commentary below about reasons for information governance ratings:
This statement is not a process and does not involve the collection of data, therefore all of this section is marked as not applicable.

C) Human rights, equality and inclusion	High risk	Medium risk		Low risk	? or N/A
1. Main audience/policy user	Public			Registrants, employees or members	
2. Participation in a process (right to be treated fairly, right for freedom of expression)	Yes, the policy, process or activity restricts an individual's inclusion, interaction or participation in a process			No, the policy, process or activity does not restrict an individual's inclusion, interaction or participation in a process	
3. The policy, process or activity includes decision-making which gives outcomes for individuals (right to a fair trial, right to be treated fairly)	Yes, the decision is made by one person, who may or may not review all cases	Yes, the decision is made by one person, who reviews all cases	Yes, the decision is made by an panel which is randomly selected; which may or may not review all cases	Yes, the decision is made by a representative panel (specifically selected) OR No, no decisions are required	N/A
	There is limited decision criteria; decisions are made on personal view	There is some set decision criteria; decisions are made on 'case-by-case' consideration	There is clear decision criteria, but no form to record the decision	There is clear decision criteria and a form to record the decision	N/A
	There is no internal review or independent appeal process	There is a way to appeal independently, but there is no internal review process	There is an internal review process, but there is no way to appeal independently	There is a clear process to appeal or submit a grievance to have the outcome internally reviewed and independently reviewed	N/A
	The decision-makers have not received EDI and unconscious bias training, and there are no plans for this in the next 3 months	The decision-makers are due to receive EDI and unconscious bias training in the next 3 months, which is booked	The decision-makers are not involved before receiving EDI and unconscious bias training	The decision-makers have received EDI and unconscious bias training within the last 12 months, which is recorded	N/A

C) Human rights, equality and inclusion	High risk	Medium risk		Low risk	? or N/A
4. Training for all involved	Less than 50% of those involved have received EDI training in the last 12 months; and there is no further training planned	Over 50% of those involved have received EDI training, and the training are booked in for all others involved in the next 3 months.		Over 80% of those involved have received EDI training in the last 12 months, which is recorded	N/A
5. Alternative forms – electronic / written available?	No alternative formats available – just one option	Yes, primarily internet/computer-based but paper versions can be used		Alternative formats available and users can discuss and complete with the team	N/A
6. Venue where activity takes place	Building accessibility not considered	Building accessibility sometimes considered		Building accessibility always considered	N/A
	Non-accessible building;	Partially accessible buildings;	Accessible buildings, although not all sites have been surveyed	All accessible buildings and sites have been surveyed	N/A
7. Attendance	Short notice of dates/places to attend	Medium notice (5-14 days) of dates/places to attend		Planned well in advance	N/A
	Change in arrangements is very often	Change in arrangements is quite often		Change in arrangements is rare	N/A
	Only can attend in person	Mostly required to attend in person		Able to attend remotely	N/A
	Unequal attendance / involvement of attendees	Unequal attendance/ involvement of attendees, but this is monitored and managed		Attendance/involvement is equal, and monitored per attendee	N/A
	No religious holidays considered; only Christian holidays considered	Main UK religious holidays considered	Main UK religious holidays considered, and advice sought from affected individuals if there are no alternative dates	Religious holidays considered, and ability to be flexible (on dates, or flexible expectations if no alternative dates)	N/A
8. Associated costs	Potential expenses are not included in our expenses policy	Certain people, evidencing their need, can claim for potential expenses, case by case decisions		Most users can claim for potential expenses, and this is included in our	N/A

C) Human rights, equality and inclusion	High risk	Medium risk		Low risk	? or N/A
				expenses policy; freepost available	
9. Fair for individual's needs	Contact not listed to discuss reasonable adjustments, employees not aware of reasonable adjustment advisors	Most employees know who to contact with queries about reasonable adjustments		Contact listed for reasonable adjustment discussion	N/A
10. Consultation and Inclusion	No consultation; consultation with internal employees only	Consultation with employees and members	Consultation with employees, members, and wider groups	Consultation with policy users, employees, members and wider groups	

Please put commentary below for human rights, equalities and inclusion ratings above:
Most of this section is marked as not applicable because decision-making for an individual is not required and no training would be necessary to follow the current position set out in our current statement. 2. Participation in a process: Our 2013 statement on testing of sight restricts dispensing opticians from being able to refract for the purposes of the sight test.

Protected characteristic	Type of potential impact: positive, neutral, negative?	Explanations (including examples or evidence/data used) and actions to address negative impact
Age	Neutral	We do not think that our policy to continue restricting dispensing opticians from being able to refract for the purposes of the sight test would have any impact related to age.
Disability	Neutral	We do not think that our policy to continue restricting dispensing opticians from being able to refract for the purposes of the sight test would have any impact related to disability.

Protected characteristic	Type of potential impact: positive, neutral, negative?	Explanations (including examples or evidence/data used) and actions to address negative impact
Sex	Neutral	We do not think that our policy to continue restricting dispensing opticians from being able to refract for the purposes of the sight test would have any impact related to sex.
Gender reassignment (trans and non-binary)	Neutral	We do not think that our policy to continue restricting dispensing opticians from being able to refract for the purposes of the sight test would have any impact related to gender reassignment.
Marriage and civil partnership	Neutral	We do not think that our policy to continue restricting dispensing opticians from being able to refract for the purposes of the sight test would have any impact related to marriage and civil partnership.
Pregnancy/ maternity	Neutral	We do not think that our policy to continue restricting dispensing opticians from being able to refract for the purposes of the sight test would have any impact related to pregnancy/maternity.
Race	Neutral	We do not think that our policy to continue restricting dispensing opticians from being able to refract for the purposes of the sight test would have any impact related to race.
Religion/belief	Neutral	We do not think that our policy to continue restricting dispensing opticians from being able to refract for the purposes of the sight test would have any impact related to religion/belief.
Sexual orientation	Neutral	We do not think that our policy to continue restricting dispensing opticians from being able to refract for the purposes of the sight test would have any impact related to sexual orientation.
Other groups (e.g. carers, people from	Neutral	We do not think that our policy to continue restricting dispensing opticians from being able to refract for the purposes of the sight test would have any impact related to other groups.

Protected characteristic	Type of potential impact: positive, neutral, negative?	Explanations (including examples or evidence/data used) and actions to address negative impact
different socio-economic groups)		

Full Impact Assessment (to be competed if required)

Step 1: Scoping the impact assessment (IA)

Name of the policy/function	Refraction by dispensing opticians for the purposes of the sight test (as set out in our 2013 statement on testing of sight)
Assessor	Marie Bunby
Date IA started	13/3/23
Date IA completed	14/3/23
Date of next IA review	March 2024
Purpose of IA	To aid Council in its decision-making in respect of refraction by dispensing opticians for the purposes of the sight test
Approver	Steve Brooker
Date approved	14/3/23

Q1. Screening assessment

- Has a screening assessment been used to identify the potential relevant risks and impacts? Tick all that have been completed:
  - ✓Impacts
  - ✓Information governance (privacy)
  - ✓Human rights, equality and inclusion
  - ☐ None have been completed

Q2. About the policy, process or project

- What are the main aims, purpose and outcomes of the policy or project?
- You should be clear about the policy proposal: what do you hope to achieve by it? Who will benefit from it?

Aims
To review whether refraction by dispensing opticians can be undertaken for the purposes of the sight test (currently restricted as set out in our 2013 statement on testing of sight).
Purpose and outcome
The purpose of the current statement on testing of sight is to set out the GOC's interpretation of what can be delegated under the Opticians Act in respect of the testing of sight. The outcome of the statement means that no part of the sight test (including refraction for the purposes of issuing a prescription) may be delegated. The purpose of the call for evidence was to review whether this should continue to remain the case.

Who will benefit
Patients and the public will benefit by being protected as their care will be provided by professionals who are appropriately trained and experienced in carrying out refraction for the purposes of the sight test. A single healthcare professional will be responsible for exercising clinical judgement on detection of eye health issues.

Q3. Activities or areas of risk or impact of the policy or process

- Which aspects/activities of the policy are particularly relevant to impact or risk? At this stage you do not have to list possible impacts, just identify the areas.

Activity/aspect
Refraction by dispensing opticians for the purposes of the sight test

Q4. Gathering the evidence

- List below available data and research that will be used to determine impact of the policy, project or process.
- Consider each part of the process or policy and identify where risks or implications might be found for: 1) Impacts; 2) Information governance and privacy implications; and 3) Human rights, equality and inclusion.

Available evidence – used to scope and identify impact
As part of our call for evidence on the Opticians Act 1989 and consultation on associated GOC policies we asked whether dispensing opticians should be able to refract for the purposes of the sight test and what the advantages, disadvantages and impacts would be of amending or removing our 2013 statement on testing of sight. We commissioned further research into refraction by dispensing opticians: • Public views on refraction - this report was produced by WA Research. It involves deliberative research to understand the views of patients and the general public on whether dispensing opticians should be permitted to carry out refraction for the purposes of the sight test, and, if so, under what circumstances and regulatory controls. • Clinical research on refraction in the sight test - this report was produced by Prof Bruce Evans, Dr Rakhee Shah, Dr Miriam Conway and Ms Liz Chapman. The report summarises clinical research on: how the sight test is delivered by commercial providers of optical services across the four nations of the UK; the possible impacts where the refraction, binocular vision and eye health checks are not carried out by the same person or not at the same time or in the same place, both with and without the oversight/supervision of an optometrist or registered medical practitioner; and the role of orthoptists in refraction and sight testing.

We also produced in-house research on international comparisons on refraction services with the sight test model in the UK which summarises our literature review.

These three pieces of research are available on our website: https://optical.org/en/publications/policy-and-research/research-associated-with-the-call-for-evidence-on-the-opticians-act

Our statement on testing of sight has been in place since 2013 and we have not received any evidence during this time that patients or the public are not being protected, or that there have been any developments in case law that would affect the statement.

Q5. Evidence gaps

- Do you require further information to gauge the probability and/or extent of impact?
- Make sure you consider:
    1) Impacts;
    2) Information governance and privacy implications; and
    3) Human rights, equality and inclusion implications.

If yes, note them here:

N/A

Q6. Involvement and consultation

Consultation has taken place, who with, when and how
Our public call for evidence and consultation was open between 28 March and 18 July 2022. This was available on our Citizen Space consultation hub. We contacted individual and business registrants, professional/representative bodies, Government departments and patient representative bodies/charities to make them aware of the consultation and to encourage responses.
Summary of the feedback from consultation
We received 353 responses from a wide range of stakeholders. Section 4 of our proposed GOC response to the call for evidence (annex 1 of the Council paper on legislative reform) analyses and summarises the feedback we received during the call for evidence. We have set out our analysis of the arguments for and against refraction by dispensing opticians in annex 2 of the Council paper. The 'GOC response – refraction by dispensing opticians' section of annex 1 summarises our proposed outcome as follows: "Our overriding consideration is patient safety. Based on the information collected during the call for evidence and findings from the subsequent research, at this point in time we are not satisfied that dispensing opticians should be permitted to refract for the purposes of the sight test. Our main concern is undetected pathologies, including subtle clues about eye health during refraction and ophthalmoscopy that may be missed if different professionals conduct these sight test components. This risk would remain even if dispensing opticians were to receive further training/accreditation

and be under the supervision/oversight of an optometrist or registered medical practitioner." While we have indicated that we may update our 2013 statement on testing of sight, at this point in time the restrictions on dispensing opticians refracting for the purposes of the sight test would remain (unless Council was to approve a different course of action).
Link to any written record of the consultation to be published alongside this assessment
Our GOC response to the call for evidence and consultation will be published on our consultation platform when it has been approved. A draft response is published as part of our March 2022 Council papers: Council meeting papers | GeneralOpticalCouncil
How engagement with stakeholders will continue
We will continue to engage with our stakeholders as we progress the work resulting from the call for evidence and the wider programme of legislative reform. This will be through informal meetings and further consultation on specific topics.

Step 2: Assess impact and opportunity to promote best practice

- Using the evidence you have gathered what if any impacts can be identified. Please use the table below to document your findings and the strand(s) affected.
- What can be done to remove or reduce any impact identified?
- Consider each part of the process or policy and identify where risks might be found for equality, human rights and information governance and privacy.
- Ensure any gaps found in Q5 are recorded as actions and considerations below.

Use the table below to document your strengthening actions (already in place or those to further explore or complete).

Activity/ aspect	Potential/actual impact	Strengthening actions to remove or reduce impact. For actions, include timeframes
Refraction by dispensing opticians for the purposes of the sight test	Risk that if we inappropriately allow dispensing opticians to refract for the purposes of the sight test, patient safety may be put at risk resulting in missed pathologies ultimately leading to sight loss and further pressure on hospital eye services.	• Our 2013 statement on testing of sight to continue to restrict dispensing opticians from being able to carry out refraction for the purposes of the sight test (because as outlined in Q6 we are not satisfied that dispensing opticians should be permitted to refract for the purposes of the sight test). • We will consider updating our statement to clarify the position in relation to pre-screening and triage checks (see Q7 below) – timeframe not yet known.
Refraction by dispensing opticians for the purposes of the sight test	Risk that dispensing opticians might feel that their skillset is not being fully utilised.	We think that the patient safety risks outweigh the risks of allowing dispensing opticians to refract for the purposes of the sight test. We would encourage dispensing opticians to continue to develop their skills mix and meet their full professional capabilities. The development of contacts lens opticians is a recent example of where this has been achieved. There may be other areas, such as low vision services, which would be a natural extension of dispensing opticians' current scope of practice.

Step 3: Monitoring and review

Q7. What monitoring mechanisms do you have in place to assess the actual impact of your policy?

In our proposed GOC response to the call for evidence we have said: "We will consider updating our 2013 statement on testing of sight to clarify the position in relation to pre-screening tests and triage checks related to the sight test that may be carried out by persons other than the optometrist or registered medical practitioner. Over time, advances in technology have meant various steps in the patient journey have become automated and safely delegated as part of pre-screening and triage. Use of autorefractors is one example of this and we understand further developments, including in relation to refraction, are on the horizon. If we decide to update our 2013 statement, we will carry out further consultation on this aspect of the testing of sight."

Please provide a review date to complete an update on this assessment.

Date: March 2024

PUBLIC
C05(23)

COUNCIL
Investment Policy

Meeting: 22 March 2023 **Status:** For noting

Lead responsibility: Yeslin Gearty (Director of Corporate Services)
Paper authors: Yeslin Gearty (Director of Corporate Services) and Manori Wickremasinghe (Head of Finance)

Purpose

1. To present the revised Investment Policy for approval following review and recommendation to Council by the Investment Committee on 8 November 2022.

Recommendations

2. Council is asked to:
   - **approve** the updated Investment Policy; and
   - **provide** advice as appropriate.

Strategic objective

3. This work contributes towards the achievement of all strategic objectives.

Background

4. The Investment Committee is a non-statutory committee. Its terms of reference require it to recommend to Council an Investment Policy, including risk appetite, ethical and sustainability considerations.

5. The current policy was approved and implemented on 22 February 2017 and is overdue review and revision. On 8 November 2022, the Investment Committee considered a revised draft Investment Policy.

6. The minutes of the November Investment Committee were shared with Council members as part of the papers for its Strictly Confidential meeting on 6 December 2022. The minutes show that the draft policy was agreed by the Committee, subject to some minor amendments which were completed and shared with Committee members by email and subsequently approved. The draft policy is therefore recommended for approval.

Analysis

7. The Committee was advised that no significant changes had been made to the current version. The main changes were applied to benchmarking percentages of asset classes held which had been adjusted as the investment background had changed since the 2017 policy was implemented and in line with adopting a “moderate risk” appetite to investing. The Committee noted how the investment managers complete

simulations of various outcomes to derive the most optimal structure for the portfolio. The Committee agreed to retain the approach of using our investment manager's Royal Bank of Canada (RBC) Brewin Dolphin risk category 6, which has a lower exposure to fixed income securities and alternatives and higher exposure to equities. The composition of assets determined by this category are shown in the table at paragraph 5.7 of the policy and wording was added in relation to the flexibility of management within those ranges. This ensures that the investment process enables RBC Brewin Dolphin to adjust the structure of the portfolio around the central optimised positions to take advantage of prevailing market conditions or specific requirements. Detailed information on the definition of what each asset class contains within the ranges set out are provided by RBC Brewin Dolphin in their regular reports to Senior Management Team (SMT), which are in turn shared with the Investment Committee. The Committee noted the weakness of sterling had impacted UK assets when compared to international assets, though this had slowly started to recover but that this was a factor in changing the approach to the diversity of assets held within the portfolio.

8. For context, RBC Brewin Dolphin has ten risk categories, ranging from one for investors: "*completely averse to any investments that could put your capital at risk. You accept that, in light of inflation, this is highly likely to have the effect of eroding the purchasing power of your capital. This typically means that your money will be held in cash, building society accounts or national savings*" to ten, for investors who are: "*prepared to make wholly speculative investments, fully aware of and accepting the possibility of losing all of your capital. This could typically be in the form of derivatives and contingent liability investments, which often include gearing which means you could lose more than your initial capital investment. You are totally insensitive to risk*".

9. The Investment Committee agreed that risk category six is most appropriate for the GOC's investments. This is described as: "*You are prepared to have a greater proportion of your investment held in equities with the aim of achieving a higher investment return over the long-term. The greater allocation to equities means the portfolio may experience heightened levels of volatility over the investment term. The portfolio will typically include two thirds of the assets invested in equities whilst the remainder will be split between cash, fixed income and alternatives. You are prepared to accept fluctuations in the value of the portfolio to achieve your investment goals.*" This position aligns to our longer-term approach to management of our investment portfolio and proportionate needs for release of funds as analysed, forecasted, and managed through our regular financial performance exercises including cashflow projections and draw down plans.

10. The Committee also review RBC Brewin Dolphin's client advice and quarterly reports. Those reviews consider the services and investment solution provided and whether they remain suitable and on track to deliver the GOC's objectives. This process allows the investment managers and the Committee to explore the subject of risk in the context of the investment, the objectives of the GOC and any known or anticipated changes in the GOC's situation which may require a change to the service or investment solutions and to consider ethical investment restrictions. The objectives are

recorded as "*You want to grow your capital over the investment period to maintain the real value of the assets while funding annual expenditure*" and "*You want to generate income to a sustainable and growing income stream over the long-term*".

11. Our intention is for the policy to now be reviewed for suitability on an annual basis. The Investment Committee will be responsible for the review and will report any changes to Council as appropriate.

Finance

12. There are no immediate financial implications associated with this item. Assumptions of investment valuations and income are regularly reviewed and incorporated into our financial planning and performance analysis.

Risks

13. Unforeseen external events or environment cause financial volatility affecting workforce and registrants. Risk of volatility in stock markets combined with rising inflation negatively impacts investment portfolio value and income, along with pressures on costs, including wage inflation, impacting ability to recruit or retain staff (or need to increase pay bill) and external impacts including significant reductions in registrant numbers and fee income, alongside reduction in value of reserves and associated investment income, some or all of which lead to inability to meet our forecasted budget.

Equality Impacts

14. N/A

Devolved nations

15. N/A

Other Impacts

16. N/A

Communications

17. N/A

Next steps

18. Publication of the policy on the GOC website.

Attachments

Annex one: Draft Investment Policy

Investment policy

Status of document:	For approval
Version:	v1
Date of approval:	TBC
Effective from:	TBC
Owner:	Director of Corporate Services
Author:	Director of Corporate Services
Planned next review date:	Approval date + 3 years

1. Introduction

1.1 The General Optical Council is the regulator for the optical professions in the UK. The Council's statutory role is to protect and promote the health and safety of members of the public by promoting high standards of professional education, conduct and performance among our registrants. The Council currently register around 33,000 optometrists, dispensing opticians, student opticians and optical businesses

1.2 This policy applies to the long-term investment of the Council reserves, and their investment by external advisors.[1]

2. Investment powers

2.1 The trustees (our Council members) have wide powers of investment as outlined in the Trustee Act 2000. This also includes the power to delegate responsibilities to an investment manager. The current investment managers are RBC Brewin Dolphin.

2.2 The charity's governing document is the Opticians Act 1989 (as amended 2005).

3. Investment objectives

3.1 The broad objective of the invested funds is to provide income and capital appreciation which, when taken together with the registration income can provide sufficient money every year to enable the GOC to meet its statutory remit.

3.2 The primary investment objective is to enhance the value of the assets after taking account of inflation by investment in a diversified portfolio of equities, fixed income bonds, stocks and cash.

3.3 The secondary investment objective is to earn an attractive level of income from the invested portfolio which has the ability to grow over time.

3.4 The trustees have adopted an exclusionary screening policy as set out in paragraph eight.

4. Glossary of terms

4.1 **A1 by S&P or P1 by Moody's:** specific credit ratings for cash held. S&P and Moody's are both rating agencies.

4.2 **Accessible reserves:** those reserves that are readily realisable within a 'relatively short' time horizon. Typically, this excludes property and similar investments.
4.3 **Benchmark:** in investment markets, investment managers are required to show the performance of a fund relative to a measure or benchmark. This can take different forms. RBC Brewin Dolphin favour composite benchmarks which are structured of a weighted index of widely recognised market indices. This tends to create a challenging liquid benchmark which is highly visible. Other alternatives can be put forward and particularly peer group benchmarks or benchmarks relative to inflation. Debt is generally of a better quality and

therefore carries a lower speculative element.
4.4 **Diversification:** mixing assets with the aim of producing a better quality (smoother or less volatile) return.
4.5 **Equities:** another term for shares.
4.6 **Ethical screening:** this is an investment review policy to manage exposure to areas which conflict with the charity's aims and objectives.
4.7 **Exclusionary screening policy:** a screening policy involving avoiding certain defined areas. Sometimes also known as a negative screening policy.
4.8 **Fixed income:** borrowings, such as government bonds (in the UK, gilts), corporate borrowings (either investment grade or other).
4.9 **Index:** included to provide a comparator as to how the different sections within the fund might be performing.
4.10 **Investment grade:** fixed income investments are categorised according to the risk of default (missing either interest or capital repayments). One of the major divisions is between those deemed appropriate for investment (investment grade) and those that fall below this threshold.
4.11 **Liabilities:** the charity's or Council's committed expenditure.
4.12 **Prohibited assets:** investments perceived to be carrying a significantly higher level of risk than is available from more traditional asset classes.
4.13 **Real assets:** typically, these are assets providing a real return. Over the longer term, they tend to provide a better level of return, and have a good record of producing returns above the level of inflation but over the shorter term they can be volatile. Equities, property and certain alternatives are all classified as real assets.
4.14 **Real value:** the value after adjusting for the impact of inflation.
4.15 **Risk:** the variability of returns.
4.16 **Trustees:** as defined in the Trustee Act 2000. Members of the GOC's Council.
4.17 **Volatility:** this definition can be substituted for risk and refers to the variability of returns.
4.18 **Wide powers of investment:** powers granted to RBC Brewin Dolphin.

5. Attitude to risk

5.1 The trustees rely on investments to help fund activities. The key risk to the long-term sustainability of the GOC is inflation, and the assets should be invested to mitigate this longer-term impact. The trustees understand that this is likely to mean investment will have an emphasis on real assets and that the capital value may fluctuate.
5.2 The trustees will tolerate volatility in the capital value of the portfolio, in line with the GOC risk appetite statement, as long as the charity is meeting its short-term commitments through either income and working capital or, if necessary, the liquidation of capital assets.
5.3 The trustees consider their appetite for risk in investing activities is moderate.

Assets

5.4 The GOC's assets can be invested widely and should be diversified by asset class, by manager and by security.
5.5 The portfolio may be invested in fixed interest, UK and overseas equities, property, private equity and any other asset that is deemed suitable.
5.6 The following asset types are prohibited:

- purchasing securities on margin

- futures/commodity contracts.
- short sales.
- leveraged derivative securities.
- speculative derivatives; and
- other complex financial instruments.

5.7 The investment manager will be instructed to invest the funds with a “Moderate Risk” classification. For current arrangements, with RBC Brewin Dolphin acting as our investment managers, we will adopt RBC Brewin Dolphin’s risk category 6 as a strategic allocation. RBC Brewin Dolphin’s risk categories are optimised and their structure is adjusted periodically to reflect the prevailing investment environment.

As at October 2022 risk category 6 was structured as follows:

Asset	Benchmark %
Sovereign bonds	5.5%
Index linked bonds	2.5%
Corporate bonds	9.0%
UK equities	24.0%
Overseas equities	44.5%
Property	3.0%
Alternatives	9.0%
Cash	2.5%

Some flexibility, within stipulated ranges, has been incorporated into the investment process to enable RBC Brewin Dolphin to adjust the structure of the portfolio around the central optimised positions to take advantage of prevailing market conditions or specific requirements.

Currency risk

5.8 The majority of the GOC's liabilities are in sterling.

5.9 The significant portion of the portfolio should be maintained in sterling assets. Where other currency assets are included, the investment manager should consider currency issues.

5.10 Investment may be made in non-sterling assets.

Credit/counterparty exposure risk

5.11 A minimum of 70 per cent of the fixed interest investments should be of investment grade.

5.12 Credit of cash institutions should be rated at least A1 by S&P or P1 by Moody's.

5.13 No more than 10.0% of the portfolio value should be placed in any one stock, institution, or fund.

6. Liquidity requirements

6.1 The trustees wish to maintain a separate working capital reserve in-line with our Reserves Policy and Working Capital Statement, (see Reserves Policy for current figure).

6.2 Liquidity/income needs from the portfolio will be reviewed with the investment

manager on a regular basis.

7. Liquidity requirements

7.1 This is a long-term investment portfolio. As part of its purpose is to support the GOC, any change in funding requirements may alter the investment objective and income requirement.

8. Ethical investment

8.1 The GOC's assets should be invested in line with its statutory remit.

8.2 The GOC operates an ethical screening policy and wishes to avoid direct investment in companies where a significant proportion of its turnover or profit comes from the sale or production of tobacco related products as sight loss can be directly attributable to smoking.

9. Ethical investment

9.1 The Director of Corporate Services is appointed as the designated investment officer with the authority to act as liaison between the GOC and the appointed investment manager.

10. Management, reporting and monitoring

10.1 The portfolio's performance will be reported through the RBC Brewin Dolphin Client Valuation and Asset Confirmation Report on a quarterly basis and commented upon in the GOC financial performance summary which is shared with the Senior management Team, Audit Risk and Finance Committee and Council. The Client Valuation and Asset Confirmation Report will also be shared with Investment Committee members outside of committee.

10.2 Meetings between the designated investment officer and the investment manager will take place at least four times each year (with other contact and discussion as required).

10.3 Performance will be monitored against agreed market benchmarks, and against the investment objective of 4.8% return over the long term.

10.4 The assets will be held in the charity nominee arrangements of the appointed investment manager.

11. Approval and review

11. It will be reviewed by the Investment Committee on an annual basis to ensure continuing appropriateness and revised every three years.

Public
C06(23)

Council

Serious and significant incidents policy

Meeting: 22 March 2023 **Status:** For approval

Lead responsibility: Yeslin Gearty, Director of Corporate Services
Paper Author(s): Andy Spragg, Head of Governance

Purpose

1. To present a new serious and significant incidents policy for Council approval.

Recommendations

Council is asked to:

- **approve** the proposed serious and significant incidents policy; and
- **delegate** any minor revisions to the Chief Executive and Registrar (in consultation with the Chair of Council)

Strategic objective

2. This work contributes towards the achievement of the following strategic objective: Building a culture of continuous improvement This work is not included in our 2022/23 business plan; however, it will contribute to the delivery of the Governance 2023/24 business plan.

Background

Never events framework and serious incident policy

3. On 2 June 2021 SMT approved a Never Events framework. This policy defined a Never Event as “an incident of the utmost criticality, which GOC internal controls should prevent from happening”.

4. The GOC has also maintained a serious incident policy in the past to ensure its compliance with serious incident guidance from the Charity Commission. The most recent update was considered by SMT in March 2021, and it was agreed the policy would be submitted to Council in June 2021 for approval. There is no record of the policy having been referred to Council for approval around that time, and therefore it is assumed the revised policy did not receive formal approval.

5. Following a review by the Head of Governance and the Director of Corporate Services, it was agreed that a new serious and significant incidents policy would be drafted. The purpose of this policy is to improve how the GOC manages significant incidents while also ensuring it is compliant with its requirements under the Charity Commission guidance on serious incidents.

Analysis

6. The new policy consolidates the earlier serious incident policy with the current reporting practices around significant incidents to Audit, Finance and Risk Committee (ARC).

7. The new policy introduces an incident management process which clarifies core roles and responsibilities. It has used learning from near miss events to improve the coordination of corporate resources during an incident. This includes a more explicit role for SMT in the form of a Strategic Command Group (SCG) and the creation of a Tactical Coordination Group (TCG) aimed at providing corporate capacity and coordination during an incident.

8. The policy also makes explicit the role of Council as trustees in respect to reporting serious incidents to the Charity Commission. Charity Commission guidance makes it clear that trustees can delegate responsibility for investigation and reporting of serious incidents to the executive. The new policy makes this delegation explicit, and Council is asked to formally approve the policy.

Finance

9. The proposed policy makes use of current resources and carries no additional financial cost. The more robust arrangements will support the GOC in the event of a significant incident that incurs a financial loss.

Risks

10. The new policy is intended to reduce risk and appropriately manage issues as these might arise. It has a direct connection with the current risk management policy and processes, and risk owners have a clear responsibility within the policy in respect to incident management and reporting. By sharing the lessons learnt from serious and significant incidents across the organisation, it is anticipated that the risk of future occurrences will reduce.

Equality Impacts

11. There are no direct equality impacts identified.

Devolved nations

12. There are no impacts for devolved nations identified.

Other Impacts

13. There are no significant impacts identified.

Communications

External communications

14. Although this is an internal policy, it will be referred to the public meeting of Council in March 2023. This supports transparency in respect to how the GOC would manage a serious or significant incident.

Internal communications

15. Once approved by Council, the policy will be circulated to all staff, published on IRIS and a short item will be included at an all staff meeting for information. Leadership Team will be asked to cascade the policy to their teams.

Next steps

16. The policy will be referred to ARC for consideration in February 2023.

Attachments

Annex 1: Serious and significant incidents policy

Serious and significant incidents policy

Status of document:	Approved by SMT 18 Jan 2023
Version:	Final version to be approved by Council March 2023.
Date of approval:	TBC
Effective from:	19/1/2023 – interim policy.
Owner:	Head of Governance
Author:	Head of Governance
Planned next review date:	March 2026

1. Policy statement

1.1 The General Optical Council (GOC) recognises the importance of effectively managing its risks and learning from incidents. An important element in ensuring objectives are met is promoting a culture in which incidents (including serious incidents, Never Events, accidents and near misses) are reported at the earliest opportunity. Timely notification of incidents provides the organisation with an opportunity to address contributory factors and prevent a recurrence. Developing a culture where staff feel confident to report incidents will support the GOC in becoming a learning organisation.

1.1.1 The Chair of Council, Chief Executive and Senior Management Team (SMT) are committed to encouraging open and fair reporting of incidents.

2. Purpose

2.1 The purpose of this policy is:

- to provide a consistent definition of a serious incident, a significant incident, near miss, and never event;
- to clarify roles and responsibilities;
- to provide information on notification, management and reporting requirements and timescales;
- to signpost tools and resources that support good practice; and
- to provide guidelines to ensure that all incidents are reported appropriately, and that lessons learned from analysis of the event are shared across the organisation.

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3. Scope

3.1 This policy applies to:

- employees (whether permanent or temporary) and workers; [1]
- members;[2] and
- contractors working with, or on behalf of, the GOC.

3.2 Compliance with this policy is mandatory. Non-compliance for employees and workers may be considered a disciplinary matter. Non-compliance for members is a breach of the terms of appointment and could result in a code of conduct investigation.

3.3 If you require further advice and guidance, you should contact the Head of Governance at speakingup@optical.org. All requests for advice will be treated in confidence.

[1] Workers are appointed under a contract of employment by the Executive. This will commonly apply where work is ad-hoc and semi-regular.

[2] Members are appointed by the Privy Council (in the case of Council Members) or via the Council's appointment processes for committee members. This will commonly apply where individuals are a member of a committee or Council.

4. Definitions

4.3. **Serious incident:** As a charity, the GOC has a responsibility to manage and report serious incidents in accordance with guidance issued by the Charity Commission. The definition provided by the Charity Commission is:

'A serious incident is an adverse event, whether actual or alleged, which results in or risks significant:

- *harm to your charity's beneficiaries, staff, volunteers or others who come into contact with your charity through its work (who are collectively referred to throughout this guidance as people who come into contact with your charity through its work)*
- *loss of your charity's money or assets*
- *damage to your charity's property*
- *harm to your charity's work or reputation.[3]'*

Annex 1 sets out examples of what the Charity Commissions considers reportable serious incidents. However, it is not intended as an exhaustive list.

4.4. **Significant incident:** For the purposes of this policy, a significant incident may not meet the threshold for reporting as a serious incident to the Charity Commission. However, any incident which is significant (i.e. below the threshold of a serious incident) must be identified, assessed and any decision taken by SMT about whether it meets that threshold reported to the Audit, Finance and Risk Committee (ARC). Examples of significant incidents are enclosed in annex 5. However, it is not intended as an exhaustive list.

4.5. **Near miss:** an event (such as a significant or serious event) which does not have (but could have had) similar consequences to those of a significant or serious event. Examples of near misses are likely to be similar to those listed under significant incidents.

4.5. **Never event:** an incident of the utmost criticality, which GOC internal controls should prevent from happening. These are described within the GOC Never Events Framework

5. Review of this policy

5.1 Governance will be responsible for reviewing this policy every three years, considering new or changes to legislation and regulations as well as best practice before presenting it for consideration by SMT and approval by Council.

6. Responsibilities

6.1 Chair of Council and Council Members

6.1.1. As trustees, the Council has a duty to report any serious incidents to the Charity Commission. It has delegated the management and reporting of serious and significant incidents to the Executive via the Chief Executive and Registrar. Reporting

[3] https://www.gov.uk/guidance/how-to-report-a-serious-incident-in-your-charity

and receiving assurance following a serious or significant incident has been delegated to ARC with a clear line of escalation to Council where concerns are substantial enough to warrant it.

6.2 Chief Executive and Registrar

6.2.1. The Chief Executive and Registrar has overall responsibility for ensuring that the GOC has in place a robust incident management and reporting framework, ensuring that:

- there is a fair incident reporting culture;
- staff are encouraged to report incidents; and
- lessons learned are shared across the organisation.

6.2.2. The Chief Executive and Registrar is accountable to the Council in respect to the management and reporting of significant incidents.

6.2.3. The Chief Executive and Registrar will be responsible for activating the incident management procedure and convening the first meeting of the Strategic Command Group (SCG). This can be done by another member of SMT in an emergency.

6.3 Senior Management Team

6.3.1. As the executive board, the SMT is responsible for ensuring that management and accountability structures and culture in the organisation are appropriate to promote management, reporting and learning from incidents. It also provides leadership as a SCG in the event an incident requires active management.

6.4 Strategic Command Group (SCG)

6.4.1. The SCG is comprised of the members of SMT and supported by the Head of Governance. The name applies only when the incident management procedure is in place and refers to meetings explicitly convened as part of this procedure. The purpose of SCG is to provide the corporate and strategic direction when responding to significant incidents. The SCG will delegate operational oversight of the incident management to the Tactical Coordination Group (TCG).

6.4.2. The SCG convenes when the incident management procedure is activated, sets the frequency of meetings and reporting requirements, and agrees the step down of the procedure when the incident has been successfully managed.

6.4.3. The SCG will be responsible for assessing whether a significant event meets the threshold for a serious event and is therefore reportable to the Charity Commission. If the SCG is unable to consider the matter, due to the nature of the event (e.g., an ongoing criminal investigation where confidentiality is critical), this decision will be made by the Chief Executive based on advice from the Head of Governance. If there a conflict of interests for the Chief Executive, then the matter will be referred to the Chair of Council for decision.

6.5 Tactical Coordination Group (TCG)

6.5.1. The Tactical Coordination Group will be comprised of heads of service with the relevant corporate remits to manage a developing incident. The type of incident and associated risks will define the membership of the TCG and will be subject to approval by SCG. This will include, but not be limited to:

- Head of Communications
- Head of Governance

- Facilities Manager (if required)
- Head of People and Culture (if required)
- Head of Legal (if required)
- Head of Finance (if required)
- Head of IT (if required)
- Risk owner
- Other heads of department as judged appropriate

6.5.2. The TCG will be convened by SMT/SCG and expected to provide SMT and risk owner with any necessary operational capacity, corporate coordination and support. The TCG will disband at the direction of SCG once the incident has been managed and the process has been stepped down to the review phase. TCG members may participate at the review stage as required.

6.6 Directors

6.6.1. Individual directors are responsible for ensuring:

- that the content of this policy is followed in their area of responsibility;
- that learning from incident reporting is shared appropriately to encourage learning in their area of responsibility; and
- that staff training needs identified in the application of this policy are met to ensure improvement.

6.7 Head of Governance

6.7.1. The Head of Governance will ensure that there is an appropriate and effective incident management framework, including but not limited to:

- arrangements for record keeping and reporting;
- documented policies, procedures and guidance;
- appropriate training and support made available and delivered; and
- adequate resources are made available for the operation of this policy.

6.8 All persons in scope of this policy

6.8.1. All persons listed in the scope of this policy are responsible for:

- familiarising themselves with its contents; and
- highlighting to their line manager any training they feel they require related to it.

6.9 Person identifying the incident

6.9.1. At all times, the safety of the public, members, workers and employees is of primary importance. As a first step, the person identifying the incident should take immediate action to ensure that they and others remain safe.

6.9.2. The incident should be reported as soon as is possible so you can seek the appropriate advice. Reporting should be directed to the Head of Governance and Director of Corporate Services (aspragg@optical.org and ygearty@optical.org). You should also inform your line manager, relevant risk owner and your director.

6.10 Risk owners

6.10.1. An incident can be thought of as a risk that has actualised. The priority for the owner of the risk to which the incident relates is ensuring the appropriate steps are taken to

manage the incident in line with the policy and then completion of any necessary recovery work.

6.10.2. The expectation is that the risk owner will fully participate in the incident management and reporting processes, and seek the necessary advice, guidance and support from the TCG and Head of Governance. The risk owner will be accountable to SCG in terms of regular reporting and keeping the necessary parties informed during the incident management procedure.

6.10.3. The risk owner should also ensure that any required updates are undertaken following the incident and investigation findings.

6.11 Investigating officers

6.11.1 Upon being asked by the Director of Corporate Services to undertake a review, the investigating officer will coordinate an investigation to identify the factors that were likely to have led to the incident. The investigating officer should liaise with the risk owner to ascertain what, if any, corrective actions are required to prevent the incident from recurring.

6.11.2 Findings are remedial actions should be recorded using the Incident Review template, which is attached at Appendix 3.

7. Policy

7.1 Incident Management

Step-up of the incident management procedure

7.1.1. Upon notification of an incident, the Head of Governance and risk owner will use the risk scoring in the corporate and departmental risk registers as a means of assessing the severity of the risk. The risk scoring should inform the decision to implement the incident management procedure, alongside the professional judgement of the risk owner and Head of Governance.

7.1.2 The extent to which this procedure is followed will determined by the following:

- The likelihood of an extended disruption due to an incident
- The risk to the public, member, workers and employees
- The extent to which the GOC is exposed to reputational, financial or legal risk.

7.1.3 The SCG will be responsible for determining the regularity by which both the SCG and TCG will convene and the necessary reporting requirements. This will be proportionate to how the situation is developing. Examples might include:

- a weekly SMT meeting with TCG meeting daily;
- both SMT and TCG meeting daily; or
- alternate days for SCG and TCG meetings.

7.1.4 This will be kept under review throughout the incident management process and can be altered as best suited to assist workflow and developments.

7.1.5 The Chair of Council, Chair of ARC and Senior Council Member will be kept apprised of when the incident management procedure has been activated by the Head of Governance. The Head of Communications will establish what member, worker and employee communications are required throughout the course of the incident.

Step-down of the incident management procedure

7.1.6 SCG will be responsible for approving the stepping down of the incident management procedure. The TCG will disband once this procedure is stepped down.

7.2 Investigation

7.2.1. The Director of Corporate Services will appoint an investigating officer to lead a review to ascertain both the cause of the incident and any lessons which can be learned. If specialist technical knowledge is not required to decide the course of the investigation (e.g for IT, health and safety or information governance incidents), a member of the Governance team should normally be chosen as the investigating officer.

7.2.2. The review should be undertaken and completed in a timely manner; normally within 10 working days of the incident, though complex investigations may take longer.

7.2.3. The risk owner is responsible for signing off the draft incident review report, including any identified corrective actions. The completed report should be sent to SMT.

7.2.4. On occasions there may be other considerations, such as potential management action, where the commissioning of the review and consideration of the subsequent report may be limited to the Chief Executive (or Chair of Council in exceptional circumstances). In such cases the investigation report would be on limited circulation until the outcome of any recommendations were agreed.

7.2.5. Risk owners and the investigating officer should assess the impact of the incident so that the investigation can be both appropriate and proportionate. The rating of the incident should be consistent with the risk matrix contained in the GOC Risk Management Policy[4]. The Head of Governance can assist with risk owners with assessing whether an incident's impact (level of harm) is:

Insignificant	Minor	Moderate	Major	Catastrophic/ Never Event

7.2.6. A complex investigation and lengthy report will not likely be required for incidents rated as either '**Insignificant'** or '**Minor'**. It remains important, however, for learning points to be highlighted and corrective action agreed with the risk owner. Reflective practice is a useful method to use when identifying learning from low-level incidents. More information on this model can be found at Appendix 2.

7.2.7. Incident scored as either '**Moderate'** or '**Major'** have consequences which are outside of GOC risk tolerances and warrant a Serious Incident Review. For these incidents, a Root Cause Analysis (RCA) should be completed. Guidance on how to complete a RCA can be found at Appendix 3, and the Head of Governance will assist the investigating officer as required. To ensure effective learning, a RCA report should be completed (including sign off from the Risk Owner) within 12 weeks of incident notification.

7.2.8 It is not anticipated that many incidents will be rated as '**Never Events'**, as the internal control environment should be sufficiently robust to prevent their occurrence. Due to

4

the severity of this type of incident, a separate framework exists which both describes them and explains how the organisation will respond if they happen.

7.3 Incident Categories

7.3.1. Grouping incidents into categories assists with incident management and facilitates reporting, analysis and learning. The 7 incident categories used by the GOC are set out in Appendix 5.

7.4. Communication and Data Protection

7.4.1. In the event of a serious incident Council and the appropriate relevant agencies must be informed either prior to, or at the same time as filing the Charity Commission online form. Depending on the nature of incident, appropriate relevant agencies may include the Professional Standards Authority and Department of Health and Social Care. Any decisions regarding the requirement to inform other agencies will be taken by the Chief Executive in consultation with the Chair of Council. For serious data breaches requiring reporting to the Information Commissioner's Officer, reporting must be made within 72 hours of being first alerted to the incident. Please refer to the Information Governance Handbook for further details about the process and paperwork.

7.4.2. Serious or significant incidents may lead to a high level of media attention, and not only in the immediate aftermath. Communications are a vital element in supporting and delivering effective management of incidents. Therefore, any media requests must be directed to the Communications Team.

7.4.3 The GOC must comply with data protection requirements at all times. Incident reports should not normally refer to individuals by name or other using other identifiable personal information. Records of communication with individuals about the incident should be kept separately. In some circumstances it may be necessary to identify individuals, for example when reporting incidents in the public interest or if there are mandatory external reporting requirements. In such circumstances, full and unredacted access to incident reports will only be granted on a need-to-know basis.

7.5 Openness and Transparency

7.5.1. Information relating to incidents including internal reports and root cause analysis are subject to requests under the Freedom of Information (FOI) Act. All requests for information regarding incidents will be handled and responded to as per statutory FOI requirements.

7.5.2 This policy requires that all incidents are assessed and if it is believed that the incident is likely to result in a high risk of adversely affecting the individuals' rights and freedoms the individual must be informed without undue delay.

7.6 Reporting

7.6.1 Incidents assessed 'Insignificant' or 'Minor' will be reported to ARC as part of its regular incident and exceptions report on a quarterly basis, as per its terms of reference. Where a significant incident occurs is assessed as 'Moderate' or 'Major', Council and the ARC will be kept informed. A report will be provided to the next scheduled meeting of ARC. Serious incidents must be reported to Council.

7.6.2 In order to ensure lessons are shared across the organisation, the Head of Governance will:

- review the draft report and assess any immediate cross-organisational implications;
- monitor the completion of agreed actions arising out of incidents; and
- update the incident log with findings, corrective actions and completion dates.

The Head of Governance will assist risk owners in identifying lessons that can be learned from incidents. The Head of Governance is also responsible for analysis of incidents across the organisation, drawing out themes or patterns. Findings from analytic work will be provided to the SMT and Leadership Team on a quarterly basis. This report will also include, by exception, details of any actions from previous incidents which have not been completed within timescales.

7.7 Sharing of Lessons Learned

7.7.1. It is the responsibility of heads of departments to ensure that there are systems in place to deliver local learning from incidents, either through information being cascaded or relayed across teams.

7.7.2 The Head of Governance will engage with all staff to deliver cross-organisational learning through channels such as IRIS/SharePoint.

Training requirements

8.1. New staff, members and workers will be made aware of their responsibilities for incident reporting as part of the corporate induction.

8.2. The policy does not have a specific, required training component.

Monitoring and compliance

9.1 The Head of Governance is responsible for monitoring and reporting on compliance with this policy.

9.2 Breaches of this policy will be reported to SMT and ARC. A breach where a serious incident is not appropriately reported to the Charity Commission or other relevant authorities is a significant incident and should be subject to investigation.

9.6. The Director of Corporate Services will meet with the Head of Governance every six months to review the management and response to incidents and near misses.

Associated documentation

10.1. While not an exclusive list, this policy should be read in conjunction with:

- Business continuity plan;
- Anti-bribery statement;
- Risk management policy;
- Never Events Framework
- Speaking Up (Whistleblowing);
- Information governance handbook;
- Information security policy;
- Health and Safety policy; and
- Code of Conduct.

Appendices

Appendix 1 – Charity Commission serious incidents examples table

Appendix 2 – Incident review template

Appendix 3 – Reflective Practice Guidance

Appendix 4 – Root Cause Analysis Guidance

Appendix 5 – GOC Incident Categories

Appendix 1

Charity Commission serious incidents examples table

Appendix 2

Incident review

Click here to enter text.

Incident number: Click here to enter text.

Related risks: Click here to enter text.

Incident Impact: Choose an item.

Incident Category: Choose an item.

Introduction

Click here to enter text.

Findings from the incident review

Click here to enter text.

The issues

Click here to enter text.

Recommendations

1. Click here to enter text.

Actions

Action	Due date	By	Date completed
1.	Click here to enter a date.		Click here to enter a date.
2.	Click here to enter a date.		Click here to enter a date.
3.	Click here to enter a date.		Click here to enter a date.
4.	Click here to enter a date.		Click here to enter a date.
5.	Click here to enter a date.		Click here to enter a date.

Signed

Click here to enter text.

Click here to enter a date.

Appendix 3 - Reflective Practice Guidance

1. Introduction

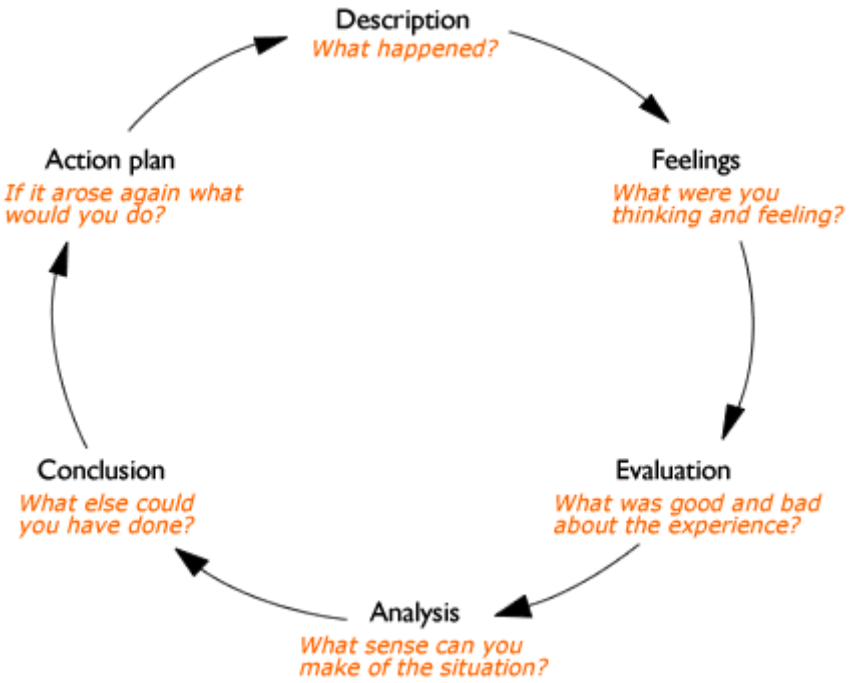
1.1 Personal reflection can help staff consider the difference between what they were thinking at the time of the incident and what has been learned looking back after the event to help them think differently if something similar happens in the future.

1.2 It is important to remember that this type of review is only appropriate for the least serious incidents – i.e. those with an impact rated Insignificant or Minor.

2. The Reflective Cycle

2.1 The reflective model adopted by the GOC for learning from incidents is based on a cycle, in which experience directly contributes to shaping a person's future actions. This is outlined below.

2.2 Also provided here is a template for capturing both the learning and the benefit to be gained from it. There is no obligation to use this document, though managers may wish to encourage their staff to do as part of the Performance Development process.



Name:	Date:
Job Title:	Department:
Brief Description of the Incident:	
1. What were you thinking and feeling at the time the incident happened?	
2. What was positive and negative about the experience?	
3. Can you make sense of the incident, and would other people agree with your analysis?	
4. What alternative actions could you have taken?	
5. If the situation happened again, what would you do?	

Appendix 4 - Root Cause Analysis Guidance (The 5 Steps)

Create the Problem Statement

The Problem Statement describes clearly the gap between what happened and what should have been achieved. It should include:

- the Focal Point (a one sentence description of the problem being investigated) / the date and time of incident / where the incident happened, and the system and process involved / what was the actual impact of the incident / what could the potential impact have been

A high quality Problem Statement contains a good level of detail and does not stray into mentioning any solutions (those come later)

Gather and Manage Data

Gather as much data as possible – this will yield causes and supporting evidence
Data can be time sensitive – gather it as soon as possible after the incident
Not all evidence is equal – high-quality evidence tends to be objective (documents, emails, computer logs) – the more subjective the evidence is (personal recollections, uncorroborated statements, etc) the lower its quality and less it should be relied upon.
All data/evidence collected must be stored securely so that it is not tampered with, destroyed or damaged
Good data storage should enable easy access for those who need it
Remember – there may be legal reasons for retaining evidence.

Analyse Cause and Effect

RCA uses a Causes & Effect chart to visually present causes and their logical relationships - this helps demonstrate the interaction of causes, effects and evidence, and help find solutions

There is no set methodology in RCA for ascertaining cause and effect, though a common technique is to use the '5 Whys' (repeatedly asking the question "why" until reaching a point where all of the issues are fully understood)

Generate Solutions

Clearly show how the proposed solution will eliminate the problem, and why this is the best course of action for the organisation to follow
Ensure there is a plan to monitor the implementation of the solution and the effect it is having – *without checking, how can the organisation be confident it has fixed the problem?*

Produce the Final Report

There will likely be a number of options available to address the identified root cause(s) - in considering which to recommend, think about the effectiveness, ease of implementation, cost/benefit, and any potential negative consequences of the possible solutions

Recommendations should address all root causes identified by the process and concentrate specifically on eliminating or reducing the likelihood of recurrence

Solutions should be SMART – Specific, Measurable, Achievable, Realistic and Timebound

Appendix 5 – Incident Categories

1. Health and Safety (including accidents and fire)

Examples of the sort of incidents that would be reported under this type are:

- Accidental injury
- Contact with or exposure to hazards
- Fires including false alarms
- Moving and handling
- Slips, trips and falls by service users, staff members and visitors

2. Security incidents

Security incidents include any incident that involved theft, loss or damage to organisation or personal property, such as:

- Deliberate damage to equipment, property and vehicles
- Loss or theft of equipment, property and vehicles
- Intruder alarms including false alarms
- Breaches of security

3. Violence and aggression incidents

Examples of incidents falling within this type of incident would include:

- Aggressive behaviour, physical assaults, verbal abuse.
- Harassment/inappropriate behaviour including sexual and racial

4. Information governance: confidentiality breaches, records management

Examples of these incidents are:

- Unauthorised or inappropriate disclosure of confidential service user information, (accidental or deliberate).
- Unavailability of records, missing or destroyed records
- Inaccurate information
- Breach of computer password security
- Loss or damage to Human Resources records
- Disclosure of staff information, accidental or deliberate

5. Information Technology (IT) incidents

Examples of reportable IT incidents are:

- IT system failures
- Network / system security
- Malware
- Loss of electronic data
- Unauthorised access or misuse of IT systems
- Inappropriate use of IT and Internet facilities, e.g. accessing pornographic/obscene material

6. Regulatory delivery

These incidents include:

- Breach of organisational policy
- Integrity of the register

- Illegal acts including legal challenge to GOC.

7. Other incidents

Wherever possible, incidents should be included as one of the above types. However these lists are not exhaustive and sometimes an incident will occur that does not apply to these types and included as ‘other’. Examples of might include:

- Financial loss
- A number of staff becoming unwell during working hours
- Non-violent / inappropriate behaviour of service user
- Use of illegal substances/drugs on GOC premises.

C07(23)

COUNCIL

Budget and business plan 2023/24

Meeting: 22 March 2023 **Status:** For decision

Lead responsibility: Leonie Milliner, Chief Executive and Registrar
Paper Author(s): Vikki Julian, Head of Communications **/** Andy Spragg, Head of Governance/ Manori Wickremasinghe, Head of Finance

Purpose

1. To seek Council approval for the budget and external business plan for 2023/24.

Recommendations

Council is asked to:

- approve the proposed budget 2023/24;
- approve of the proposed external business plan 2023/24; and
- delegate any minor corrections to the Chief Executive and Registrant, in consultation with the Chair of Council.

Strategic objective

2. The business plans and budget for 2023/24 sets out how the GOC will deliver its strategic objectives for the year ahead.

Background

3. The proposed budget 2023/24 is included as **annex 1.** The external business plan is included as **annex 2.**

4. The five-year forecast 2023/24 and internal business plan are being considered as part of the Strictly Confidential session of Council on 21 March 2023.

5. The business plan and budget plan are approved annually by Council, in accordance with the GOC scheme of delegation. As part of fulfilling its terms of reference, ARC is required to: “review and challenge as appropriate the proposed budget in advance of each financial year and report its opinion to Council prior to the budget being considered by Council”. It is also required to provide Council ongoing assurances in respect to the management of performance, finance and risk.

6. The business plans and budget have been produced by departments and reviewed by the Chief Executive and individual directors. The Head of Governance and Head of Finance have supported these sessions and provided additional advice and guidance where required. The external business plan has been drafted by the Head of Communications in consultation with SMT.

7. The internal business plan and proposed performance monitoring framework for 2023/24 was reported to ARC on 31 January 2023. No substantive changes to the internal business plan or how performance is reported to Council were raised. ARC has also been engaged throughout the budget and business planning process in regular updates via the Director report.

8. ARC considered the proposed budget on 28 February 2023. The Committee minutes will be included in the papers for the Strictly Confidential meeting of Council on 21 March 2023. As part of its discussions, the Committee agreed to recommend the budget to Council.

Analysis

9. The internal business plan and external business plan process has been developed in 2022/23 to incorporate more forward planning and engagement with services by the Chief Executive and Registrar at the drafting stage. It is proposed that this will be further developed and integrated into the business planning process for 2024/25.

10. The proposed budget (along with the five-year forecast, which is not included with these papers) aligns to our 'Fit for the Future' strategy for 1 April 2020 to 31 March 2025 and describes the resources required for the 2023/24 financial year to achieve our vision of being recognised for delivering world-class regulation and excellent customer service.

11. In advance of presenting the draft budget to ARC, the SMT considered the proposed budget and five-year forecast and considered that it is aligned with the proposed 2023/24 business plan; achievement of the GOC's objectives and the 'Fit for the Future' strategic plan and is sufficient for effective delivery of the GOC's regulatory functions.

12. When considering the draft budget, the Audit Risk and Finance Committee (ARC), also reviewed the Q3 forecast, five-year forecast and latest financial performance report, all of which have been provided to Council either as part of this session or the Strictly Confidential session (where papers contain sensitive or confidential information). Council members will note that the construction of the budget is an exercise that is not performed in isolation but is completed alongside the five-year forecast and considers delivery of both our Strategic Plan and 2023/24 business plan, alongside movement of reserves predictions (and the reserves policy), cashflow and draw down projections, all of which have been analysed in the preparation of this budget.

13. Our focus from November 2018 to March 2021 was to achieve financial stability (breakeven or better) for business as usual (BAU) operations by the 2021-22 financial year. We achieved our goal a year earlier than planned, in 2020-21, and continue to plan for a breakeven position BAU operations over the period of the five-

year financial forecast, as well as in the proposed 2023/24 budget, with a proposed surplus for BAU activity before expenditure from the strategic and legal reserves of £60k (2022-23 £664k forecast). This will help us ensure our long-term financial stability and achievement of our strategic objectives.

14. When approving the 2022/23 budget in March 2022, Council approved significant investment of our strategic reserves in four additional strategic projects aligned to our 'Fit for the Future' strategic plan (C07(22) 'table C'), alongside continued investment from reserves in the four strategic projects previously approved by Council: implementation of our IT strategy; GOC Refresh (Change Management Office (CMO)); the implementation phase of the Education Strategic Review (ESR); and completion of our CET/CPD project.

15. In December 2022, Council also approved additional spend of up to £91,741 from the strategic reserve to fund the balance of investment required for the electronic case management system (SC35(22)) and the allocation of contingency from strategic reserve of up to £85,569. The proposed 2023/34 budget and five-year forecast includes all approved strategic and legal reserves expenditure.

16. The Q3 forecast for BAU 2022/23 anticipates a surplus of income over expenditure of £664k at the year-end, which will further strengthen our reserves. The five-year forecast ensures that our five-year reserve levels are within reserve policy limits, whilst carrying out the BAU and strategic projects authorised by Council.

17. The proposed budget and five-year forecast have been developed through work undertaken since November 2022 and takes into account a review of the progress made in delivery of the current business plan, review of financial performance and the Q3 (2022/23) reforecast, planning by managers responsible for delivery, and direction from SMT about priority activities to achieve the strategic objectives.

18. The budget also sets out the investment from our strategic and legal reserves in accordance with agreed Council strategic priorities, whilst maintaining reserve levels within the policy limits. Although our business-as-usual budget achieves a better than breakeven bottom line of £60k surplus, after investment in strategic projects and unrealised investment gains there is a planned deficit of £1.479M. This represents an appropriate use of those funds held in our general reserve funds.

19. In years two to five of the five-year forecast (including in the proposed 2023/24 budget) £150k (for year two) is earmarked from the strategic reserve for potential future projects, the cost and type of which will be subject to approval by Council in accordance with the scheme of financial management, followed by £300k (including funds earmarked for IT related strategic projects) in years three to five. Potential future projects include MyGOC; policy development and consultation required as a result of the outcome of our analysis of evidence received from our 2022 call for evidence; and/or the DHSC's programme of legislative reform, and preparation for

the 2025-2027 3-year CPD cycle. All potential future projects funded by the strategic reserve will require the preparation of a full business case and approval from Council.

20. There is a short-term risk on market volatility of market value of our investment portfolio, which represents the majority value of reserves. However, we are confident in our quarterly re-forecasting capabilities and consequential agility in business planning and project rephasing to enable us to reduce or delay any planned drawdowns from reserves should such a risk materialise.

New or reallocated activity included in the proposed 2023/24 budget

21. The proposed budget includes a staff pay and performance award of 6.6% of payroll for the Q1 2023/24 general (cost of living) increase and the outcome of year-end performance reviews. In addition, 0.4% of payroll (£20k) is included in the HR budget for 2023/24 in-year recognition awards and a further 1% of payroll (£58k) is included in the CEO contingency budget for any additional movements in salaries following the anticipated introduction of a new reward and recognition policy in Q2 2023/24.

22. The increase in the overall budget for the Regulatory Strategy directorate compared to the Q3 forecast reflects the expanded remit of the work undertaken, including a larger education team (to manage the requirements of the new adaptation programme), an additional post in the communication team, and an increase in costs associated with CPD and providers' adaptation to meet the education training requirements (ETR). This work will be realised and implemented through 2023-24 and into 2024-25, during which time some staff will move from ESR project work to focus on ETR operational areas, with the exception of some key research strands (SCOPE and the planned longitudinal research).

23. Some smaller projects related to our policy and standards work identified in 2022-23 are incorporated in Regulatory Strategy directorate BAU operations proposed budget. This includes £115k for patient/public engagement, research and consultation activities to inform the review of professional standards and the development of associated guidance and a small one-off budget (£5k) for additional research related to business regulation.

24. The implementation of the Continuing Professional Development Project (MyCPD) will conclude in the coming year and staff involved in the project will move across into BAU expenditure to support operational work (at a cost of £90k in BAU as opposed to being met from strategic reserves). In addition, the budget includes £40k for CPD auditor/reviewer fees, which is a new cost from 2023/24, and an additional £15k in anticipation of new contractual arrangements for the MyCPD website in 2022/23.

25. The Regulatory Strategy budget also includes an additional £92k for an anticipated increase in education visitor fees and expenses to cover an increased visit schedule and the new quality assurance and enhancement methodology.

26. The IT BAU budget also includes a reallocated £320k from CMO/ strategic IT projects to reflect the shift of activity from strategic reserve to BAU.

27. The increase in the overall budget for the CEO's budget compared to the Q3 forecast reflects recruitment into the vacant manager post in Governance team, (which has been unfilled since Q2 2022/23). The CEO contingency budget includes an additional 1% of payroll (£58k) for any additional movements in salaries following the anticipated introduction of a new reward and recognition policy in Q1/Q2 2023/24.

28. An additional £30k is included in facilities budget for retrieval and archiving of the remaining boxes in storage. This project is not yet fully scoped and costs may be more significant depending on nature of the boxes' content.

29. The Change Team managed Fit for the Future programme will complete planned projects totalling £1.1m, which include the IT strategy project, a new case management system (CMS) and replacement for the MyGOC system in 2023-24. We are scoping an office accommodation project, having stopped work on the previously approved office refurbishment/re-design of our office at 10 Old Bailey. The office accommodation project costs are ear-marked for year 4. This may see us releasing £370k unutilised funds from the refurbishment of our current office and requesting new funds from Council from reserves for an alternative project in the future.

30. All completed strategic projects funded from reserves, where project implementation requires ongoing operational management, will then be funded through BAU. No ongoing post implementation costs will be met from reserves. All proposed projects where funding from reserves is required will be subject to Council approval.

31. In respect of financial resilience and ongoing oversight, as with previous years, the budget will be subject to three in-year reviews and quarterly re-forecasting. This approach is supplemented with monthly financial performance which includes reviews of investment performance, revenue and reserve levels and business plan progress reporting.

Finance

32. Financial implications are set out in the body of the proposed budget.

Risks

33. Analysis of the risks to GOC are identified in the body of the proposed budget.

Equality Impacts

34. The actions required to fulfil the GOC's equality duties and commitments in 2023/24 are set out in the proposed internal business plan. Impact assessments will be

undertaken for individual pieces of work set out in the internal business plan when and if required.

Devolved nations

35. The internal business plan sets out the proposed activity relating to devolved nations, including the implementation of the new Welsh Language Standard in 2023/24.

Other Impacts

36. Other impacts are set out in the body of the proposed budget.

Communications

External communications

37. A full external communications campaign will accompany publication of the external business plan.

Internal communications

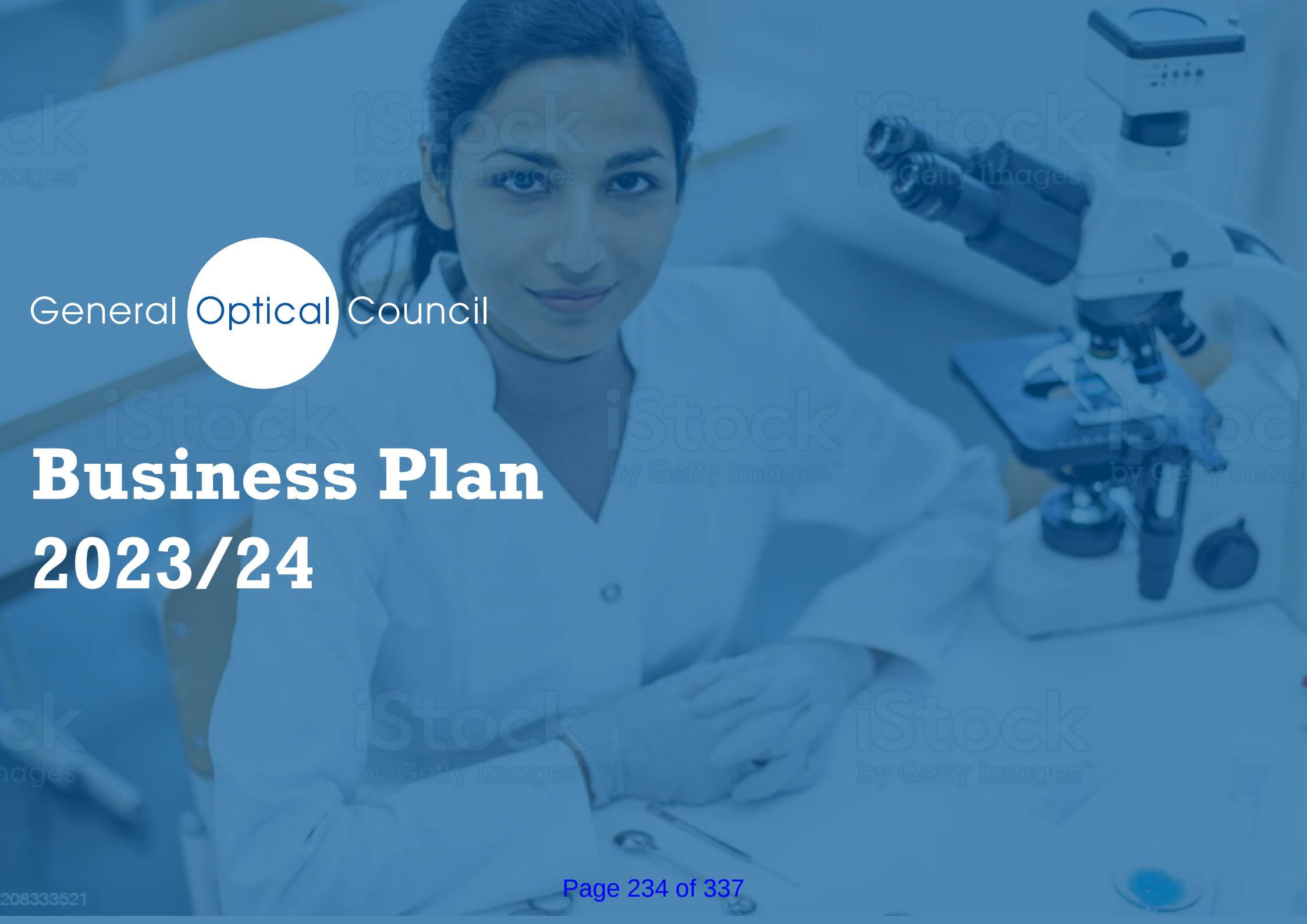
38. We have engaged Directors and service heads while producing the draft external business plan. The final versions of the internal and external plans will be communicated to all staff.

Next steps

39. Subject to Council approval, the external business plan will be published via the GOC website. The performance monitoring framework will mean that Council and ARC will regularly review the organisations progress in respect to its business plan and finances in 2023/24.

Attachments

Annex 1 – proposed GOC external business plan 2023/24
Annex 2 – proposed GOC budget 2023/24



General Optical Council

Business Plan 2023/24

Foreword

Leonie Milliner
Chief Executive and Registar

This, our 2023-24 financial year, marks the fourth year of our five-year strategic plan 'Fit for the Future'. Within this business plan, we highlight some of the key work programmes we aim to deliver to achieve our vision of being recognised for delivering world-class regulation and excellent customer service.

This includes the work we do to protect the public and uphold public confidence in the professions and businesses we regulate, with a renewed focus on offering high quality services to our registrants, and supporting eye-care professionals to contribute to their full professional capability in the best interests of patients. It also sets out how we are preparing for regulatory reform and investing in our organisation so it is fit for the future.

We will continue to put GOC values and our public duty to progress equality, diversity and inclusion at the heart of all we do. I look forward to working with all our stakeholders to deliver this ambitious programme of work for the year ahead.

Our Business Plan for 2023/24

We are the UK-wide regulator for optometrists and dispensing opticians, student optometrists and dispensing opticians, and optical businesses. We protect the public and uphold high standards in the optical professions by:

- setting standards for the performance and conduct of our registrants
- maintaining a register of individuals who are fit to practise or train as optometrists or dispensing opticians, and bodies corporate who are fit to carry on business as optometrists or dispensing opticians
- approving qualifications leading to registration
- investigating and acting where registrants' fitness to practise, train or carry on business may be impaired.

Our mission is to protect the public by upholding high standards in the optical professions. Our vision is to be recognised for delivering world-class regulation and excellent customer service.

In April 2020, we launched 'Fit for the Future', a new five-year strategic plan spanning 2020-25, outlining how we would achieve our vision and mission. The plan has three key priorities:

- world-class regulatory practice
- transforming customer service
- continuous improvement.

This business plan for 2023/24 demonstrates how we will protect the public and ensure registrants can contribute to their full professional capabilities across each part of the UK.

Protecting the Public

The public must have confidence in our ability to protect them, and our registrants must consider that we are fair, proportionate and that our focus is on public protection.

We will do this by maintaining a register of individuals who are fit to practise or train, and bodies corporate who are fit to carry on business. This includes managing our annual registrant and student renewal processes. We will also review the way we manage the assessment of applications from optical professionals who have qualified outside the UK and Switzerland who wish to register in the UK.

We will maintain fair, proportionate, and efficient processes for investigating fitness to practise concerns, including:

- continuing to embed improvements in our triage and casework processes to speed up investigations and improve the number of hearings that conclude first time
- delivering a new, effective, electronic case management system to support the robust management of our end-to-end casework process
- sharing learning from FTP outcomes with registrants through our FTP bulletin to embed good practice.

Supporting our registrants to uphold high standards

Our focus will be on offering high quality services to our registrants, supporting them to maximise their professional capability in the best interests of patients. We will make improvements to the MyGOC and MyCPD online platforms and implement a new customer care strategy, working towards the Customer Service Excellence Standard, to ensure we are supporting registrants effectively.

We will continue to administer our new, more flexible CPD scheme, which gives registrants more control over their learning and development and the ability to tailor their own personal scope of practice to develop and diversify their skills throughout their career, maximising their professional capability. We will also support CPD providers by implementing a new audit system and hosting opportunities for engagement.

Following the introduction of our new education and training requirements (ETR), providers of GOC-approved qualifications will be submitting their plans to meet our new requirements, which we will review and note. Whilst providers are adapting their qualifications to meet our new requirements, we will continue to quality assure GOC-approved qualifications and prepare for the introduction of our new Quality Assurance and Enhancement Method.

We have commissioned the Sector Partnership for Optical Knowledge and Education (SPOKE) to run a knowledge hub for the sector to support the introduction of the ETR for dispensing, optometry and qualifications leading to specialist entry to the GOC register.

We will also progress plans for longitudinal research, which will measure the effectiveness of our new outcomes and standards on registrants' competence, confidence and capability.

We will continue to engage with professionals and professional bodies to ensure we deepen our understanding of the optical sector, including further developing the GOC's collective understanding of optical care provision through visiting different practices and settings around the UK.

Reforming our Regulation

We will work to ensure our legislation and associated policies are fit for purpose to deliver world class regulation.

We will review and consult on our Standards of Practice to ensure they are up to date, maintain best practice and respond to developments in the professions and wider healthcare sector. This will involve extensive stakeholder engagement on key topics such as social media and online conduct, maintaining professional boundaries, leadership, delegation and supervision, technology, AI and digital literacy.

Last year we launched a call for evidence to inform the development of a potential business case for future change to the Opticians Act, as well as any changes to our associated policies. In 2023 we will complete our analysis of evidence received and publish our response. We will also undertake desk-based research projects to fill in any knowledge gaps and follow-up consultations as required, as well as continuing to engage with and influence DHSC on healthcare regulatory legislative reform.

Fit for the Future

We will continue work to make our organisation fit for the future, including delivering a new electronic case management system to improve how we share information, investing in our staff with a new people plan and installing new audio-visual facilities in our hearings and meetings rooms to better facilitate remote and hybrid engagement in our work by stakeholders.

We will continue to maintain strong governance procedures, including implementing the recommendations from our Governance review, undertaking all member appointments and supporting the work of our Council and committees to ensure they inform decision-making and identify and manage any risk appropriately.

We will develop a new communications strategy which will enhance our customer service and demonstrate to our stakeholders how we protect the public and uphold high standards.

We will also begin work on developing our next five-year corporate strategy, including undertaking research around the current state of the optical sector in order to identify key priorities for engagement.

We will continue our public duty and commitment to progress equality, diversity, and inclusion, which underpins all our work, including delivering our EDI strategy and annual report about how EDI is embedded across the organisation.

Keeping Accountable

In aspiring to be world-class we should be rated highly by the Professional Standards Authority, aiming to meet all their standards. We should also retain the confidence of the optical professions and for the first time will be surveying business registrants.

Public confidence in the professions we regulate is already strong and we expect this to be maintained if we are to uphold high standards. By protecting the public, we are also protecting the reputation of the optical professions. We will continue to run our annual survey measuring public perceptions of the professions and experience using optical services.

We will measure and track success on a business-as-usual basis quarterly reporting to our leadership team and Council.

Our Budget 23/24

The majority of our income comes from fees set for our registrants, which we use to deliver our core functions, strategic objectives and mission.

Our focus for our 2023/24 budget is to continue to deliver value in our business-as-usual (BAU) operations, planning for for a better than break-even position for BAU and achieving a surplus before reserve expenditure.

We plan to only use our strategic or other reserves to achieve the successful completion of strategic projects and other Council-approved designated operations. We will invest effectively and appropriately in achieving our strategic aims while ensuring we maintain reserve levels within our Reserves Policy limits.

Budget 2023/24	000 (thousands)
Income	£11,012
Expenditure (business as usual)	£10,952
Surplus / (Deficit) before reserve expenditure	**£60**
Reserve expenditure	£1,814
Surplus / (Deficit) after reserve expenditure	**(£1,754)**
Unrealised investment gains	£275
Surplus / (Deficit)	**(1,479)**

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Linkedin: General Optical Council

You can get this plan in Welsh by visiting www.optical.org

General Optical Council

Budget for year ending 31 March 2024

General Optical Council
Budget – 2023-24

Contents

General Optical Council
Budget – 2023-24

GOC Summary P&L 2023-24 budget					
	Year 1		Year 2 (Budget)		
	2022-23		2023-24		
	Oct.'22 (Q3) Forecast £'000	Budget £'000	Oct.'22 Forecast £'000	Budget £'000	Variance with Oct.'22 £'000
Income	10,247	9,994	10,980	11,012	32
Expenditure (BAU)	9,583	9,946	10,846	10,952	(106)
BAU Surplus / (Deficit) before reserve expenditure	**664**	**48**	**134**	**60**	**(74)**
Reserve (strategic & legal) Expenditure	1,418	1,920	1,809	1,814	(4)
Surplus / (Deficit) after reserve expenditure	(754)	(1,872)	(1,676)	(1,754)	(78)
unrealised investment gains	(550)	247	-	275	275
Surplus / (Deficit) after reserve expenditure and unrealised investment gains	**(1,304)**	**(1,625)**	**(1,676)**	**(1,479)**	**197**

Highlights

The proposed 23/24 budget projects a surplus before expenditure from the strategic and legal reserves of £60k (in 2022/23 the proposed budget surplus before expenditure from the strategic and legal reserves was £48k; the Q3 forecast anticipates a surplus at year end of £664k before expenditure from the strategic and legal reserves).

The proposed 23/24 budget after expenditure from the strategic and legal, but before the investment gains is a deficit of £1,754k (in 2022/23 the proposed budget deficit was £1,872k; the Q3 forecast is a deficit at year end of £754k). The anticipated surplus/(deficit) for the 23/24 budget year is a deficit of £1,479k (In 22/23 we anticipated a budget deficit of £1,625k; forecast at Q3 to be £1,304).

General Optical Council
Budget – 2023-24

Table A
Budget 2023-24: analysis by departments and projects
Income and Expenditure Accounts

	Year 1	Year 2		
	2022-23	2023-24		
	Q3 Forecast	Oct '22 Forecast	BUDGET	Variance
	£'000	£'000	£'000	£'000
Income				
Registration	9,989	10,706	10,729	23
Dividend Income	246	263	263	0
Bank & Deposit Interest	1	1	10	9
Other Income	11	10	10	0
Total Income	**10,247**	**10,980**	**11,012**	**32**
Expenditure				
CEO's Office				
CEO	219	336	331	5
Governance	621	731	706	25
Total CEO's Office	**840**	**1,067**	**1,036**	**30**
Regulatory Strategy				
Director of Regulatory Strategy	127	114	113	1
Policy & Standards	214	498	471	27
Communications	212	303	298	5
Education & CPD Operations	571	696	764	(68)
Education & CPD Development	211	290	275	15
Total Regulatory Strategy	**1,336**	**1,902**	**1,921**	**(20)**
Regulatory Operations				
Director of Regulatory Operation	124	134	132	2
Case Progression	2,136	2,262	2,221	41
Legal	224	224	213	12
Hearings	1,368	1,178	1,338	(161)
Total regulatory Operations	**3,852**	**3,797**	**3,904**	**(106)**
Corporate Services				
Director of Corporate Services	158	118	122	(4)
Facilities	1,088	1,077	1,135	(59)
Human Resources	458	544	511	33
Finance	454	501	505	(4)
Registration	526	590	614	(24)
Total Corporate Services	**2,684**	**2,829**	**2,887**	**(58)**

General Optical Council
Budget – 2023-24

Table A (Contd.) -Income and Expenditure Accounts (Contd.)

	Year 1	Year 2		
	2022-23	2023-24		
	Q3 Forecast	Oct '22 Forecast	BUDGET	Variance
	£'000	£'000	£'000	£'000
IT (BAU)	742	1,074	1,062	13
Depreciation & Amortisation	130	178	143	35
Total Expenditure	**9,583**	**10,846**	**10,952**	**(106)**
Surplus / (Deficit) before reserve expenditure	**664**	**134**	**60**	**(74)**
Reserve Expenditure				
Standards Review and Implementation Project	32	0	0	0
Completion of CPD project	36	0	0	0
Education Strategic Review project	188	327	372	(44)
IT Strategy Project	272	420	419	1
Change	526	608	562	46
Strategic Projects	136	0	0	0
Potential Projects*		150	150	0
Complex Legal Cases	200	200	200	0
Project Depreciation & Amortisation	28	104	101	3
Case Management System			10	(10)
Total Project expenditure	**1,418**	**1,809**	**1,814**	**(4)**
Surplus / (Deficit) after project expenditure	**(754)**	**(1,676)**	**(1,754)**	**(78)**
Unrealised Investment gains	**(550)**	0	275	275
Surplus / (Deficit)	**(1,304)**	**(1,676)**	**(1,479)**	**197**

General Optical Council
Budget – 2023-24

Table B
Budget - Including Project Expenditure

	2022-23	2023-24		
	Q3 Forecast	Q2 Forecast	Budget	Variance from Q2 forecast
	£'000		£'000	
Income				
Registration	9,989	10,706	10,729	23
Dividend Income	246	263	263	-
Bank & Deposit Interest	1	1	10	9
Other Income	11	10	10	0
Total Income	**10,247**	**10,980**	**11,012**	**32**
Expenditure				
Staff Salaries Costs	5,446	6,213	6,181	32
Other Staff Costs	320	371	318	53
Staff Benefits	18	23	49	(26)
Members Costs	1,159	1,259	1,315	(56)
Case Examiners	82	100	107	(7)
Professional Fees	619	815	708	107
Finance Costs	80	92	94	(2)
Case Progression	1,017	901	887	14
Hearings	314	211	286	(75)
CPD & Standards	101	118	114	4
Communications	38	45	54	(9)
Registration	19	10	19	(9)
IT Costs	606	1,053	1,039	14
Office Services	977	1,004	1,040	(36)
Other Costs	49	159	162	(3)
Depreciation & Amortisation	158	282	244	38
Upcoming Projects	-	0	150	(150)
Total Expenditure	**11,002**	**12,656**	**12,766**	**(110)**
Surplus / Deficit	**(755)**	**(1,676)**	**(1,754)**	**(78)**
Unrealised Investment gains	(550)	0	275	275
Surplus / (Deficit)	**(1,304)**	**(1,676)**	**(1,479)**	**196**

General Optical Council
Budget – 2023-24

Assumptions

Income

- Registration fee for FC & BC registrants will be increased +£10 p.a. from yrs. 3 onwards. This rate may change but will at least cover the inflation rate as advised by the Council in Nov.'22. Student income will stay the same.
- Low-income fee would be £100 less than normal renewal fee from 24/25.
- Student numbers increase by 4%.
- Initial registration figure £75 and the £40 fee for transfer between registers will not be increased.
- 80% of new registrants would be transfers and 20% would be direct.
- There is a risk of volatility of 9.2% of investment valuation.

Expenditure

- There will be no new strategic projects costing more than the potential ear-marked project levels.
- There will be no high-value fixed asset purchases over the forecast values.
- General and performance related pay increase for 2023-24 will be 6.6%.
- Flexible working will continue for staff, members, and panels.

Risks not covered in Q3 (2022/23) +4yr forecast

- Cost of Welsh language translation is not yet scoped and not included in the above forecasts or budget. The one-off cost is now estimated to be lower than the original estimate of c£165,000 and ongoing costs of c£75,000 a year previously forecasted.
- Archiving project is not yet scoped, however £30k is included in facilities budget. Cost may be more significant depending on nature of the boxes' content.
- Extra cost (holiday pay, Employer NI and PAYE, pension) related to worker/member classification of Hearings panel. This may cost about £73k p.a. We are observing the Somerville vs NMC before deciding.
- There is a risk of de-regulating students and reduction of registration income, although this may be offset by reduced operating and administrative costs.

Staff pay award

The proposed budget includes a staff pay and performance award of 6.6% of payroll for the Q1 2023/24 general (cost of living) increase and the outcome of year-end performance reviews.

In addition to the 6.6%, 0.4% of payroll (£20k) is included in the HR budget for 2023/24 in-year recognition awards and a further 1% of payroll (£58k) is included in the CEO contingency budget for any additional movements in salaries following the anticipated introduction of a new reward and recognition policy in Q1/Q2 2023/24.

C08(23)

COUNCIL

Communications strategy

Meeting: 22 March 2023 **Status:** For Decision

Lead responsibility: Vikki Julian, Head of Communications
Paper Author(s): Vikki Julian, Head of Communications
Lead Responsibility/Project Director: Steve Brooker, Director of Regulatory Strategy

Legal Review	N/A
Finance Review	N/A

Purpose

1. To seek Council approval for the proposed communications strategy (included at annex one).

Recommendations

2. Council is asked to:
   - approve the communications strategy
   - delegate any minor changes to the strategy to the Chief Executive and Registrar, in consultation the Chair of Council.

Strategic objective

3. This work supports the delivery of all three strategic objectives.

Background

4. Improved communication and engagement is a core ambition of our five year 'Fit for the Future' strategic plan and is critical to the delivery of our regulatory objectives.

5. The appointment into a newly created post of Head of Communications in August 2022 presented an opportunity to realign resources and priorities to create a more strategic and proactive approach to our communication activities.

6. Following a period of observation and knowledge gathering, the new Head of Communications has devised a communications strategy to support the delivery of the 'Fit for the Future' strategic priorities for the remainder of the strategic plan, and to help us prepare for the next strategic planning period, 2025-2030.

7. The strategy has been developed in conjunction with the communications departmental business plan and budget for 2023/24. It incorporates feedback from the Council following its strategy day on 2 March 2023. It has also been shaped by input from the Communications team, Head of Governance, Head of Policy and

Strategy, Director of Regulatory Strategy, SMT, and the Chief Executive and Registrar.

Analysis

8. The proposed communications strategy explains how the communications team will be developed to support our strategic priorities and identifies the external and internal communications and engagement activities necessary to fulfil our strategic objectives and support the organisation to achieve its mission and vision.

9. The strategy identifies our stakeholders and audiences and sets out how and when we should communicate with them. It also sets out the key channels and devices we should use to do so effectively.

10. The strategy includes specific communications risks, in line with a new risk register, which has been developed to help manage the mitigation of identified communications risks.

11. It sets out core guiding principles for a new strategically-focused method of approaching communications, along with a programme of work designed to enhance and amplify the effectiveness of our communications and engagement work.

12. Some of the key considerations of the strategy include: how we develop an authoritative voice and brand; expanding thought leadership and influencing (including new areas of work such as public affairs); how the communications function should be developed to deliver this ambitious programme of work.

13. Recognising that our staff, workers and members are our most important communicators, it also sets out how we can utilise networks and provide support and guidance so that everyone can be a confident and effective communicator.

Finance

14. The proposed strategy and associated business plan are included in the 2023/24 business plan and budget paper.

Risks

15. Specific communications risks are identified as part of this strategy.

Equality Impacts

16. EDI has been considered as part of the strategy and forms an important part of all communications considerations.

Devolved nations

17. Delivery of Welsh Standard Language Requirements is included as part of the strategy.

Communications

External communications

18. Although the strategy will significantly impact our external communications, it does not in itself require an external communications plan.

Internal communications

19. This will be communicated on an organisational wide level with specific communications devised for more impacted teams.

20. Specific aspects, such as the branding refresh, will require stand-alone communications approaches.

Next steps

21. Subject to Council approval, the communications strategy will be implemented on an organisational wide level.

Attachments

Annex one: Communications strategy

Communications Strategy

March 2023

1. Mission and vision

The General Optical Council is the regulator for the optical professions in the UK. Our mission is to protect the public by upholding high standards in the optical professions. Our vision is to be recognised for delivering world-class regulation and excellent customer service. In April 2020, we launched 'Fit for the future', a new five-year strategic plan for 2020-25, outlining how we would achieve our vision and mission.

The 'Fit for the Future' strategic plan has 3 key priorities:

- world-class regulatory practice
- transforming customer service
- continuous improvement.

Our communications play a crucial role in helping us achieve our mission and vision. High quality communications are critical in maintaining public confidence in the GOC as a world-class regulator. Communications should also underpin the excellent customer service that we offer to our registrants and other stakeholders.

This strategy sets out how our communications will support the delivery of the 'Fit for the Future' strategic priorities for the remainder of the plan until March 2025. It outlines the core communications principles that will drive forward our work; explains how the communications team will be developed to support our strategic priorities; and identifies the external and internal communications and engagement activities necessary to support the organisation to achieve its mission and vision.

2. Context

2.1 Capacity

The Communications team is a team of four, comprising of: Head of Communications, Communications Manager, Communications Officer and Public Affairs and Communications Officer. There is an additional part-time communications post which sits within the Change team (until 2024). All the post holders are communications generalists, meaning they have a wide range of skills across the communications mix and can work across different disciplines. The team structure has been in place for six months, except for the Communications and Public Affairs Officer post, which commenced in January 2023.

The appointment of a new Head of Communications presents an opportunity to realign resources and team priorities to create a more strategic and proactive communications team. Since 2020, some progress has been made to streamline

processes, update mailing lists, upskill the team, bring design work inhouse and improve joint-working. However, many of the key building blocks for effective communications and engagement are underdeveloped. Additionally, across the business, there is a variable understanding of, and differing approaches to, communications. This creates inconsistency in terms of quality and means we do not always speak to our audiences in an authoritative way.

2.2 The purpose of our communications

In line with our vision, mission and strategic priorities, the key purpose of our communications is to develop and maintain confidence in the organisation's ability to protect the public by upholding high standards. We do this by:

- projecting our authority through our unified voice, brand, messaging, and engagement;
- building and maintaining our reputation as a world-class regulator with registrants and the public;
- ensuring our stakeholders are aware of our role and our aims;
- clearly communicating the relevance of our functions and work in relation to public protection and upholding high standards in the profession;
- precisely communicating what is required and expected in terms of our statutory obligations; and
- working in partnership with stakeholders to achieve our mission, including involving people in our decision making, and ensuring individual and collective feedback on our work.

To achieve this, our Communications team undertakes the following functions:

- **providing communications support and expertise to the organisation** to ensure our voice and brand and messaging are appropriate and that our communications are in line with our strategic priorities. This includes producing key corporate communications;
- **maintaining, developing, and translating our brand and messaging** to ensure our vision and mission is at the heart of what we do;
- **managing and developing content for our external facing channels** to ensure stakeholders are aware of our mission and the work we do to achieve this, and so we can provide excellent customer service to our stakeholders;
- **reputation monitoring and crisis communications** so that confidence in us as a regulator is maintained and enhanced;
- **proactively communicating our purpose and work** in line with our strategic priorities, including media relations and wider engagement with stakeholders; and
- **undertaking quality internal communications** to enhance the customer service we offer to our stakeholders and to ensure our staff, members, contractors and workers are fully engaged with our vision and mission. This is particularly important in relation to the ongoing Change programme.

There are also some functions which we do minimally, which will need to develop to ensure effective communications. These include:

- developing and streamlining our intelligence gathering so we can broaden our engagement with stakeholders and the sector and improve our effectiveness as a regulator. This will involve building a public affairs function, extending our social media monitoring and broadening the scope of our work to the wider healthcare sector.
- enhancing our planning and strategic oversight to ensure the organisation's communications needs are being met and that staff, members and workers are supported and empowered to engage with our audiences.

3. Audiences and channels

Understanding who we are talking to and what our audiences want to hear from us is at the crux of effective communications. Putting the needs of our audiences at the centre of our work is crucial if we are to be seen as a world-class regulator and provide excellent customer service. It is also important that, particularly where it comes to our statutory obligations and our expectations of registrants, that we communicate clearly and precisely.

Currently, we have a variable level of knowledge and understanding about our key audiences' communications preferences. The Registrant and Public Perceptions surveys provide a snapshot. The 2022 Registrant survey showed that most registrants (88%) preferred to hear from us via email bulletins. Far fewer used the website (33%) or interacted via social media (5% use LinkedIn and 4% use Twitter). Most felt the frequency of the bulletins was about right and in terms of content, most (81%) found it informative. The survey also covered the FtP specific bulletin, which 85% found useful. One of the areas for improvement outlined in the Stakeholder Perceptions survey was developing and demonstrating our knowledge of the optical sector. As a result, in 2023 we launched our optical practice familiarisation programme. The 2022 Public Perceptions survey demonstrated that the public have a high level of trust in the optical sector and high levels of satisfaction.

Our identified audiences are as follows:

External	
Registrants **1.** Student dispensing opticians and optometrists **2.** Fully qualified dispensing opticians and optometrists **3.** Businesses and body corporates	Core – we need to communicate regularly Important to acknowledge the differing needs of fully qualified dispensing opticians and optometrists – for example, newly qualified vs someone more established in their career
Optical representative and membership bodies across all nations Broader optical sector e.g. manufacturers of appliances	Core

Public • "The general public" • Members of the public who need to use our (GOC) services • Patients (e.g. those who regularly use optical services)	People who need to use our (GOC) services and patients are a core audience who are generally more engaged, and we will need to communicate with them frequently In terms of the wider public, we would want them to know the optical sector is regulated
Patient representative groups and third sector organisations	We should engage with where relevant to our work, particularly where this involves informing relevant policies
Professional Standards Authority	Core – it is crucial we regularly demonstrate our good practice and compliance with PSA standards
Other health and social care regulators, including MHRA and CQC Regulators outside of healthcare where relevant	We should engage with where relevant to our work particularly where there are broader public protection aims. e.g. education regulators
Education • CPD providers • Providers of GOC approved qualifications • FE & HE statutory education, training, regulatory, quality assurance, research and funding bodies in each of the four nations • Prospective providers of GOC approved qualifications	Core – we need to communicate regularly
NHS and healthcare commissioners • Regional areas for NHS England • The devolved nations	We should engage with where relevant to our work
Government/Westminster/devolved administrations • MPs/Lords with specific interest in eye health/optical sector • DHSC • Government bodies in all nations of UK	We should engage reactively where relevant to our work but also proactively seek opportunities to influence policy in line with our strategic aims
Media • Optical sector • National/local • Member/ governance sector	We should engage where relevant to our work but also proactively seek opportunities to build our reputation as a world-class regulator
Internal	
Staff	Core
Council	Core but tailored for relevance

Members (other than Council members)	Core but tailored for relevance
Workers	Core but tailored for relevance
Contractors	Core but tailored for relevance

2.4 Communications channels

The existing channels we use to deliver our communications are as follows:

External (owned)	
Website	
My GOC/My CPD	
Social media	Twitter, LinkedIn, YouTube
E-bulletins	Registrant bulletins
FtP focus	Formerly PDF, now new email format
Brand	
Events	Roadshows, launches
Reports	Annual report, external business plan, policy reports
External (not GOC)	
Media	
Events	

4. Risk

Effective communications are an important part of supporting the organisation to manage risk and maintain the confidence of the public and registrants. In light of this, a new communications risk register has been developed to mitigate communications risks. There are also specific strengths, weaknesses, opportunities, and threats related to our current communications capacity which are shown in the SWOT analysis below.

Strengths	**Weaknesses**
• Clearly defined audiences • Restructured team bringing in new capabilities and the ability to change and innovate • Capacity and skill to deliver comms projects in-house • A clear set of strategic priorities to inform our approach to communications and engagement • Strategic approach to programmes means opportunities for proactive comms • Recognised authority on optical regulation	• Branding and messaging are inconsistent and need refreshing • Timeliness and consistency of communications • Reactive rather than proactive • Communications across the organisation are not coordinated • We need to communicate complicated concepts • Lack of joined up working with the sector bodies • Large volume of work requiring communications input • Variable engagement across organisation with communications

• Most of the public have high levels of trust in the optical professions	• Yet to embed “comms first” approach to all projects
Opportunities • Engaged stakeholders • Interesting projects with broad scope which give the opportunity to communicate proactively • MyGOC project offers an opportunity to communicate and interact with our registrants in a dynamic way • A revised CRM will allow us to segment and target our audiences more effectively and analyse communications and engagement • Brand refresh will ensure all staff understand and implement • Remote environment offers more tools and opportunities to engage (Microsoft Teams, webinars, surveys, polls) • Getting staff and Council actively involved in communications • Collaborating with the professional bodies strategically to best serve our registrants • To be truly UK-wide by working with the devolved nations	**Threats** • Resource and capacity in the team between meeting short-term needs, including crises, and long-term strategic needs is difficult to balance • Reputational risk of not being able to control the behaviour of our audiences on social media • Not meeting our registrants’ needs and losing their confidence • The public not understanding our role leading to a lack of public confidence • Being considered ineffective by stakeholders • Gap in customer service function (which often falls to the Communications Team which is outside of their remit) and therefore a risk of not delivering our strategic priorities

5. Broad communications principles

This strategy is underpinned by the following communications principles:

- Everyone is a communicator: empowering staff to think about how what they do is communicated both internally and externally leads to improved customer service and being seen as a world-class regulator;
- Communications first: making sure communications, particularly messaging, are considered as part of all our work;
- Targeted: making sure we get messages to the right people and in the right way and at the right time;
- Accessible and inclusive: using methods and language that meet the needs of the audience and takes into account our commitment to equality, diversity and inclusion;
- Integrated: using a multi-channel approach for maximum impact
- Collaborative: co-creating with our internal and external audiences where relevant, listening and responding accordingly

It will also be delivered in accordance our overarching values:

- We act with integrity
- We pursue excellence
- We respect other people and ideas
- We show empathy
- We behave fairly
- We are agile and responsive to change.

6. Key activities

6.1 World-class regulatory practice

To deliver world-class regulatory practice, we must be *seen* to deliver world-class regulatory practice. This means communicating proactively about all elements of our work and how it contributes to protecting the public. This is also an important opportunity to communicate our understanding of, and engagement with, the optical sector which will contribute to enhanced customer service.

An authoritative voice fit for a world-class regulator

- The public must have confidence in our ability to protect them and registrants must feel that we are fair, proportionate and that our focus is on public protection and ensuring high standards are upheld. We will develop a new set of corporate messages where this is front and centre and embed it in all of communications. These will be accessible, inclusive, and targeted appropriately by audience. We will share and run training on these key messages, to ensure everyone is empowered to deploy the organisational voice.

- We will proactively seek opportunities in the media, events and through stakeholder engagement to deploy this new messaging. We will arrange media training for key spokespeople to ensure they are prepared for enhanced engagement. We will continue to respond to reactive media opportunities but will also widen the net, seeking to achieve national coverage particularly where it relates to public protection and enhances our reputation as a world class regulator.

Thought leadership and influencing

- Developing the Public Affairs function – a world-class regulator should aim not just to demonstrate its effectiveness but to influence and shape decision making in its broad area of work. For example, the proposed private members bill for the eye health strategy is a great opportunity to engage with MPs interested in the optical sector and show the importance of effective regulation. We will aim to proactively engage with opportunities like this to demonstrate the importance of regulation in protecting the public and will seek out further opportunities for proactive engagement for example via consultations, Select Committees and All-Party Parliamentary Groups.

- Position the GOC as thought leaders – a new thought leadership blog, hosted on our website, will give us the opportunity to highlight and discuss issues of importance, demonstrate our engagement with the sector and position our leadership team as key spokespeople with the sector. We will also use social media to position our leaders as experts in regulation, ensuring they provide target commentary around our work and demonstrate their knowledge around the optical sector. There are also opportunities to use social media to position our Council members similarly.

- State of the nation report – as well as preparing for our new corporate strategy, this is a key opportunity to develop and demonstrate our knowledge and expertise. It will also provide us with data and other content which we can use for wider engagement, for example, with Parliamentary stakeholders and optical sector bodies. We will aim to deliver a final report in 2024, which will be shaped by a series of engagement opportunities this year. This will be backed by a fully integrated multi-channel communications campaign to encourage maximum collaboration from stakeholders.

Regulation in the round

- FtP is a core area of our regulatory work, and one which generates a high level of interest. It is important that we communicate effectively about this as it is a core way in which we protect the public. We will launch a revamped, fully digital version of the FtP focus bulletin for registrants, which aims to demystify the FtP process and demonstrate the positive work we do to support registrants to uphold high standards.

- A world-class regulator should also be communicating about the positive, proactive things we are doing to enhance public protection. Regulatory and legislative reform presents a key opportunity for us to demonstrate leadership in the sector and engage with stakeholders. Our engagement should focus on how a modern effective regulator protects the public. Consulting on our new standards of practice presents a further key engagement opportunity. We will work collaboratively with the Policy and Standards team to deliver a fully integrated campaign which maximises engagement and positions us as a modern world-class regulator.

Area of work	**KPI**
Public Affairs • Set up new function • Regular briefings and enhanced monitoring • Proactively engaging with Parliamentary stakeholders on the State of the Nation, legislative reform, and new standards programmes of work	Increased engagement as a result of enhanced monitoring. At least one meeting in Westminster Participation in any consultations or calls for evidence Aim for an APPG or Committee appearance if we can add value
Blog	10 x blogs a year. Media coverage of blogs and improvement in stakeholders

	feeling we understand the sector via the Registrant survey
State of the nation exercise	Increased positive engagement with stakeholders
Enhanced media activity	Increased positive/neutral coverage in sector press plus a piece of national coverage centred around public protection. Aim for at least one TV/radio contribution if it adds value
FtP bulletin	3 x bulletins a year in new digital format
Regulatory reform	Increased positive engagement
New standards of practice	Positive engagement from stakeholders with the process

6.2 Transforming customer service

The 'Fit for the Future' strategic plan focuses on how we can best meet the needs of patients, the public and other customers, as well as making it easier for them to work with us. The communications team has a key role to play in this, internally and externally.

The team supports the whole organisation by providing advice, shaping messaging and ensuring the corporate brand is deployed correctly. It also supports critical corporate projects such as our annual report. Externally, it holds important expertise about communicating with our audiences, as well as possessing the skills to be able to do so.

While several important capabilities are already in place, a key part of this strategy will be to develop the critical building blocks to enable Communications to provide excellent customer service to our external audiences and stakeholders.

Building on the basics

- Team development – all posts in the team are now filled, including the additional Public Affairs Officer post. This ensures we have enough capacity to deliver our core communications work. However, our ability to deliver internal communications effectively remains a capacity concern, as at present this is done on an ad hoc basis. Should there be any scope for additional capacity, we would look to recruit a post to focus on this. The team will be effectively managed and continue to develop their skills where needed in line with our developing People Plan.

- Building knowledge and specialisms with the team – in a relatively small organisation it is important to maintain a team of multi-skilled communications generalists able to undertake work across the communications mix. However, to deliver effective communications, it is important to build subject knowledge within the team. Each business area will have a dedicated member of the team to work with, which will help build understanding and ensure consistency. This is critical to core areas of work where we are supporting registrants to uphold high

standards, for example in CPD and Education. Each of these areas will have a new communications plan.

- Strategic, integrated communications planning – previously most communications activity was ad hoc and proper planning was sometimes lacking. The implementation of a whole organisation communications grid will allow for strategic planning of communications activity and enable the team to provide proper support to key areas of work. Additionally, building the communications business plan by ensuring that all activities which require communications work are captured will ensure the communications team can deliver on the organisation's strategic priorities and promote a communications-first approach.

- Refreshing the brand and ensuring it is used correctly – the current corporate branding was put in place in 2003. Though it is still visually largely fit for purpose it could be modernised slightly, moving away from icons that were popular in the early 2000s towards a more photographic approach. Over the years use of the brand has become inconsistent and patchy. We will undertake a brand refresh to modernise the brand, taking the opportunity to ensure that key channels and documents are appropriately branded, and staff are trained to use the brand correctly. The Communications team will also take a more active role in controlling the brand. Key corporate publications such as the annual report, business plan and templates will be refreshed as part of this.

- Website refinement – our website is our core digital presence and a critical "shop window" to our work. The current website was launched just over a year ago. It is largely fit for purpose but would benefit from an audit of content and refinement in terms of the way information is organised to make it easier to find things. We propose to undertake this in the first half of 2023, in collaboration with teams across the business.

- Intranet refresh – Iris intranet is a core channel for internal communications. However, it has become unwieldly and inconsistent. We propose to undertake a full refresh of the platform, restructuring it so it is easier to navigate and auditing the content. Once this is completed, we will train staff on how to update their pages and encourage them to be responsible for their own sections, with oversight from the communications team.

- My GOC project – the revamp is a critical project for the organisation and is the main way that many registrants interact with the GOC. It presents a fantastic opportunity to refresh the way we communicate with registrants and improve the customer service we offer so it is integrated and more accessible. The communications team will support delivery of the project and play a crucial role in developing the content for the platform, supporting the Registration team.

- Enhancing our commitment to Equality, Diversity and Inclusion – we will consider EDI in all areas of our communications work. We will produce an EDI annual report alongside our external business plan and annual report. Communications will also support with implementation of the Welsh Language Standards.

- Continuing with what works well – our email bulletins and social media are rated highly in our Registrant survey, and we will continue to produce these, maintaining their quality and ensuring we maximise them as devices for engagement.

Developing the communications function

- Developing an appropriate crisis communications response – communications play a core role in dealing with any serious or significant incident which may impact the organisation's reputation negatively. Being able to minimise any reputational fallout is crucial to ensuring we are seen as a world-class regulator. It is critical that we have a broad plan in place for dealing with such incidents before they happen, so we can be clear in our approach and manage them effectively. We will develop a crisis communications protocol in conjunction with relevant teams across the organisation.

- Making the most of our intelligence gathering – we will implement new and additional monitoring across news and Parliamentary affairs and recommend how we should respond to developments. We will also introduce a new horizon scanning report for Council to keep them abreast of external developments, working closely with the Policy and Standards team.

Area of work	**KPI**
Revamped team with additional Public Affairs post	Recruit by Jan 2023
Embed organisation-wide Comms calendar	By Jan 2023
Ensure all planned activities which have critical communications activity are captured in the Communications business plan and engage with relevant teams to ensure comms-first approach	Business plan sign off by March 23
Branding refresh including revised annual report, external business plan and EDI annual report. New Annual Monitoring Report Q3	Deliver branding refresh by Q3 Annual report laid before Parliament December 2023 EDI annual report completed by December 2023 External business plan by Q2 Increased readership of these publications More effective engagement/positive coverage
Website refinement	Deliver by Q3. Improvements in search function
Intranet revamp	Restructure by summer Q2 Training completed by Q3
My GOC	Project due to complete by Q3 2024

	Registrants tell us customer service has improved in registrant survey
Bulletins and social media	Deliver 6 e-newsletters Grow Twitter and LinkedIn following by 10%
Develop crisis communications plan	Deliver by Q2 All reputation-impacting incidents handled effectively
Implement new news monitoring provider New internal news round-up	By Q2. Improved access to relevant news stories. New news-round up to distribute relevant information and improve staff engagement with wider sector
Use Dods Parliamentary monitoring more effectively	Better quality briefings. Quicker distribution of relevant information
New Horizon report for Council	Quarterly report delivered
New communications plans for CPD and Education	Improved knowledge in the communications team Increased completion of CPD Positive engagement with new education requirements

6.3 Continuous improvement

The 'Fit for the future' strategic plan has a clear focus on investing in and improving our infrastructure and supporting and empowering our staff so we have the core capabilities in place to be a world-class regulator and deliver effective customer service. Communications makes an important contribution to the continuous improvements set out in this plan.

Everyone is a communicator

- Embedding a communications first approach – almost all the work we do has a communications element, whether that be communicating with registrants, providers or other stakeholders or with our staff and members internally. The role of the communications team is to provide support to make sure our communications are quality, timely and in line with our values. This means making sure that communications are considered at the beginning of every piece of work and that staff consider how we will talk about our work to audiences. The communications team will deliver effective in-house support and expertise to realise this.

- Optimising existing networks – our Council members and staff bring valuable existing connections which we will utilise more effectively to advance our engagement work.

- Supporting our Council members and staff to communicate – our Council members and staff are our most important communicators. We will support them to communicate by providing improved briefings pulling together core information, and working in conjunction with the Governance team, new

guidance on communicating and social media, so everyone can feel empowered and confident in talking about the GOC's work.

Effective evaluation

- We need to understand more about how effective our communications and messaging are in order to make continuous improvements. We will develop a new set of metrics to report on the effectiveness of communications to SMT to give a broader understanding of what is working well.

Area of work	**KPI**
Embedding communications first approach	Increased staff engagement with communications Communications rated highly internally Higher quality communications
Optimising our networks	Increased, higher quality, stakeholder engagement
Supporting our people to communicate	Improved briefings New guidance on communicating for council Increased social media reach
Evaluation	New metrics in SMT report Broader understanding of effectiveness

Internal Business Plan - 2022/23 Q3 update - Council Report

Exceptions Report

All critical and essential Q1, Q2, and Q3 activities are either complete or on track to be complete

Case Progression

Legal

Registration

Facilities

Finance

Comms

Education

Hearings

Activity	BAU/Project	Timing	Priority	Success Measures	RAG	Comments
Timeliness in fitness to practise (hearings)	BAU	Q1-Q4	Essential	Improved timeliness: - 90% of all cases will conclude first time - 85% of substantive cases will conclude first time - 90% of hearing dates utilised - 75% of all substantive hearings with be scheduled within 30 weeks of disclosure		**Why amber/red:** 78% of all cases have concluded first time. 66% of substantive matters have concluded first time against an 85% objective due to a high number of cases going part-heard (12 in Q1-Q2 of this year, with only one event going part heard in Q3) **How we will get back to green:** An options paper was presented to SMT in November 2022 setting out a number of actions that will be completed to address the part-heard hearings issue. This included a review of the case management meeting process as well as a review of the time-estimate calculation. At present, there is no dedicated resource or spare capacity within the team to complete this activity and it is being prioritised as and when possible, but it is likely to be delayed. As an interim measure, the scheduling team are adding proportionate days to all substantive listings as a matter of course. This may increase member costs but is a necessary and proportionate short-term trade off to losing months with cases going part-heard.
Increase Clinical Adviser (medical) Pool	BAU	Q1-Q3	Essential	We will have appropriate number of expert advisors in our pool to ensure that we comply with legislative requirements		**Why amber/red**: Due to resourcing challenges, the project did not commence in Q1. Limited progress has been made in Q2 and Q3 as, alongside BAU work, focus within the team has and will continue to be on improving the timeliness challenge, addressing the part-heard hearings issue, and the implementation of the case management system. We have scheduled, and expect to run, 77 hearing days in Q4 with up to 60% of those hearing days running parallel or three events per day. There is currently no dedicated resource or spare capacity within the team to complete this activity. **How we will get back to green**: Likely to be delayed and will run into the 23/24 financial year.

On track to be completed / Complete	Work is on track to be completed within timeframe or work is already complete
Off track	Work is not on track to be completed within timeframe
Deadline missed	Deadline for work has been missed

Change

Activity	BAU/Project	Timing	Priority	Success Measures	RAG	Comments
Facilitate and support identified change projects within directorates	Strategic Project	Q1	● Essential	- Projects scoping completed, budgets and benefits agreed, and plans in place. - Measurements agreed and communicated with process for data collection. - Implementation timely and within costs		**Why amber/red**: The Fit for the Future programme boards remain focussed on the 11 strategic projects. The projects are in different phases as defined by the SCB Quarterly dashboard report. Currently; - 3/11 are in 'Concept' phase (27%) - 2/11 are in 'Definition' phase (18%) - 6/11 are in 'Development' phase (54%) - 0/11 are in 'Closure' phase (0%) It remains amber until 100% complete. Note that both 'Definition' and 'Development' phases require benefits agreement as part of gate reviews. **How we will get back to green**: Strategic Change Board Quarterly reports and agreed project assurance mechanisms. Please also note that the People Plan Programme Board has also relaunched with a focus on pace and outcomes (and possibly including customer care and future office accommodation within its remit – subject to agreement by SCB/SMT)
Facilitate redesign of processes	Strategic Project	Q3	● Essential	To ensure that internal processes are lean and involve all impacted		**Why amber/red**: Process mapping is synonymous with both strategic projects and continuous improvement and therefore, plays a vital part in the Fit for the Future Programme (i.e., across its full lifecycle). Significant progress has been made in areas relating to CMS and MyGOC project recently, whereby processes have been extensively mapped and evidenced. That said, not all the projects have completed their definition phases, so this remains amber and likely to remain as amber until late 2023. **How we will get back to green**: Members of the CMO team are undertaking Lean Six Sigma training which provides skills in process mapping, eliciting requirement, and undertaking business analysis. More projects across the Fit for the Future Programme (as well as wider continuous Plan 23/24 can benefit from this lean skillset. The ambition to create a 'PMO centre of excellence' to compile, reference and see worked examples is part of a developing 'CMO toolkit', the challenge however, is to reach adoption and commitment levels (i.e., to apply consistently as an organisation)

On track to be completed / Complete	Work is on track to be completed within timeframe or work is already complete
Off track	Work is not on track to be completed within timeframe
Deadline missed	Deadline for work has been missed

IT

Activity	BAU/Project	Timing	Priority	Success Measures	RAG	Comments
Tender for a new Internet line	BAU	Q1	Essential	New, higher capacity line is in place		**Why amber/red:** Tender complete but installation preparation work has taken much longer than anticipated. It is currently on hold as our landlord is yet to approve our Risk Assessment Method Statements. **How we will get back to green:** Escalated to Corporate Services Director to try to push through but live now unlikely before Q1 2023-2024.
Laptop refresh of oldest 50% of laptops (not Case Examiners)	Department Project only (minor scale)	Q2-Q4	Essential	New laptops in place		**Why amber/red:** The IT Team is now setting up / reconfiguring laptops using the Microsoft tool Autopilot, which was the main technical challenge of this project. However, as we are moving to a new IT Managed Services Provider (MSP), Rock, whose technical environment will need laptops set up differently, so the procurement of laptops has been postponed. **How we will get back to green:** Autopilot ready to use for deployment but pragmatic decision made to delay procurement. The procurement process will start in Q2 2023-2024 with deployment in Q3-Q4.
Support the business to produce a Tender for new support contract for MyCPD which ends April 2023	Continuous Improvement Project	Q3-Q4	Essential	New supplier in place with no system downtime or service impact		**Why amber/red:** Due to capacity issues and staff changes the Business was not able to start the process as planned. **How we will get back to green:** The Business is now exploring options with our current supplier and the process is progressing and will be completed in Q4 2022-2023.
Annual Internal & External Penetration Test & Remedial work	BAU	Q4	Essential	The report notes more positive practices than remediation measures.		**Why amber/red:** This work has been postponed until 2023-2024 so that it reviews our new MSP environment (rather than the one we are moving from). It will also include testing all of our web sites. **How we will get back to green:** A new test of our web sites will take place in Q1-Q2 of 2023-2024 financial year. The original test has been delayed and will now take place in Q3-Q4 of 2023-2024.

On track to be completed / Complete	**Work is on track to be completed within timeframe or work is already complete**
Off track	**Work is not on track to be completed within timeframe**
Deadline missed	**Deadline for work has been missed**

CPD

Activity	BAU/Project	Timing	Priority	Success Measures	RAG	Comments
Introduce new audit and portfolio review system - Recruiting to and training of auditors under new CPD arrangements	Continuous Improvement Project	Q3-Q4	● Critical	- Auditors and portfolio reviews in place by September/October 2022		**Why amber/red**: System not ready to launch the provider audits and registrant reviews and, for this reason, recruitment of auditors/reviewers was delayed. **How we will get back to green**: Continue with audit and review platform build ready for first audit/review in April 2023. Recruitment campaign for 2x CPD provider auditors and 30x Registrant CPD record reviewers launched in February 2023, with excellent initial response rate for both positions.

On track to be completed / Complete	Work is on track to be completed within timeframe or work is already complete
Off track	Work is not on track to be completed within timeframe
Deadline missed	Deadline for work has been missed

Legislative Reform

Activity	BAU/ Project	Timing	Priority	Success Measures	RAG	Comments
Complete analysis of call for evidence for GOC legislative reform	Strategic Project	Q2	Essential	Report produced summarising analysis of consultation and next steps by end of Q2		**Why amber/red**: • When this target was originally set, it was on the basis of an external agency carrying out the analysis, but we did not receive any bids for this work. We therefore carried out this work internally and Council agreed a revised timetable for publication of the report to give us sufficient time to carefully analyse all the information and discuss items with the Advisory Panel (14 October 2022) and at Council Strategy Day (17 November 2022), as well as commission research to fill evidence gaps, before completing the report and taking it to Council in March 2023. • We received a huge amount of information (over 8,000 comments and links to more than a hundred articles) during the call for evidence which took longer to analyse than originally anticipated. • The Government's timetable for legislative reform has slowed down in the past six months and this has given us more time to prepare. **How we will get back to green**: We completed an initial analysis in mid October and are discussing our findings and the proposed GOC response with SMT and Council, considering whether any further research is needed in addition to what we commissioned following Council in September 2022. We are on track to present the draft GOC response to Council in March 2023.
Plan GOC business cases for GOC legislative reform	Strategic Project	Q3	Essential	Business cases complete by end of Q3		**Why amber/red**: Our decision to slow down completion of analysis of the call for evidence (see previous row) has meant that we have not been able to complete business cases. **How we will get back to green**: We have redefined and rephased this work as part of our 2023/24 business plan.
Develop policy positions and commission any proposed consultation or research into any changes associated with call for evidence following agreement of business cases (e.g. sight testing and contact lens legislation, business regulation)	Strategic Project	Q3-Q4	Essential	Documented policy positions and commissioning of consultation or research by end of Q4		**Why amber/red**: Our decision to slow down completion of analysis of the call for evidence (see previous rows) has meant that we will not be able to develop policy positions and commission further consultation/research by end of Q4. **How we will get back to green**: We have redefined and rephased this work as part of our 2023/24 business plan.

On track to be completed / Complete	Work is on track to be completed within timeframe or work is already complete
Off track	Work is not on track to be completed within timeframe
Deadline missed	Deadline for work has been missed

Policy & Standards

Activity	BAU/Project	Timing	Priority	Success Measures	RAG	Comments
Develop and launch consultation Standards of Practice (taking into account progress of legislative reform and call for evidence outcomes)	Continuous Improvement Project	Q3-Q4	● Essential	Consultation starts by end of Q4		**Why amber/red**: The Standards Manager post has been vacant for all of Q3 so we have not been able to progress the consultation following completion of the background research in Q2. Now that the Standards Manager is in post, we have also extended the timetable for this work to allow for more effective stakeholder engagement, including with the public and patients, before we begin our formal consultation. **How we will get back to green**: A new Standards Manager started in post on 9/1/23 and we have re-phased this work as part of our 2023/24 business plan – background work and stakeholder engagement will begin in Q1-Q2 to prepare for revision of the standards, with revised standards for consultation produced in Q3 and consultation in Q4 of 2023/24. This work will carry over into the business plan for 2024-25. We will not achieve the target in our Strategic Plan 2020-25 to publish and implement new standards for individuals by 31 March 2024, but will publish the new standards in September 2024, with a possible implementation period after that.

On track to be completed / Complete	**Work is on track to be completed within timeframe or work is already complete**
Off track	**Work is not on track to be completed within timeframe**
Deadline missed	**Deadline for work has been missed**

HR

Activity	BAU/Project	Timing	Priority	Success Measures	RAG	Comments
Management support	BAU	Q3	● Essential	Annual Survey		**Why amber/red**: Fair and consistent implementation and application of policies remains an issues in staff survey output. **How we will get back to green**: • Management training and employee focus groups through 2023, to assist with and improve consistency of approach and transparency on policy development and implementation • Use of pulse surveys throughout the year on specific related matters to gain feedback and inform on progress. • Development and implementation of revised policies such as Reward & Recognition

On track to be completed / Complete	Work is on track to be completed within timeframe or work is already complete
Off track	Work is not on track to be completed within timeframe
Deadline missed	Deadline for work has been missed

Governance

Activity	BAU/Project	Timing	Priority	Success Measures	RAG	Comments
Final Business Plan	BAU	Q4	Essential	Efficient preparation and timely distribution		**Why amber/red**: Activity description stated draft internal plan would be presented to Council in December 2022 – the schedule was revised to accommodate an additional CEO review when preparing the internal business plan. Council was updated at its December meeting and no concerns raised regarding the timescale. ARC reviewed draft plan at its meeting on 31 Jan 2023. **How we will get back to green**: SMT was asked to note update above and agreed a revised RAG rating of green.

On track to be completed / Complete	Work is on track to be completed within timeframe or work is already complete
Off track	Work is not on track to be completed within timeframe
Deadline missed	Deadline for work has been missed

Quarterly Performance Dashboard – 2022/23

Off track
At risk
On track

FINANCE	Q1	Q2	Q3	Q4
Budget Operate within budget – Tolerance is ±10%	+3%*	+14%*	+7%	
Reserves Operate within our reserves policy – Tolerance is ±10%	0%	0%	0%	
Change Deliver agreed planned strategic investment – Tolerance is ±10%	+45%	+6%	+6%	

CUSTOMER	Q1	Q2	Q3	Q4
FTP timely updates Customers who receive an update every 12 weeks – Target is ≥90%	94%	92%	94%	
Registration Application forms completed – Target is ≥90%	98%	99%	98%	
Education quality of CPD provision CPD provision meets registrant expectations – Target is ≥90%	93%	93%	92%	

PEOPLE	Q1	Q2	Q3	Q4
Investment in People Planned events realised – Target is ≥90%	none	100%	100%	
Turnover Staff turnover – Target is ≤17% (excluding FTCs ending)	28%	17%	16%	
Vacancy Rate Staff vacancies – Target is ±10% of total headcount (not FTE)	8.8%	6.5%	5%	
Engagement Index Staff engagement score (Pulse survey) – Target is to achieve an upward trend (Green is ≥70%)	67%	80.2%	71.6%	

PERFORMANCE	Q1	Q2	Q3	Q4
FTP Timeliness FTP cases resolved within 78 weeks (rolling median) – Target is ≥60%	60%	54%	53%	
Education Approved qualifications adapted to meet new education and training requirements – Target is 100% by September 2025 (apart from CoO SfR)	0%	0%	5%	
Registration Quality & Accuracy Overall accuracy – Target is ≥95%	99%	98%	98%	

KPI	Information about current status	Budget implications	Associated risks
Investment in People **Planned events realised –** **Target is ≥90%**	• Output from appraisals has been collated and a training needs analysis completed. • A list of training courses has been developed and we will be arranging from Nov to March 2023. The following training will be completed before end of March 2023 – 1x introduction to management for new managers, 1x intermediate Excel, 1x Resilience training, and 1x Carrying out Investigations. We are also reviewing the Induction process and mandatory training.	• Underspend on training	• Disengagement from under investment in people
Turnover **Staff turnover –** **Target is ≤17% (excluding FTCs ending)**	• Improved analysis of figures has now removed short-term roles and provide clearer insight into trends • Total turnover for last 12 months remains high at 21% but this includes fixed term contracts and agreed exits. • Voluntary turnover rates is at 16% below target. We hope and expect this trend to continue.	• N/A	• Loss of high-performing or critical staff • Impact on performance and productivity
FTP Timeliness **FTP cases resolved within 78 weeks (rolling median) –** **Target is ≥60%**	• We continue to see the impact of the increase in substantive events not concluding during the back end of 2021-2022 and first half of 2022-2023. While all bar one of these hearings should conclude during Q3 and Q4 of this year, this will inevitably result in a higher than expected end-to-end timeline for FtPC resolved cases and a fewer percentage of cases concluding within projections. • Of the ten cases scheduled during Q3, only one did not conclude and so we are seeing the expected improvement from the changes implemented since Q1. • Overall, the median for all resolved cases (including case examiner decisions) is currently 78 weeks • On a positive note, our newer cases are progressing promptly through the investigation process in response to our new pod structure providing early and consistent legal input into the direction of the case with an increasing number reaching case examiner stage within six months (67% of new matters to date)	• Hearings Team at full stretch. Business case to be prepared for additional manager for SMT's consideration as part of the 24/25 budget planning process	• PSA standard 15. • Resource implications for supporting key projects (including CMS and AV testing)
Education **Approved qualifications adapted to meet new education and training requirements –** **Target is 100% by September 2025 (apart from CoO SfR)**	• Whilst at 5%, this is green as we are on track with eight adaptation notifications received and being processed, two of which have been noted. • We are aware of dates of submissions for other providers and plans for all those due to offer adapted programmes from September 2023 through to September 2024.	• N/A	• N/A

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Council

Financial performance report for the period ending 31 December 2022 and Q3 forecast of 2022/23

Meeting: 22 March 2023	**Status:** for noting
Lead responsibility: Yeslin Gearty (Director of Corporate Services)	**Paper author:** Manori Wickremasinghe (Head of Finance)

Purpose

1. To provide a summary of the financial reports and the latest forecast for year 2022/23 presented to ARC.

Recommendations

2. Council is asked to:
   - **note** the financial performance for the nine months ending 31 December 2022 in annex one
   - **note** the Q3 forecast for the current year 2022-23 in annex two.

Strategic objective

3. This report is relevant to delivery of all our strategic objectives.

Background

4. The forecast for 2022/23 relates to year three of the current strategic plan and is consistent with delivery of the current year's business plan.

Analysis

5. The December 2022 financial performance showed a surplus of £1,106k on business-as-usual activities and a surplus of £170k before portfolio gains/losses. The report compares these results to the 22/23 Q2 forecast. The results have improved against both budget and the 22/23 Q2 forecast. Reduction in expenditure through savings and delays in activity as well as higher than forecast income have contributed to the higher than anticipated surplus.

6. Detailed analysis of performance and the risk of achieving the 22/23 Q3 forecast is included in the report (annex one).

7. The positive levels of surplus in the December financial performance impacts the 22/23 Q3 forecast made in January. The 22/23 Q3 forecast is a part of a

quarterly exercise using both actual performance to December and future predictions for 22/23 Q4. The 22/23 Q3 forecast for the current year is included in annex two.

8. The new forecast projects a £1,304k deficit after planned expenditure from reserves and unrealised investment gains (£664k projected surplus in business as usual) at the end of the current year. This forecast is included in our five-year forecast, which enables us to make better decisions regarding new projects, working capital, cashflow, and reserves management.

Finance

9. There are no additional financial implications of this work.

Risks

10. The following risks are associated with finance, as identified in the finance risk register:
    - The GOC fails to deliver value for money
    - The GOC is unable to deliver its strategic plans, programme of change, and business as usual either sufficiently quickly or effectively
    - Capability and Resilience: Small teams leads to over reliance on particular individuals, causing burnout and errors and/or impacts organisational delivery if absent or on departure.

11. Reporting and monitoring financial performance against budgets and forecasts are a fundamental part of managing and mitigating these risks.

Equality Impacts

12. No equality impact has been undertaken.

Devolved nations

13. There are no implications for the devolved nations.

Communications

External communications

14. None planned.

Internal communications

15. The financial report and the forecast are shared with the Leadership Team and SMT as part of the regular financial reporting process.

Attachments

Annex one: Financial performance report for period ending 31 December 2022.
Annex two: Q3 Forecast for 2022-23.

Financial Performance Report for the Period ending 31 December 2022

General Optical Council
Financial Performance Report for the 09 months ending 31 December 2022

Contents

General Optical Council
Financial Performance Report for the 09 months ending 31 December 2022

GOC :- Summary P & L to 31 Dec 2022					
	Actual	Budget	Variance	Q2 Forecast	Variance
	£000's	£000's	£000's	£000's	£000's
Registrant Income	7,575	7,370	205	7,565	10
Other Income	215	193	22	206	9
Expenses - BAU	(6,684)	(7,514)	830	(7,006)	322
Surplus / (Deficit) -BAU	**1,106**	**49**	**1,057**	**765**	**341**
Project expenditure	(936)	(1,387)	451	(1,105)	169
Surplus / (Deficit) -before portfolio Gains/Losses	170	(1,338)	1,508	(340)	510

Highlights

The results before unrealised gains/losses for the period ending 31 December 2022 show a positive variance of £1,508k against the budget and a £510k against the latest Q2 forecast. The BAU results before strategic projects show a positive variance of £1,057k against the budget and £341k against the forecast.

The total registrant income of £7,575k is £203k favourable to the budget, and £10k favourable against the Q2 forecast. The total expenditure (including projects) of £7,620k is £1,281k favourable to the budget and £491k favourable to the forecast.

Key drivers of the improved performance

Key drivers for positive variance are a combination of a reduction in expenditure through savings and delays in activity as well as higher than forecast income. The combination of delays and savings during Q1 was £692k and was absorbed by Q2 forecast. At the end of Q2 there was further positive variances of £510k. This may well be because of a culture of precautionary and risk-averse budgeting, as well as an indicator of the number of change objectives within the business plan with little or no historic budget data to support assumptions and budget planning. We address this through three re-forecast exercises during each year, re-allocating and prioritising operational requirements.

Reduction in expenditure through savings were made across many departments, for example, some activities were completed more quickly than forecasted, there has been a reduction in office expenses, and a reduction in planned agency staff forecasted across departments. In addition, some in-person events moved to remote, creating savings, several refunds were received for office services, the staff training budget remains under-utilised, and we've seen lower than expected demand for IT equipment and printing.

Reduction in expenditure has also been achieved through delays or retiming of activity. Some business activities have been delayed due to delays in staff recruitment, for example, the standards review. Some activities have been re-timed to better fit with wider project priorities, such as the commissioning research, communication activities, central staff training plan and recruitment of procurement experts. Other delays in expenditure have occurred because of delays in case examiner decisions and other case progression activities,

The effect of staff vacancies/ recruitment shortages as a key driver for savings/ delays is now reducing as recruitment market pressures ease, (ref. table 2 on page 6).

Risks for achieving Q2 Forecast

All known delays in expenditure beyond 2022/23 are now being captured in the 2023/24 budget. Others are forecasted in Q4 of the current year. Any further delays in Q4 may impact on 2023/24 if not identified and managed carefully. Case progression related legal charges could become more complex, although these costs are now captured in a systematic and agreed process.

The market volatility of portfolio is still being carefully watched, but this is an external risk. The performance has been improving in Q3, but the market value is still below 31 March 2022 level. HoF and the Director of Corporate Services review the situation closely with Brewin Dolphin.

Future Impacts (So what?)

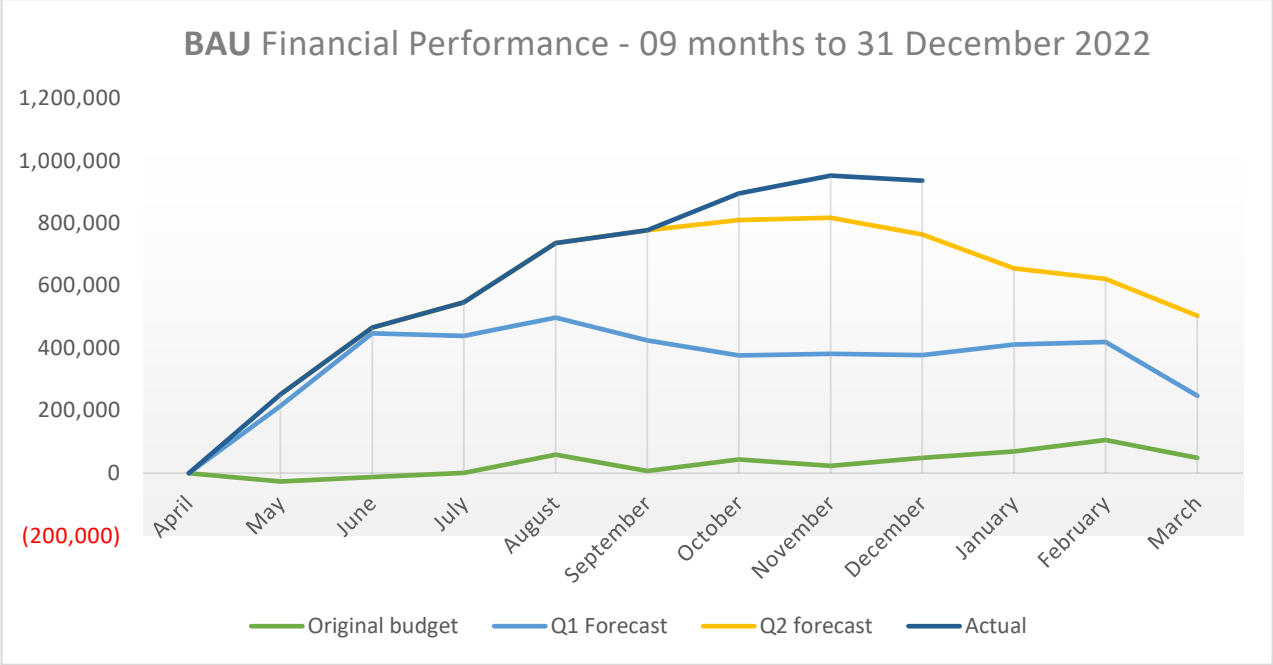
Market volatility and the possibility of further reduction of reserves during the short to medium term means that we will continue to prioritise working in an agile and responsive manner to achieve planned goals, continuing with the efficiency and value-for-money culture embedded in staff values during difficult times when there was a deficit budget.

Joined up planning continues to be encouraged so that timing of activities and possible impacts on budget and drawdowns can be carefully managed.

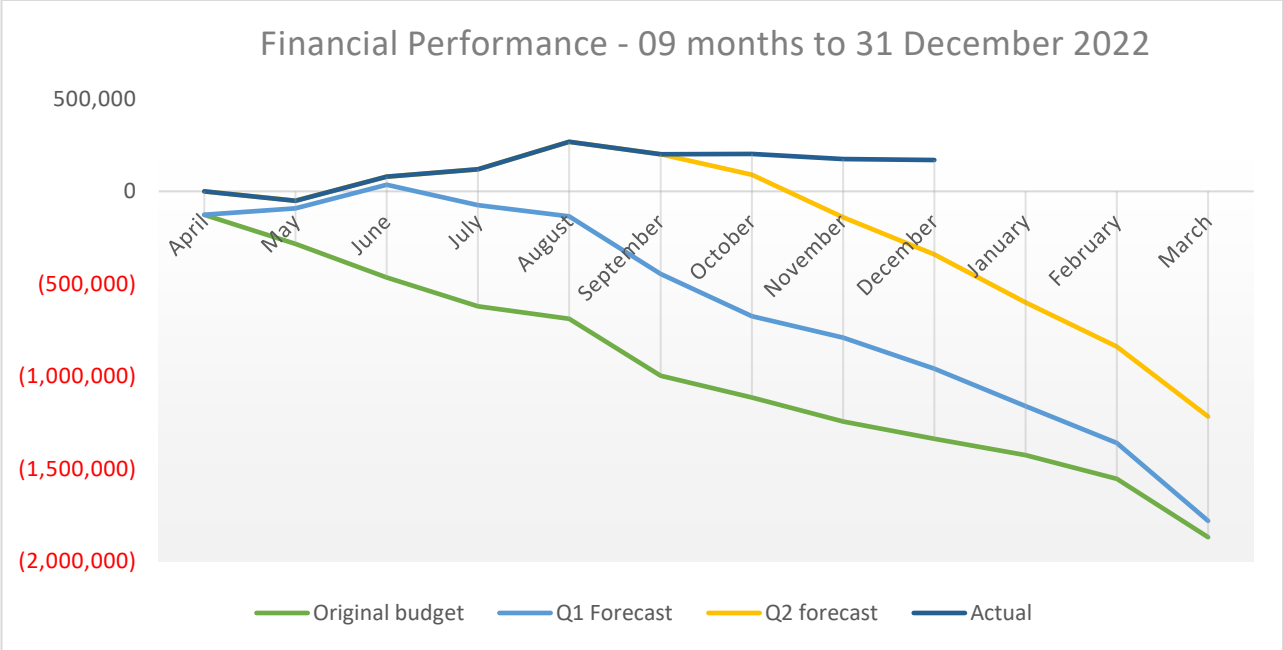
Any delays of part-heard cases beyond 2022/23 will affect the 2023/24 budget.

Rising inflation may increase our costs, although we update and review our forecasts regularly.

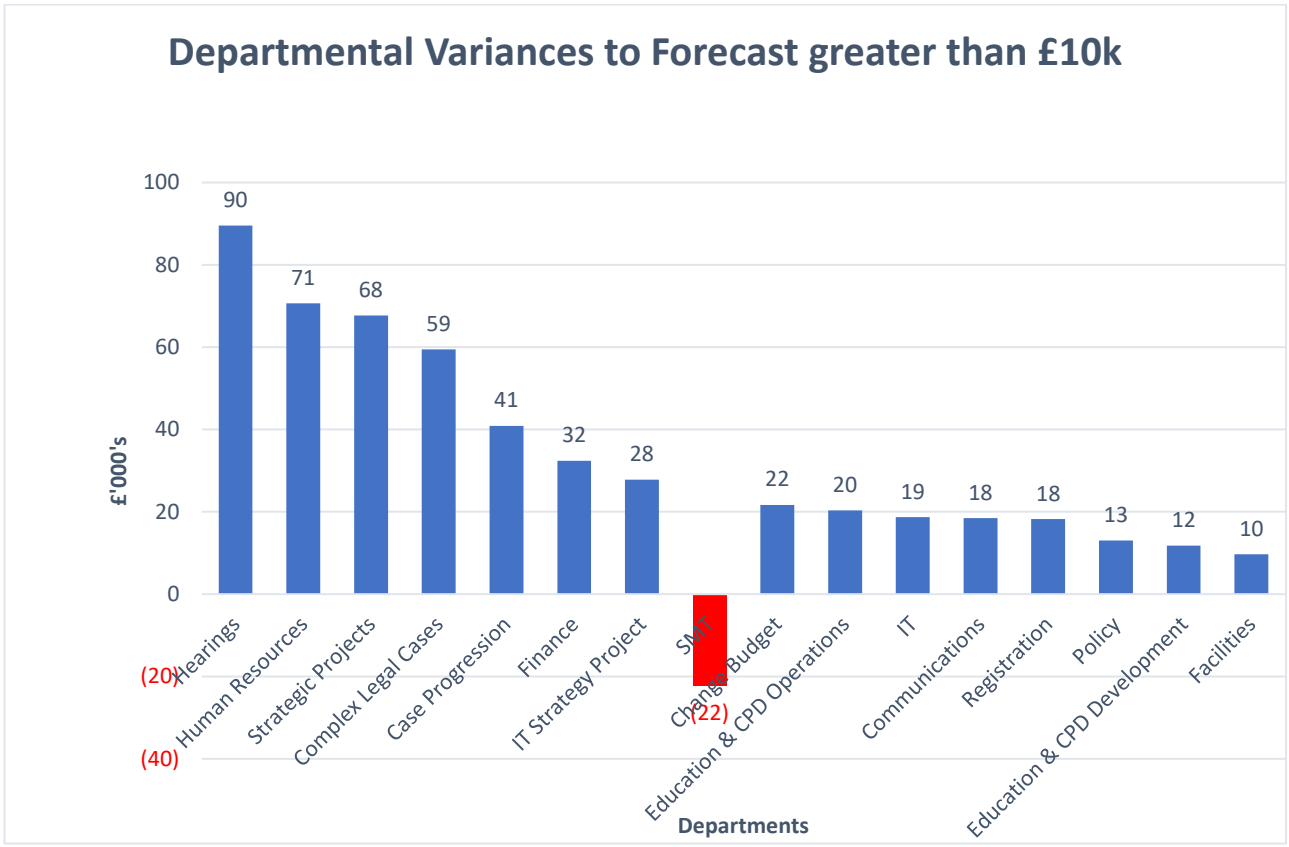
Graphical analysis on Financial Performance and Variance



Graph 1



Graph 2



Graph 3

Cash and Cash Equivalent Summary - 31 Dec 2022

	Actual £'000	Budget £'000	Variance £'000	Q2 Forecast £'000	Variance £'000
Cash at Bank	858	281	577	564	294
Short term Investments	2,150	750	1,400	2,150	0
Working Capital	**3,008**	**1,031**	**1,977**	**2,714**	**294**
Investments	8,574	10,150	(1,576)	8,320	254
Total	**11,582**	**11,181**	**401**	**11,034**	**548**

Table 1

Headcount December 2022 (F T E's)

	Actual FTC* Dec-22	Actual Perm. Dec-22	Actual Total Dec-22	Q2 Forecast Dec-22
Chief Executive Office	-	7.0	7.0	9.0
Regulatory Strategy	1.8	17.4	19.2	23.0
Regulatory Operations	7.0	33.0	40.0	39.0
Corporate Services	1.8	19.4	21.2	21.4
Change	5.0	7.8	12.8	16.0
Total Headcount	**15.6**	**84.6**	**100.2**	**108.4**

Table 2

General Optical Council
Financial Performance Report for the 09 months ending 31 December 2022

Analysis of BAU expense variance December	
Savings	£'000
Efficiency	6
Other savings	179
Staff vacancy gaps (excluding efficiency measures)	32
Other delays and timing	131
Others	46
Additional expenses	393
Additions	(70)
Total Expense Variance	323

Table 3

Analysis of savings over past quarters (BAU exp.)					
Savings	Q1	Q2	Q3	Q4	Total
	£'000	£'000	£'000	£'000	£'000
Efficiency	-	6			6
Covid related savings	-	-			-
Other savings	80	93	179		352
Total Savings					358

Table 4

General Optical Council
Financial Performance Report for the 09 months ending 31 December 2022

Table A
Income and Expenditure Accounts

	April - December			April - December		
	Actual £'000	Budget £'000	Variance £'000	Actual £'000	Forecast £'000	Variance £'000
Income						
Registration	7,575	7,370	204	7,575	7,565	10
Dividend Income	192	185	7	192	195	(3)
Bank & Deposit Interest	21	1	21	21	10	12
Other Income	2	7	(6)	2	1	0
Total Income	**7,789**	**7,563**	**226**	**7,789**	**7,770**	**19**
Expenditure						
Executive Office						
CEO's Office	163	163	1	163	176	13
Governance	447	498	51	447	443	(4)
Total Executive	**610**	**661**	**51**	**610**	**619**	**9**
Regulatory Strategy*						
Director of Regulatory Strategy	101	97	(4)	101	101	(0)
Policy & Standards	134	210	76	134	147	13
Standards	0	69	69	0	0	(0)
Communications	148	220	71	148	167	18
CPD	1	203	202	1	0	(1)
Education & CPD Operations	361	618	257	361	381	20
Education & CPD Development	181	0	(181)	181	193	12
Total Regulatory Strategy	**925**	**1,416**	**491**	**925**	**988**	**63**
Regulatory Operations						
Director of Regulatory Operations	93	94	1	93	93	0
Case Progression	1,522	1,569	47	1,522	1,563	41
Legal	173	155	(18)	173	180	7
Hearings	866	844	(21)	866	955	90
Total Regulatory Operations	**2,653**	**2,661**	**8**	**2,653**	**2,791**	**138**
Corporate Services						
Director of Corporate Services	130	101	(29)	130	95	(36)
Facilities	764	808	44	764	774	10
Human Resources	314	415	100	314	385	71
Finance	293	343	50	293	326	32
Registration	391	442	51	391	409	18
Total Corporate Services	**1,893**	**2,109**	**216**	**1,893**	**1,988**	**95**

General Optical Council
Financial Performance Report for the 09 months ending 31 December 2022

Table A (Contd.)

	April - December			April - December		
	Actual £'000	Budget £'000	Variance £'000	Actual £'000	Forecast £'000	Variance £'000
IT (BAU)	506	577	71	506	524	19
Depreciation	97	90	(7)	97	96	(1)
Total Expenditure	**6,684**	**7,514**	**830**	**6,684**	**7,006**	**323**
Surplus / (Deficit) before project expenditure	**1,106**	**49**	**1,057**	**1,106**	**764**	**342**
Project Expenditure						
Completion of CPD Project	36	33	(4)	36	29	(8)
Education Strategic Review project	117	153	36	117	121	4
Standards Review and Implementation	23	101	78	23	22	(0)
IT Strategy Project	148	363	215	148	176	28
Change	371	582	212	371	392	22
Complex Legal Cases	151	0	(151)	151	211	59
Strategic Projects	71	137	65	71	139	68
Project Depreciation & Amortisation	18	18	0	18	14	(4)
Total Project expenditure	**936**	**1,387**	**451**	**936**	**1,105**	**169**
Surplus / (Deficit) after project expenditure	**170**	**(1,338)**	**1,508**	**170**	**(341)**	**511**
Investment gains	(653)	185	(839)	(653)	(918)	265
Surplus / Deficit	**(483)**	**(1,152)**	**669**	**(483)**	**(1,259)**	**775**

- *High budget variance in some department s of Regulatory Strategy was due to directorate restructure. Education expanded to development and operation, CPD was absorbed under Education, Standards and Policy was consolidated.*

General Optical Council
Financial Performance Report for the 09 months ending 31 December 2022

Table B
Income and Expenditure Accounts Including Project Expenditure

	April - December			April - December		
	Actual £'000	Budget £'000	Variance £'000	Actual £'000	Forecast £'000	Variance £'000
Income						
Registration	7,575	7,370	204	7,575	7,565	10
Dividend Income	192	185	7	192	195	(3)
Bank & Deposit Interest	21	1	21	21	10	12
Other Income	2	7	(6)	2	1	0
Total Income	**7,789**	**7,563**	**226**	**7,789**	**7,770**	**19**
Expenditure						
Staff Salaries Costs	4,066	4,501	435	4,066	4,090	24
Other Staff Costs	87	329	242	87	171	83
Staff Benefits	94	98	4	94	94	(0)
Members Costs	719	871	152	719	755	36
Case Examiners	52	97	46	52	62	11
Professional Fees	334	649	315	334	498	163
Finance Costs	75	73	(2)	75	76	1
Case Progression	746	530	(217)	746	803	57
Hearings	172	156	(16)	172	230	58
CPD & Standards	57	79	22	57	53	(4)
Communication	24	42	18	24	33	8
Registration	8	9	1	8	8	(0)
IT Costs	376	588	212	376	385	9
Office Services	661	732	71	661	702	41
Other Costs	32	38	6	32	42	10
Depreciation & Amortisation	116	109	(7)	116	110	(5)
Total Expenditure	**7,619**	**8,901**	**1,281**	**7,619**	**8,111**	**492**
Surplus / Deficit	**170**	**(1,338)**	**1,508**	**170**	**(341)**	**511**
Unrealised Investment gains	(653)	185	(839)	(653)	(918)	265
Surplus / (Deficit)	**(483)**	**(1,152)**	**669**	**(483)**	**(1,259)**	**775**

General Optical Council
Financial Performance Report for the 09 months ending 31 December 2022

Balance Sheet as at 31 December 2022

	2022-23 31 December 2022 £'000	2021-22 31-Mar-22 £'000	Variance £'000
Fixed Assets			
Refurbishment	535	591	(56)
Furniture & Equipment	94	117	(23)
IT Hardware	30	41	(11)
IT software	48	65	(17)
Case Management WIP	7	1	6
Total Tangible Fixed Assets	**714**	**814**	**(107)**
Investment	8,574	9,260	(686)
Total Fixed Assets	**9,288**	**10,074**	**(786)**
Current Assets			
Debtors, Prepayments & Other Receivable	388	525	(137)
Short term deposits	2,150	7,700	(5,550)
Cash and monies at Bank	858	1,848	(990)
Total Current assets	**3,396**	**10,073**	**(6,677)**
Current Liabilities			
Creditors & Accruals	852	1,017	(165)
Income received in advance	2,409	9,303	(6,894)
Provision for rent	294	214	80
Total Current Liabilities	**3,555**	**10,534**	**(6,979)**
Current Assets less Current Liabilities	**(159)**	**(461)**	**302**
Total Assets less Current Liabilities	**9,129**	**9,613**	**(484)**
Long Term Liabilities	0	0	0
Total Assets less Total Liabilities	**9,129**	**9,613**	**(484)**
Reserves			
Legal Costs Reserve	700	700	0
Strategic Reserve	2,000	2,000	0
Covid -19 reserve	1,800	1,800	0
Infrastructure / dilapidations	1,250	1,250	0
Income & Expenditure	3,378	3,863	(485)
Total	**9,129**	**9,613**	**(484)**

Q3 Forecast Report for 12 months to 31 March 2023

General Optical Council
Q3 Forecast Report – 2022-23

Contents

General Optical Council
Q3 Forecast Report – 2022-23

GOC Summary P&L Q3(2022/23) forecast for 2022-23

	Budget £'000	Q1 forecast £'000	Q2 forecast £'000	Q3 Forecast £'000	Variance to Budget £'000	Variance to Q2 Forecast £'000
Income	9,994	10,093	10,217	10,247	253	30
Expenditure (BAU)	9,946	9,839	9,721	9,583	363	138
Surplus / (Deficit) before reserve expenditure	**48**	**254**	**496**	**664**	**616**	**168**
Reserve (Strategic & legal) expenditure	1,920	2,029	1,722	1,418	502	304
Surplus / (Deficit) after project expenditure	(1,872)	(1,775)	(1,226)	(754)	1,118	471
Unrealised Investment gains	247	(864)	(918)	(550)	(797)	368
Surplus / (Deficit)	**(1,625)**	**(2,639)**	**(2,144)**	**(1,304)**	**321**	**839**

Highlights

The Q3 forecast for 2022/23 provides comparisons against the previous quarterly forecasts and 2022/23 budget.

The 2022/23 approved budget anticipated a breakeven level for BAU operations. Since then, the surplus before reserves expenditure (BAU surplus) has increased at each forecast.

The key drivers of improved performance are:

The positive forecast is largely due to higher than anticipated income (primarily from increases in applications for international registration) and a combination of savings and delays in both BAU and strategic project expenditure.

The combination of efficiencies and savings totalling £358k was absorbed by Q1-Q3 re-forecasts.

In addition, the scoping of some of the strategic projects/project elements as they prepare to move into the development stage has resulted in more accurate project planning and financial forecasting, fine-tuning planned financial spending, with some workstreams being reprioritised. Quarterly forecasts assist in our agile approach to plotting future BAU and project spending with a greater degree of accuracy as activities progress.

The investment portfolio improved after a decline in value in Q1 and Q2 (2022/23). The year 2022 was quite a volatile period for the market value of the investment portfolio, affecting our unrealised income and reserve levels.

General Optical Council
Q3 Forecast Report – 2022-23

Reduction in expenditure through savings were made across many departments, for example, some activities were completed more quickly than forecasted, there has been a reduction in office expenses, and a reduction in planned agency staff forecasted across departments. In addition, some in-person events moved to remote, creating savings, several refunds were received for office services, the staff training budget remains under-utilised, and we've seen lower than expected demand for IT equipment and printing.

Causes of delayed expenditure also vary. Some delays were due to the dependencies of other activities which did not materialise; other delays were due to change of staff and recruitment of consultants. There were also delays in commissioning research, re-phrasing of communication activities, case examiner decisions several case progression activities, and recruitment of procurement experts.

Risks to achieving the Q3 Forecast

The highest risk, although at a lower likelihood, is the loss of unrealised investment gains due to the possibility of market volatility. We hope this risk is minimal with only a month to complete the financial year.

All known delays beyond 2022/23 are now being captured in 2023/24 budget. There are several delays included in Q4 of the current year, which may impact 2023/24 if not managed carefully. Case progression related legal charges could get more complex, although these costs are now captured in a systematic and agreed process.

The market volatility of the investment portfolio is still being carefully watched, but this is an external risk. The performance has been improving in Q3, but the market value is still below 31 March 2022 level. The Head of Finance and Director of Corporate Services review the situation closely with Brewin Dolphin.

General Optical Council
Q3 Forecast Report – 2022-23

Table A
Income and Expenditure Accounts

	2022-23				
	Budget	Q1 Forecast	Q2 Forecast	Q3 Forecast	Variance
	£'000	£'000	£'000	£'000	£'000
Income					
Registration	9,737	9,836	9,959	9,989	30
Dividend Income	246	246	246	246	0
Bank & Deposit Interest	1	1	1	1	0
Other Income	10	10	11	11	0
Total Income	**9,994**	**10,093**	**10,217**	**10,247**	**30**
Expenditure					
CEO's Office					
CEO	218	248	232	219	14
Governance	668	626	613	621	(8)
Total CEO's Office	**886**	**874**	**846**	**840**	**6**
Regulatory Strategy					
Director of Regulatory Strategy	130	139	128	127	0
Policy & Standards	367	287	254	214	40
Communications	292	285	251	212	38
Education & CPD Operations	1,028	867	569	571	(2)
Education & CPD Development			269	211	59
Total Regulatory Strategy	**1,817**	**1,577**	**1,470**	**1,336**	**135**
Regulatory Operations					
Director of Regulatory Operation	125	124	124	124	1
Case Progression	2,057	2,081	2,120	2,136	(17)
Legal	203	208	230	224	6
Hearings	1,122	1,225	1,353	1,368	(15)
Total regulatory Operations	**3,507**	**3,638**	**3,828**	**3,852**	**(24)**
Corporate Services					
Director of Corporate Services	135	132	122	158	(35)
Facilities	1,063	1,055	1,059	1,088	(29)
Human Resources	544	598	519	458	61
Finance	502	479	476	454	22
Registration	561	580	551	526	26
Total Corporate Services	**2,806**	**2,845**	**2,728**	**2,684**	**44**

General Optical Council
Q3 Forecast Report – 2022-23

Table A (Contd.)
Income and Expenditure Accounts (Contd.)

	2022-23				
	Budget	Q1 Forecast	Q2 Forecast	Q3 Forecast	Variance
	£'000	£'000	£'000	£'000	£'000
IT (BAU)	810	764	724	742	(18)
Depreciation & Amortisation	120	141	127	130	(3)
Total Expenditure	**9,946**	**9,839**	**9,723**	**9,583**	**140**
Surplus / (Deficit) before reserve expenditure	**48**	**254**	**494**	**664**	**170**
Reserve Expenditure					
Standards Review and Implementation Project	188	92	32	32	(0)
Completion of CPD project	44	29	29	36	(8)
Education Strategic Review project	201	393	176	188	(12)
IT Strategy Project	438	462	396	272	124
Change	811	589	544	526	18
Strategic Projects	215	260	216	136	80
Potential Projects*	0	0	0		0
Complex Legal Cases	0	180	300	200	100
Project Depreciation & Amortisation	24	24	29	28	1
Case Management System					
Total Project expenditure	**1,920**	**2,029**	**1,722**	**1,418**	**303**
Surplus / (Deficit) after project expenditure	**0**	**(1,775)**	**(1,227)**	**(754)**	**473**
Unrealised Investment gains	247	**(864)**	**(918)**	**(550)**	368
Surplus / (Deficit)	**(1,624)**	**(2,639)**	**(2,145)**	**(1,304)**	**841**

General Optical Council
Q3 Forecast Report – 2022-23

Table B
Q3 Forecast - Including Project Expenditure

	2022-23				
	Budget	Q1 Forecast	Q2 Forecast	Q3 Forecast	Variance
	£'000	£'000	£'000	£'000	£'000
Income					
Registration	9,737	9,836	9,959	9,989	30
Dividend Income	246	246	246	246	0
Bank & Deposit Interest	1	1	1	1	0
Other Income	10	10	11	11	0
Total Income	**9,994**	**10,093**	**10,217**	**10,247**	**30**
Expenditure					
Staff Salaries Costs	5,911	5,672	5,521	5,446	75
Other Staff Costs	473	442	358	320	39
Staff Benefits	133	43	20	18	2
Members Costs	1,190	1,135	1,148	1,159	(10)
Case Examiners	128	127	92	82	11
Professional Fees	885	1,077	760	619	141
Finance Costs	77	77	83	80	2
Case Progression	750	941	1,081	1,017	64
Hearings	208	255	329	314	15
CPD & Standards	113	54	118	101	18
Communications	71	47	45	38	6
Registration		19	19	19	-
IT Costs	782	780	689	606	83
Office Services	949	955	965	977	(11)
Other Costs	51	80	59	49	10
Depreciation & Amortisation	144	165	156	158	(2)
Upcoming Projects		-	-	-	-
Total Expenditure	**11,865**	**11,868**	**11,444**	**11,002**	**442**
Surplus / Deficit	**(1,871)**	**(1,775)**	**(1,227)**	**(755)**	**472**
Unrealised Investment gains	247	(864)	(918)	(550)	368
Surplus / (Deficit)	**(1,624)**	**(2,639)**	**(2,145)**	**(1,304)**	**840**

General Optical Council
Q3 Forecast Report – 2022-23

Detailed analysis of the Q3 2022/23 forecast

Revenue

Overall revenue forecast at £9,989k has increased from the Q2 forecast by £30k. £17k of the increase is due to non-UK applications. We expect these levels to be high throughout the remainder of the year.

We were cautious in forecasting unrealised investment gains in Q2 at a very high volatile time. Since then, we have made marginal increases to the value.

Expenditure

Efficiencies and savings

£179k savings made during the last quarter was absorbed into the current forecast.

Staff Salaries

We have been able to recruit to most staff vacancies, bringing down the staff salary variance to £75k from previous forecast analysis. The Q1 had a £239k variance and Q2 had £153k variance. The past vacancies contributed to some delays in operations.

Headcount Projection (FTE's) - 2022-23

	Budget Mar-23	Q1 Forecast Mar-23	Q2 Forecast Mar-23	Q3 Forecast Mar-23
Chief Executive total	9	9	9	9
Regulatory Strategy	23.6	22.3	22	23.6
Regulatory Operations	32.8	38	40	40
Corporate Services	19.9	22.9	23.4	23.4
Change	17	18	16	16
Total Headcount	102.3	110.2	110.4	112

PUBLIC
C12(23)

PUBLIC COUNCIL

Report from the Chair of Council

Meeting: 22 March 2023 **Status:** For noting

Lead responsibility & paper author: Dr Anne Wright (Chair of Council)

Introduction

1. This report covers my principal activities since the last Council meeting on 07 December 2022.

2. I would like to welcome our two new Council Members, Ken Gill, and William Stockdale to their first public meeting of Council. Ken is a Lay Member with an accountancy background and wide non-executive experience of public bodies including as Vice Chair of an NHS Trust. He joins the Audit, Risk and Finance Committee. William is a Registrant Dispensing Optician who lives and works in Northern Ireland. He joins the Nominations Committee. I also welcome Clare Minchington to her new role as Senior Council Member. In this capacity Clare also chairs the Remuneration Committee. I welcome Sinead Burns as new Chair of the Audit, Risk and Finance Committee, Tim Parkinson as new Chair of the Companies Committee, and Lisa Gerson as new Chair of the Registration Committee. I also welcome new members of the Companies Committee.

3. I would also like to welcome on behalf of the Council all GOC new starters including colleagues that have recently joined the Regulatory Strategy Directorate, and the Registration and Governance Teams. I also congratulate colleagues who have been promoted to new roles in the GOC.

Management

4. I have had weekly catch-up meetings with the Chief Executive and Registrar (CE&R) and the Head of Governance. I have received briefings from members of the Senior Management Team (SMT), Leadership Team (LT) and Governance on a range of priorities.

5. I have held quarterly 1:1 meetings with individual SMT members as well as other meetings on specific priorities and issues. I met with the new Governance and Compliance Manager, Jenny Hazell on 3 March 2023, for an introductory meeting. On the 14 December 2022, I also joined and contributed to the pre-seasonal break All-Staff meeting.

6. I have joined a number of events held by the GOC networks, including those for Embrace Chinese New Year, LGBTQ+ History Month, and Women's History Month.

Council and Committees

7. I chaired the meeting of the Nominations Committee on 26 January 2023, and attended meetings of the Audit, Risk and Finance Committee (ARC) on 31 January 2023 and 28 February 2023. I also joined the Remunerations Committee meeting on 21 February 2023. I attended the Advisory Panel meeting on the 10 March 2023.

8. From the beginning of the year, I have held fortnightly meetings with the new Senior Council Member (SCM) Clare Minchington and had my last fortnightly meeting with the former SCM, Glenn Tomison on 12 December 2022. I have chaired regular informal Council catch-up sessions. I also had induction and catch-up meetings with two new Council Members, Ken Gill and William Stockdale. I attended the ARC handover meeting with SCM, Clare Minchington, and ARC Chair, Sinead Burns on the 23 January 2023. In addition, I chaired the Council Strategy Day at the GOC offices on 2 March 2023, and contributed to the Companies Committee member induction held on 3 March 2023.

9. Recruitment of two new Council Associates is under way, and as Chair of the Appointment Panel I have conducted briefing and shortlisting meetings ahead of the final interviews to take place later this month. The other members of the Panel are Registrant Council Member Roshni Samra and Independent Member of the Nominations Committee Nick Yeo. Response to the recruitment campaign was

very strong, with over 60 applications, and I am grateful to all those who put themselves forward, as well as to the Association of British Dispensing Opticians (ABDO) for their support in promoting the Council Associate development opportunity to their members, and for hosting a webinar on 15 February 2023.

Stakeholders

10. 13 December 2022: GOC and Health and Care Professions Council (HCPC) quarterly meeting with Christine Elliott.

11. 13 December 2022: GOC and Nursing & Midwifery Council (NMC) Chair's meeting with Chair, Sir David Warren, and CEOR Andrea Sutcliffe. I was accompanied by the Chief Executive and Registrar, Leonie Milliner.

12. 11 January 2023: GOC and Federation of Ophthalmic & Dispensing Opticians (FODO) Annual Catch-Up meeting with Chair, Sarah Joyce, and Chief Executive, Harjit Sandhu. I was accompanied by Leonie Milliner and Clare Minchington.

13. 17 January 2023: I joined a Patient Safety Workshop hosted by the HCPC Chair Christine Elliott.

14. 26 January 2023: GOC and Royal College of Ophthalmologists (RCOphth) Annual Catch-Up meeting with President, Professor Bernie Chang and CEO, Kathy Evans of RCOphth. I was accompanied by Leonie Milliner and Clare Minchington.

15. 01 February 2023: GOC and ABDO Annual Catch-Up meeting with President, Daryl Newsome and new Chief Executive, Alistair Bridge, accompanied by Leonie Milliner and Clare Minchington.

16. 07 February 2023: GOC and Association for Independent Optometrists and Dispensing Opticians (AIO) Annual Catch-Up meeting with Chair, Dr Christian French and Head of Secretariat/Chief Executive, Mike Ockenden, accompanied by Leonie Milliner and Clare Minchington.

17. 09 February 2023: GOC and Department of Health and Social Care (DHSC) introductory/catch-up meeting with Deputy Director Professional Regulation, Phil Harper and Workforce Deputy Branch Head, Sean Marchesi-Denham at DHSC. accompanied by Leonie Milliner and Steve Brooker.

18. 07 March 2023: GOC and Association of Optometrists (AOP) Annual Catch-Up meeting with Chair, Julie-Anne Little and Chief Executive, Adam Sampson, accompanied by Leonie Milliner and Clare Minchington.

19. 21 March 2023: Patient Safety Workshop hosted by HCPC.

Council Member meetings with stakeholders

20. William Stockdale attended an introductory meeting with Alistair Bridge, Chief Executive of ABDO, on 19 January 2023.

21. William Stockdale and Sinead Burns met with Raymond Curran, Head of Ophthalmic Services at the Health and Social Care Board, Northern Ireland's national optometric adviser on 3 February 2023.

PUBLIC
C13(23)

COUNCIL

Chief Executive & Registrar's Report

Meeting: 22 March 2023 **Status:** For noting

Lead responsibility & paper author: Leonie Milliner (Chief Executive & Registrar)
Council Lead(s): Dr Anne Wright CBE

Purpose

1. To provide Council with an update on stakeholder and other meetings attended by the Chief Executive and Registrar and activities not reported elsewhere on the agenda.

Recommendations

2. Council is asked to note the Chief Executive and Registrar's report.

Strategic objective

3. This work contributes towards the achievement of all parts of our Strategic Plan and our 2022/2023 Business Plan.

Background

4. The last report to Council was provided for its December meeting.

Analysis

5. I am delighted to report that on 9 March 2023 I was admitted as a Freeman of the City of London at a ceremony conducted by the Clerk to the Chamberlain's Court at London Guildhall. This followed my admittance as a freeman of the Worshipful Company of Spectacle Makers at the GOC's offices in February 2023. Photographs of both ceremonies were published on the GOC twitter and LinkedIn accounts.

6. I also wish to thank the optical businesses and hospitals who are facilitating our optical practices' familiarisation programme, including the Prison Opticians Trust who organised my visit to HMP Brixton Prison in early January with Council member Mike Galvin.

7. We celebrated LGBTQ+ History Month in February, as well as Women's History Month and International Women's Day in March with a range of engagement activities and events. This included a fantastic talk by Leah Shearer, Private Secretary to the Minister for Women, Maria Caulfield MP, and an in-person Women's Network lunch at 10 Old Bailey.

8. Our staff network groups have been particularly busy since Council last met. Our Embrace network hosted a talk to celebrate Chinese New Year on 19 January 2023, ably led by Denise Voon (Optometric Advisor to the GOC). Our Staff Wellbeing and Engagement Group (SWEG) continues to organise regular staff coffee break sessions. We have seen a significant rise in engagement with staff at these events. Of note was Steve Brooker's (Director of Regulatory Strategy) SWEG coffee break entitled 'Life Through My Lens' on 30 January 2023, where Steve talked about his passion for photography and shared some of his outstanding images of British and Costa-Rican wildlife. Keith Watts' (Change Lead - Regulatory Operations) also led a two-part SWEG coffee break, a genre-hopping journey through 1970s popular music. We marked the anniversary of Russa's invasion of Ukraine with a SWEG coffee-break, learning a traditional Ukrainian dance and learning about Ukrainian culture. In addition, People and Culture facilitated a 'my personal best' all-staff physical challenge in February 2023.

9. The GOC staff network chairs met with Coal Authority chairs for a session on sharing best practice and looking at collaborative opportunities.

10. The People and Culture team hosted an all-staff interactive wellbeing session, entitled 'Building Resilience - People and Culture' where staff were able to discuss the professional benefits of embarking on a resilience-building journey. All-staff and manager focused appraisal training has been organised for this month to support the forthcoming performance reviews scheduled for all staff in April and May. Training and professional development opportunities for staff continue to be identified and supported.

11. We were finally able to host our staff Christmas lunch in February 2023, having cancelled the event twice due to transport strikes. Industrial action continues to disrupt both postal services and staff and member transport into Old Bailey.

12. Since Council last met, I have held weekly meetings with the Chair of Council and Head of Governance, and I chaired the regular Tuesday evening Council catch-up sessions. I also held an induction meeting with two newly appointed Council Members, Ken Gill on 19 December 2022 and William Stockdale on 16 January 2023.

13. Along with the Chair of Council I was delighted to attend the Association of British Dispensing Opticians (ABDO) Council Associate webinar on 15 February 2023 to promote GOC Council associate recruitment campaign.

14. In addition, I also attended the Council seminar on refraction on 20 February, the Council strategy day on 2 March 2023, the Companies Committee member induction on 3 March 2023 and the Advisory Panel meeting on 10 March 2023. I

also attended the Nominations Committee meeting on 26 January 2023 and the Audit, Risk and Finance Committee meetings on 31 January 2023 and 28 February 2023.

15. I held weekly 1:1 Senior Management Team (SMT) and Head of Governance meetings as well as various internal meetings with relevant staff including Chairing fortnightly SMT meetings, monthly all-staff meetings, Programme Board, Strategic Change Board, Risk Register and Leadership Team (LT) meetings. I also held a GOC's new starters meeting each month, and I would like to formally welcome the following staff who have joined the team since Council last met:

    Michael Edache - Registration Officer
    Charlotte Urwin -Head of Strategy, Policy and Standards
    Rebecca Chamberlain -Standards Manager
    Catherine Walker - Communications and Public Affairs Officer
    Jenny Hazell -Governance and Compliance Manager
    Danny Reyes Alzate - Education Administrator – Operations
    Sophie Cattermole -Business Change & Engagement Manager

16. In addition, I would like to place on record our special thanks to Marie Bunby, (Policy Manager) who provided and continues to provide an outstanding contribution to the Policy and Standards Department.

Change Directorate

Change Management Office

17. The most recent Q3 (2022/23) strategic project assurance report was considered and approved at SCB on 2 February 2023 and was subsequently received at ARC on 28 February 2023. Please see the ARC minutes included in the strictly confidential meeting for more information on strategic projects.

18. Project management discipline continues to be utilised across all areas of work, with increased use of focus groups across the business aimed at ensuring participation and buy in at all stages of our fit for the future project processes. The recent appointment of a part time business change communications manager will help bolster internal business change communication capacity.

IT

19. The contract for the delivery of our managed services has now been signed with the new provider Rock, who is expected to be in place by April 2023. Transition processes are in place including taking into account effective communication with and necessary training for staff as a result of the change from one provider to another.

20. We also successfully obtained Cyber Essentials accreditation on 27 January 2023. This self-assessment certifies that the organisation has the technical controls in place to protect against common online security threats.

21. The IT team are now in the process of pursuing Cyber Essentials Plus, which is the highest level of certification offered and is a more rigorous test of the organisation's cyber security systems. Cyber security experts will carry out vulnerability tests to make sure that the organisation is protected against basic hacking and phishing attacks.

Corporate Services

Facilities

22. In the latest quarterly Health and Safety report to the Audit, Finance and Risk Committee, no incidents, near misses or breaches were reported. We continue to review display screen and home working assessments. Additional staff have been appointed as fire wardens and first aiders and received appropriate training.

23. Part of our office have had some minor re-decoration, with painting of some areas.

HR

24. We continue to review and revise our internal people policies. In February, following a detailed consultation, we launched new policies for annual leave, special leave and full range of family support policies. All policies are legally compliant and based on best practice. The HR Zone on our intranet IRIS was also updated to be more user friendly for employees.

25. Our annual staff survey results were presented to SMT, Council and all employees at an all staff meeting at the end of January 2023. The results were positive, and we continue our work to modernise our pay policy and to support and train our managers in applying our policies consistently and fairly, including commissioning new manager training. SMT have been supported to reflect and enhance their practice as business leaders this quarter with an executive coach, who has provided 1:1 coaching for each member of SMT, as well as observing an SMT meeting and providing feedback. An SMT workshop is planned for May 2023.

26. Work is ongoing to develop the reward and recognition policy and to provide briefing sessions for employees and managers. Our external pay and reward consultants (QCG) have supported the Head of People and Culture to write a first draft of a new reward and recognition policy which has been discussed in detail by the Senior Management Team alongside financial cost modelling and draft new pay scales. The new policy has been reviewed by our internal Policy Review Group in advance of a three week all staff consultation. We will take onboard the

feedback from employees before confirming the next steps, including transitional arrangements.

27. In February we collated responses from stakeholders to provide feedback to the PSA on their proposed evidence framework for Standard 3. In March, the Gender Pay Gap report goes to SMT and demonstrates that the GOC is as fair and equal employer with mean and median pay gaps well below the regulation sector and not for profit sector.

Equality diversity and inclusion

28. In March we submitted a response to the Welsh Language Commissioner's draft compliance notice on the Welsh Language Standards. While confident in our ability to meet all the standards, we have sought a longer implementation period, especially where the standards relate to our online MyGOC and MyCPD platforms.

29. We provided feedback to the PSA on their proposed evidence framework for Standard of Good Regulation 3 (Equality Diversity and Inclusion).

30. The GOC consultation regarding gender on the register closes in mid-March, and conversations have been held with the Association of Optometrists and are planned in with the GMC to discuss their experiences. Similarly, we have had feedback from patients via General Pharmacy Council's patient panel.

Registration

31. Registration has been busy with annual renewal for fully qualified and body corporate registrants, which opened on 23 January 2023 and will close on 31 March. The current renewal rates are on track with recent years trends.

32. We have also processed nearly 300 applications from newly fully qualified registrants and added them onto our register.

33. Volumes of applications from optical professionals who qualified overseas continue to rise. A total of 350 new applications were received in 2022 compared to 177 in 2021, representing almost a 100% increase during the year. Most applications have come from applicants in Nigeria and India. We will shortly begin an exercise to recruit more international applicant assessors to support the increased workload. Until we bolster our capacity to manage the assessment of applications, processing times will be increased. We want to provide an excellent service whilst ensuring that the correct level of scrutiny is applied and will communicate any changes in timeframes to applicants appropriately.

34. In time we will consult on a revised process for managing applications from optical professionals who qualified overseas in line with the new ETR.

Regulatory Operations

35. We have progressed well with the discovery phase for our new case management system, with the team leading over 25 process walk-through sessions with our new supplier. We are encouraged by the level of understanding secured at this stage and are on track to deliver phase one of the project within planned timescales.

36. I must record a special mention to Keith Watts who, as well as leading the project management for the case management system, has also overseen the progression of our fitness to practise improvement programme 2.0 until he hands this workstream back to the team, as planned, later on this month. Of the 19 original workstreams, four have been completed; our approach to the investigation of potential criminal allegations, scope for voluntary removal, case examiners decisions review cycle and the development of a customer feedback process. The programme will undergo a checkpoint review this month and a realignment of deliverables to reflect progress on the case management system.

37. The Casework and Hearings teams have continued to work hard to address the increase in events not concluding in time as reported at the last meeting. Since January only one case has not concluded as expected. There have been a number of unavoidable postponements this quarter due to the unforeseen absence of key personnel on re-scheduled hearings, and this will have a negative impact on our timeliness into Q2 of 2023-24.

38. Over the last few years there have been steady and continuous improvement in our triage, casework, and hearings operations, with the teams delivering through some very challenging times. We want to recognise the support and robust check and challenge received from our stakeholder groups and partners in helping us deliver these outputs. This hard work continues as we commit to continuously improving our fitness to practise function to ensure improvements are sustained.

Regulatory Strategy

Paediatric Optometry

39. In January, we became aware of a post on LinkedIn raising concerns about optical professionals refusing to carry out sight tests for very young children (those under 3) and telling parents to come back to the practice when the child was older or could read their letters. It is unclear from the post precisely why optical professionals are refusing to provide care and those who responded to the post have given different reasons why this might be happening:
    - Optical professionals don't feel competent to carry out these sight tests as it is not within their scope of practice and/or they lack appropriate training to work with young children; or

- optical professionals lack the necessary equipment to carry out these tests appropriately; or
- the optical business has decided not to provide care to these young patients for financial reasons as the tests can take a long time to complete and may require specialist equipment; or
- parents are being turned away by unregulated staff who do not understand that optical professionals may be able to carry out sight tests on these children.

40. We discussed these concerns with representatives from all the optical professional bodies at a meeting in January. In response to the concerns, the College of Optometrists has issued guidance to all its members about examining young children and not turning them away. Although the GOC does not explicitly require registrants to follow the guidance of optical membership/representative bodies, registrants are expected to be aware of current good practice, which includes publications by the College of Optometrists and others.

41. The concerns raised engage several of our standards for both individual registrants and optical businesses, including standards related to equality, inclusion and diversity, and referring patients only when clinically justified. We will continue to engage with the optical professional bodies on this issue and, where the thresholds for action have been met, we may investigate concerns as a fitness to practise matter. We will keep our position under active review in response to developments.

Legislative Reform

42. On 17 February 2023, DHSC published the outcome of its 2021 consultation on reforms to healthcare regulation, plus a consultation on the draft section 60 order for physician associates and anaesthesia associates. The section 60 order will act as a template for the future regulation of other healthcare professionals, including dispensing opticians and optometrists. In a press release, we publicly welcomed the documents as an important milestone on the road to reform, although it is frustrating that the timetable for reform of the Opticians Act remains unclear.

43. The GOC will respond to the consultation, with responses due by 16 May. Although the government's timetable is unclear, a substantial change programme will be required to prepare GOC for the reforms, for example to our governance arrangements, our regulatory operations and to our public register. The executive is starting to think through what that might involve and the resources we will need to deliver this change programme.

44. The GOC's call for evidence on legislative reform is covered extensively elsewhere on the agenda for today's meeting.

Standards Review

45. Since the last Council meeting, we have taken forward our work to review our standards. The overarching aim of the standards review is to revise and update the existing Standards of Practice for Optometrists and Dispensing Opticians, Standards for Optical Students and Standards for Optical Businesses, to comply with the GOC's statutory duties, and ensure continued public protection.

46. The timetable for the review includes a series of stakeholder 'conversations' on topics of interest, such as the use of social media or maintaining professional boundaries. We will also seek the views of patients and the public on these topics, likely through commissioning an external research company. We will provide interim updates to Council through the Chief Executive's report to Council.

47. We expect to bring the draft standards to Council for review in December 2023, with consultation on the proposed standards from January to March 2024. We anticipate publishing the new standards in September 2024, alongside plans on how we will implement the new standards.

Research

48. We have begun work on the 2023 annual public perception research and registrant survey. The public perception survey helps us understand patient satisfaction levels with optical services, while the registrant survey will help us to understand workforce issues and challenges registrants face in the workplace. We will also be asking for registrant views on the CPD scheme this year. Both reports will be presented to Council, likely at the September meeting.

Communications

49. On 25-27 February we attended 100% Optical, one of the largest optical events in the UK with over 10,000 optical professionals in attendance. Our stand was reasonably well-attended and I am hugely grateful to GOC staff answered registrants' questions and hand out copies of our standards and guidance.

Education

50. In January 2023, providers of GOC approved qualifications submitted their annual monitoring review (AMR) returns, in which they reflect on key changes, events, metrics, and risks to their programmes. This information informs our quality assurance activities to ensure providers continue to meet GOC education handbook requirements. We are reviewing information submitted and will be preparing qualification reports as well as an annual sector report, the latter presented to Council in the summer.

51. Quality assurance visits to education providers are continuing as planned. We continue to assess whether to hold visits virtually or on site, taking into account the purpose of the visit and an assessment of risk. Since December 2022, one on-site visit has taken place, and three are scheduled to take place shortly.

52. One provider has made excellent progress meeting outstanding conditions and has therefore been removed from the Serious Concerns Review (SCR); this provider will now be subject to our standard quality assurance processes. There are currently no SCRs in place for providers of GOC approved qualifications.

53. We have noted the adaptations of four existing GOC-approved qualifications to the new education and training requirements. All are due to deliver adapted qualifications from September 2023. An additional five notification of adaptation submissions have been received and are currently being reviewed.

54. We have launched a new, automated system for Continuing Professional Development (CPD) providers to pay their annual renewal fee.

55. As of 1 March 2023, a one year into the current 2022-24 three-year CPD cycle, 41 per cent of registrants had completed their peer review requirement and 37 per cent of registrants had recorded one CPD point per month on average (logging one point every month would achieve the minimum points total by end of cycle). A concern is that a significant minority of registrants have not logged a personal development plan, which is a requirement at the start of the cycle. We will be writing to those registrants who have not logged a personal development plan to address this shortfall.

56. Registrant reported quality of CPD events attended and of the CPD providers hosting them is positive, with the majority (~94% each) receiving excellent to good feedback (a rating of 85% or higher).

57. In April 2023, we are hosting a CPD provider forum to give an overview of the new CPD scheme and CPD data gathered so far, to discuss the upcoming GOC provider audit function, and provide an opportunity for providers to share their feedback about the scheme and ask any questions they may have.

58. We are at the design and build stage with our external provider to develop the new CPD audit and reviewer system, enhancing the functionality within MyCPD. We had a good response to the recruitment campaign for CPD auditors and reviewers, with interviews currently taking place. Training for the roles will take place in April 2023.

<u>Governance</u>

59. The Governance team continues to support Council, its committees, and the executive management meetings. It is preparing a calendar for the next few years and will be consulting members on this shortly. The next steps of the governance review will be a governance manual, which will be presented at Council in June 2023 for approval. After this, the governance review will transition into a member support review aimed at identifying how we can best support our diverse cohort of committee and Council members.

External stakeholder engagement

60. Since the last Public Council meeting on 7 December 2022, I have attended the following external meetings and engagements:

- 8 December 2022: I chaired the optical sector Chief Executives' meeting with the Chief Executives of the relevant sector bodies – Association of Dispensing Opticians (ABDO), Association of Optometrists (AOP), College of Optometrists (COO), and Federation of Ophthalmic and Dispensing Opticians (FODO).
- 12 December 2022: Decision Review Group meeting involving GOC legal and policy team and the Nursing and Midwifery Council (NMC) Lawyer, Rakesh Sharma.
- 13 December 2022: The Worshipful Company of Spectacle Makers' (WCSM) Court Luncheon invited by the Clerk to WCSM, Helen Perkins.
- 13 December 2022: GOC and NMC Chair's meeting with Chair, Sir David Warren, CEO, Andrea Sutcliffe, and Governance Officer - People and Organisational Effectiveness, Jennifer Daniel at NMC.
- 14 December 2022: Chief Executives of Health and Social Care Regulators (CESG) meeting Chaired by the General Dental Council (GDC).
- 14 December 2022: CEO Challenge Supporting your staff through the cost-of-living crisis event hosted by Public Chairs' Forum (PCF) and Association of Chief Executives (ACE).
- 15 December 2022: Advisory Committee on Degree Awarding Powers (ACDAP) organised by the Quality Assurance Agency (QAA)
- 21 December 2022: meeting with Dr David A. Woolf Medi-Optics Opticians
- 21 December 2022: GOC and QCG Consulting meeting with Associate, Paula Hayes, Senior Consultant, Peter Fairchild and Junior Consultant, Sara Datsova
- 05 January 2023: Optical Practices' Familiarisation Programme: HMP Brixton Prison Trip. This on-site visit looked at how optical services are delivered in secure establishments, and was facilitated by Prison Opticians Trust.
- 11 January 2023: GOC and FODO meeting with FODO Chair, Sarah Joyce, and FODO Chief Executive, Harjit Sandhu.
- 11 January 2023: GOC and QCG meeting with Associate, Paula Hayes, Senior Consultant, Peter Fairchild and Junior Consultant, Sara Datsova
- 23 January 2023: Discussion regarding optometry education and training with Medical Directorate Lead, Pushpinder Mangat at Health Education, and Improvement Wales (HEIW).

- 24 January 2023: GOC and Optical Suppliers Association (OSA) meeting with OSA Vice Chair, Roy Stoner and OSA Policy Consultant, Ann Blackmore.
- 26 January 2023: GOC and Royal College of Ophthalmologists (RCOphth) meeting with President, Professor Bernie Chang and CEO, Kathy Evans of RCOphth.
- 1 February 2023: GOC and ABDO meeting with President, Daryl Newsome and Chief Executive, Alistair Bridge at ABDO.
- 7 February 2023: GOC and Association for Independent Optometrists and Dispensing Opticians (AIO) meeting with Chair, Dr Christian French and Head of Secretariat/Chief Executive, Mike Ockenden at AIO.
- 8 February 2023: meeting with Principal, Emma Bentley at Gate One.
- 08 February 2023: meeting with, Professor John Wild, Head of School at School of Optometry and Vision Sciences.
- 09 February 2023: meeting of the Optometric Advisory Board with Optometry NHS Education for Scotland including the relevant sector bodies.
- 09 February 2023: GOC and Department of Health and Social Care (DHSC) meeting with Deputy Director Professional Regulation, Phil Harper and Deputy Branch Head, Sean Marchesi-Denham at DHSC.
- 10 February 2023: Optical practices familiarisation programme meeting with Clinical Council Vice Chair, Zoe Richmond, CEO, Janice Foster, Optical Lead Clinical Team Member, Danielle Ellis and Office Manager, Jacque Fooks for Eye Health Commissioning at Local Optical Committee Support Unit (LOCSU).
- 15 February 2023: Webinar organised by ABDO for potential dispensing optician applicants for GOC Council Associates.
- 15 February 2023: Leonie Milliner's Worshipful Company of Spectacle Makers (WCSM) Freedom Ceremony with the company Master and Clerk, Helen Perkins at WCSM.
- 16 February 2023: Health Education England (HEE) roundtable meeting with healthcare regulators organised by Medical Director, Professor Sheona MacLeod, Reform and Professional Development at HEE.
- 22 February 2023: Chief Executives of Regulatory Bodies (CEORB) meeting organised by GDC with the relevant regulatory bodies.
- 23 February 2023: ACDAP organised by the QAA
- 23 February 2023: Quarterly 1:1 meeting with CEO, Ian Humphreys at COO.
- 27 February 2023: 100% Optical event at ExCel London.
- 27 February 2023: meeting with Head of Hakim Group Professional Advancement and Governance, Claire Slade.
- 27 February 2023: meeting with Jennie Jones - Partner at Optical Consumer Complaints Service (OCCS)
- 06 March 2023: Round Table - roundtable meeting Clinical Outcomes and Quality NHSE Eyecare Transformation Programme, organised by National Clinical Director for Eye Care, Louisa Wickham.
- 07 March 2023: GOC and AOP meeting with Chair, Julie-Anne Little and Chief Executive, Adam Sampson at AOP.

- 17 March 2023: 1:1 meeting with Chief Executive of ABDO, Alistair Bridge.
- 09 March 2023: Leonie Milliner's Admission Ceremony for the Freedom of the City with members of the Worshipful Company of Spectacle Makers.
- 16 March 2023: ACDAP organised by the QAA
- 16 March 2023: optical sector Chief Executives' meeting with the relevant sector bodies - ABDO, AOP, COO, and FODO.
- 17 March 2023: meeting with Neil Retallic, Director of Professional Development, Grant Duncan and Head of Professional Development, Specsavers

61. A range of other engagements by Directors are listed in Annex 1.

Finance

62. This paper requires no decisions and so has no financial implications.

Risks

63. The strategic risk register has been reviewed in the past quarter and discussed with ARC.

Equality Impacts

64. No impact assessment has been completed as this paper does not propose any new policy or process.

Devolved nations

65. We continue to engage with all four nations across a wide range of issues.

Other Impacts

66. No other impacts have been identified.

Communications

External communications

67. This report will be made available on our website, but there are no further communication plans.

Internal communications

68. An update to staff normally follows each Council meeting, which will pull out relevant highlights.

Next steps

69. There are no further steps required.

Attachment

Annex 1 - Directors’ stakeholder meetings.

Annex 1 - Meetings/visits since last Council meeting

Philipsia Greenway Director of Change	Yeslin Gearty Director of Corporate Services	Dionne Spence Director of Regulatory Operations	Steve Brooker Director of Regulatory Strategy
09.01.2023 - NIHR documentary analysis with Louise Wallace	22.12.22 Meeting with Malcolm Bradley, partner Farebrother Property, regarding building management	08.12.22 Sandra Holmes - College of Optometrists, introductory meeting	Weekly National Optometric Advisers meetings
27.01.2023 - Chief Executives of Regulatory Bodies (CEORB) meeting organised by GDC with the relevant sector bodies	11.01.23 meeting with Peter Fairchild, Paula Hayes, Sara Datsova QCG – Pay & Reward specialists	14.12.22, 06.01.23, 10.01.23 Stuart Gunning, Andrew Hughes, Kelly Scott, Darren Barbour, Ryan XXX - Equiniti / ITS Computing, case management system kick-off meeting,	Chair Optical Sector Policy Forum meetings – every other month
	13.01.23 meeting with Phillip Payne, director Brewin Dolphin re Investment management	09.01.23, 06.03.23 Dr Louise Wallace, NIHR Witness to Harm project review	4.1.23, 10.1.23 – WA Comms, public and patient research on refraction
	17.01.23 meeting with Ashley Norman, Director TIAA – internal auditors. Catch up meeting	09.01.23 Michael Obichere, Independent Office for Police Complaints, case management system insights	12.1.23 – Tony Harvey, sustainability
		11.11.23 Rachel Birks, Fameeda Shafiq, Ward Hadaway –quarterly performance review	13.1.23 – Vision Express, briefing on business model

	23.01.23 Meeting with Adam Halsey HayesMacintyre – external auditors	16.01.23 Shannett Thompson, Kingsley Napley quarterly performance review	17.1.23 – Eye Health Forum
	08.02.23 Institute of Regulation, Risk Management Special Interest Group	17.02.23 Quarterly Defence Stakeholder Group meeting	19.1.23 – Industry familiarisation visit, three businesses in Wakefield
	24.02.23 meeting with Phillip Payne, director Brewin Dolphin re Investment management	20.01.23 Mark Stobbs, Professional Standards Authority	23.1.23 – SSISG, funding workstream
	27.02.23 Meeting with Malcolm Bradley, partner Farebrother Property, regarding building management	31.01.23 Kelly Reid, TIAA – Change audit interview	23.1.23 – Joint regulators group on Welsh Language Standards hosted by GMC
		01.02.23 Rachel Cooper, Katie Clark, CMS – panel firm performance review	23.1.23 – HEIW, optometry education in Wales

		02.02.23 Peena Govind and team, Vision Express – optical familiarisation visit	24.1.23 – Europe Economics, business research
		03.02.23 Louise Robbins, Clyde, and Co – legal review	24.1.23 – DHSC, business regulation
		06.02.23 Jennie Jones, Sue Clark, Richard Edwards, Optical Consumer Complaints Service – forward look	24.1.23 – Optical Suppliers Association, introductory meeting
		08.02.23 Lesley Maslen, NMC – introductory meeting	25.1.23 – Primary Care Stakeholder Forum

		09.02.23 Joanna Farrell, Neil Murray, GMC – introductory meeting	26.1.23 – AOP, routine catch up
		01.03.23 Steve Wright, Siobhan Carson, Professional Standards Authority – oversight reflections	6.2.23 – Charles Rendell, CQC, emerging concerns protocol
		02.03.23 Kate Westbrook, Thrings Solicitors – legal review	8.2.23 – NHS England, routine catch-up
		07.03.23 Paul Chapman-Hatchett, The Astra – domiciliary care overview	8.2.23 – College of Optometrists, annotations on GOC register
		20.03.23 Optical Express, Glasgow – optical familiarisation visit (refractive surgery)	9.2.23 – DHSC, legislative reform (along with Chair and CEO&R)
			24.2.23 – NHS England, data sharing
			25.2.23 – 100% Optical
			28.2.23 – Cross Regulatory Forum Digital Apps
			3.3.23 – Nicholas Rumney, autorefractors briefing
			16.3.23 – Optical Sector CEOs meeting alongside CEO&R
			17.3.23 – Specsavers, introductory meeting

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General Optical Council

DRAFT minutes of the meeting of the Advisory Panel held on Friday 10 March 2023 at 9:15am via MS Teams

Present: Jacqui Adams, Rukaiya Anwar, Kay Bagshaw, Geraldine Birks, Peter Black, Gordon Dingwall, Dean Dunning, Giles Edmonds, Lynn Emslie, Josie Forte (Chair), Mike Galvin, Lisa Gerson, Sally Gosling, Louise Gow, Anthony Harvey, Sarah Joyce, Andrew Logan, Wayne Lewis, Haseena Lockhat, Andrew Logan, Deirdre McAree, Dan McGhee, Frank Munro, Clare Minchington, Joy Myint, Tim Parkinson, Neil Retallic, Chloe Robson, Roshni Samra, Alison Sansome, Amit Sharma, Alicia Thompson, Nilla Varsani, Catherine Viner, Marcus Weaver, Anne Wright (Chair of Council) and Mary Wright.

Apologies: Gordon Ilett, Imran Hakim and Nigel Best.

Absent: Imran Jawaid

GOC Attendees: Steve Brooker (Director Regulatory Strategy), Marie Bunby (Policy Manager), Rebecca Chamberlain (Standards Manager), Nadia Denton (Governance Officer) *Minutes*, Yeslin Gearty (Director of Corporate Services), Kiran Gill (Head of Legal), Aaron Grell (Education Manager), Jenny Hazell (Governance and Compliance Manager), Vikki Julian (Head of Communications), Lamine Kerroubi (Casework and Resolutions Administrator), (Philippa Mendonsa (Head of Education), Leonie Milliner (Chief Executive and Registrar), Samara Morgan (Head of Education), Nadia Patel (Head of Registration), Ben Pearson (Education Officer), Ivon Sergey (Governance Officer), Andy Spragg (Head of Governance) and Charlotte Urwin (Head of Strategy, Policy and Standards).

	Welcome and Apologies
1.	The Chair opened the meeting, welcomed those present and acknowledged the newly recruited Companies Committee members. Panel members were informed that the new Governance and Compliance Manager, Standards Manager and Head of Strategy, Policy and Standards would be present on the call.
2.	It was noted that Gordon Ilett, Imran Hakim and Nigel Best had sent apologies.
	Declaration of Interests and confidentiality AP01(23)
3.	The Panel noted that the following members had advised of changes to their interests: • Geraldine Birks (Registration Committee); • Sally Gosling (Education Committee); • Lynn Emslie (Registration Committee); • Nilla Varsani (Standards Committee); and • Jacqui Adams (Education Committee)

4.	The Head of Governance provided some advice on declarations of interest. Panel members were reminded to be mindful of their interests when providing advice to Council so as ensure transparency. Panel members were asked to state their interests when commenting as part of the discussion.
	ACTION: Governance Officer to update the register of interests according to the declared changes of interest.
	Minutes of Previous Meetings AP02(23)
5.	The minutes of the meeting held on 14 February 2023 were **approved** as a true record of the proceedings subject to a note that Anthony Harvey and Peter Black had been present.
	Actions point updates AP03(23)
6.	It was suggested that an action point to progress environmental sustainability should be added to the action tracker for the Standards Committee. The Panel noted that the executive had taken on board the feedback given on this point and that the forthcoming review of the Standards would include consideration of this issue.
	Matters Arising
7.	There were no matters arising.
	Call for evidence research and advice to Council AP04(23)
8.	The Head of Strategy, Policy and Standards opened the item, outlining the call for evidence and areas of focus for the meeting. It was noted that Advisory Panel's advice was being sought specifically on the delegation of refraction to Dispensing Opticians. The Policy Manager provided a summary of the responses received by the GOC, the research commissioned and the questions the Panel was being asked to consider.
9.	There was a range of views expressed, with a broad consensus around the following: • the capability of dispensing opticians to provide refraction was not disputed, subject to additional training (which might be pre- or post-registration), and the option to pursue a professional pathway to become an optometrist was already well-established; • the intentions behind the proposal to allow dispensing opticians to refract for the purposes of the sight was not clear and in particular, it was felt that there was an absence of compelling evidence that this would benefit the patient or protect the public, or that it would be safe to do so. The Panel also noted the technology to auto-refract was already available and queried what additional benefits would be provided by a dispensing optician refracting for the purposes of the sight test; • there was concern regarding the risk of missed pathologies and health issues only being identified at a late stage. This was particularly if refraction only tests were permitted, but also should the refraction and eye health checks not be carried out by the same professional in a single visit. Should dispensing opticians be permitted to refract, training requirements should equip them to determine the final refraction result taking into account binocular vision and any pathology the patient had; • the arguments around freeing up the time of optometrists to enable them to deliver more clinical care were not considered persuasive, given that refraction took approximately five minutes and would likely need to be repeated by the optometrist supervising a dispensing optician;

	• the arguments around the reallocation of cost savings to the NHS hospital eye services were not considered persuasive; • there was concern around continuity of care and making the pathway for patients more complex, particularly those in vulnerable circumstances, such as children with special educational needs and disabilities or adults in domiciliary care settings; • there was concern that even if patients were given the choice to see one or more healthcare professionals during their appointment, they may not understand the options they are being presented with (and therefore unable to make an informed choice); • concerns that the dispensing optician workforce might not wish to take on this work or that there might not be the numbers to do this in the future; and • in relation to autonomous decision-making by dispensing opticians, there were concerns around governance arrangements, for example, how dispensing opticians would be supervised to ensure ongoing competence in refraction. The governance arrangements in hospitals were different to community settings. The view was expressed that allowing pre-screening to be undertaken by staff other than the optometrist was already in effect splitting up the sight test, which could present a risk. However, it was also acknowledged that pre-screening was well-established, common practice and conducted under supervision of an optometrist.
	DHSC's Regulating healthcare professionals consultation analysis
10.	The Director of Regulatory Strategy introduced the item. The Panel discussed whether the change in legislation was likely to allow the GOC to prosecute cases involving illegal practice and was advised that this was unlikely to change.
	External business plan AP05(23)
11.	The Head of Governance and Head of Communications presented the item. The Panel was informed the external business plan was based on the internal business plan and that this version was a revision on the approach taken in previous years. In discussion it was noted that although adherence to GOC Standards was not explicitly mentioned in the document, all GOC work was geared towards providing public protection and that the External Business Plan was only intended to highlight key points.
	ACTION: Head of Governance to send an email to the panel to provide clarification as to why there is a reference to Switzerland in the business plan.
	Date of Next meeting
12.	The date of the next meeting was noted as Monday 12 June 2023.
	Any Other Business
13.	There was no other business.
	The meeting closed at 10:56am.

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General Optical Council

GENERAL OPTICAL COUNCIL

DRAFT Minutes of the meeting of the Companies Committee held on Friday 10 March 2023 at 11:30 hours via Microsoft Teams

Present: Gordon Dingwall, Giles Edmonds, Sarah Elizabeth Joyce, Wayne Lewis, Deirdre McAree, Dan McGhee, Amit Sharma and Tim Parkinson (Chair).

Apologies: Imran Hakim and Gordon Ilett

GOC Attendees: Steve Brooker (Director of Regulatory Strategy), Marie Bunby (Policy Manager), Nadia Denton (Governance Officer) *Minutes*, Kiran Gill (Head of Legal), Phillipa Mendonsa (Head of Education Operations *for item 4 only*) and Anne Wright (Chair of Council)

	New Committee member introductions
1.	Tim Parkinson introduced himself as the new Committee Chair. A round of introductions were carried out and the Committee welcomed the following new members: • Giles Edmonds • Gordon Dingwall • Amit Sharma
	Minutes from break out session held on 14 October 2022
2.	The minutes from the breakout session held on 14 October 2022 were approved as an accurate record.
	Business Regulation – advice to Council COM02(23)
3.	The Director of Regulatory Strategy introduced Deborah Drury, an external consultant from Europe Economics. Deborah presented the findings of the research into mapping of optical businesses. Committee members were asked to note that the report was confidential. The presentation was recorded.
4.	The Committee discussed the presentation in the consultant's presence where the following points were noted: • that while the report looked at ownership models overall it did not segment small husband/wife holdings, such organisations may want to be on the business register but under the current wording of the Act, cannot register; • the nature of risk had changed since the report was last undertaken in 2013, with more issues to do with clinical eye care issues, online practice and technology than ten years ago; • in relation to option 1 in the paper, the price per registrant increase was limited to new registrants; • preparation time had not been factored into the estimated cost to business of inspection, although Europe Economics clarified they had assumed preparation would be done outside of office hours.

	Europe Economic consultant left the meeting.
5.	The Committee were asked to comment on whether they thought business regulation should be extended to all businesses. They agreed with the proposal on the basis that it would be proportionate and applied consistently. In discussion it was suggested that option five, the consumer redress scheme was disproportionate and that there was no evidence that mandating engagement with the Optical Consumer Complaints Service (OCCS) was necessary. It was noted that business regulation was not widespread across all other healthcare regulators. It was suggested that the GOC should take some learnings from the process of business regulation as carried out in the pharmacy industry. It was noted that while optical businesses in Northern Ireland were subject to regular NHS inspection, this was not the case in England and it was only optical businesses with NHS contracts that had to undergo an inspection every three years.
6.	The Committee discussed the need for registrant directors within optical businesses and agreed that there should be individuals with clinical experience making key decisions within a given business, particularly in the context of legal accountability. It was noted that if the proposals went ahead and in order to create a level playing field, sole trader businesses would need to be registered as their activities carried the same level of risk from a public safety perspective.
7.	The Committee were informed that the framework to extend business regulation would take at least six to nine months to develop. It was noted that if business regulation extension went ahead the policy work would be brought back to the Committee before being presented to Council for final approval (post-consultation).
	Continuous Professional Development (CPD) Scheme one year on: an employer perspective COM03(23)
	The Head of Education Operations joined the meeting for this item only.
8.	The Head of Education Operations asked the Committee to note the paper and provide feedback regarding the Continuous Professional Development (CPD) cycle from an employer perspective. In discussion the Panel indicated that successful implementation of CPD would take a shift in mindset amongst registrants. It was suggested that the self-directional aspect required more guidance from the GOC to allow practitioners to better understand what was expected of them and to feel that the learning they were undertaking was valid. Also, that simplification of the CPD self-reflection functionality on the website would be helpful to registrants It was agreed that the move from Continuous Education Training (CET) to CPD was positive but that there were still questions about the extent to which it had been embedded into the profession with more work required from the GOC to facilitate the cultural shift required to maximise the benefits of the new approach to registrants' professional development.
	Any Other Business
9.	There was none.
	Meeting Close
10.	The meeting closed at 12:34 hours.

DRAFT minutes of the Education Committee held on Friday 10 March 2023 at 11.30am via MS Teams	
Present:	Mike Galvin (Education Committee Chair), Jacqui Adams, Dean Dunning, Sally Gosling, Andrew Logan, Frank Munro, Neil Retallic and Alicia Thompson.
In attendance:	Aaron Grell (Education Operations Manager), Lamine Kherroubi (Casework and Resolutions Administrator), Philippa Mendonsa (Head of Education Operations), Samara Morgan (Head of Education Development), Ben Pearson (Education Manager), Ivon Sergey (Governance Officer - Minutes), Allison Siveyer (CPD Development Manager) and Lisa Venables (Education Manager).

	Welcome and Apologies
1.	The Chair opened the meeting and welcomed everyone.
2.	Apologies were received from Imran Jawaid and Mary Wright.
	Minutes from break out session held on 14 October 2022
3.	The minutes of the last meeting were approved as a true record.
	EDI discussion
4.	Head of Education Operations invited views on the initial design stage of GOC regulatory approach to Equality, Diversity and Inclusion (EDI) in Education, and specifically in the approval and quality assurance of qualifications.
5.	The Committee commented there are several bodies such as educative institutions and the Government that currently drive the sector's approach to EDI. Care would need to be taken in data requirements and policy implementation ensuring that it is proportionate to the sector, and that the GOC takes into account differences, such as regional differences. The Committee sought more clarity on what datasets would be required and how the data would be analysed. The Committee suggested that the national dataset may not be the most reliable option and other data sets should be considered. There was risk that smaller departments' analysis of areas like leadership may not be representative.
6.	The Committee was advised that the GOC had insight into the approaches by the various providers to date through the adaptation processes and annual monitoring reports. These showed that there could be improvements regarding EDI data capture and analysis. The Committee suggested inviting providers to demonstrate how they incorporated EDI into their programmes for the GOC to review, which could be part of a thematic review process. It was important for the GOC to be able to explain to providers the basis of compliance of the standard and how the providers could demonstrate this.

7.	The Committee noted there were plans to review how other health care regulators and sector bodies were approaching the issue. The Committee suggested that alternative ways to meet the GOC legal and statutory duty in relation to EDI in Education should be explored.
8.	Education Committee **noted** the paper and discussed the following questions: 1. Should national datasets form part of our considerations when reviewing qualifications against our standards (and, if so, how could we use them)? 2. Should we consider provider-level datasets as well? 3. Does the committee agree that our approach to considering adverse findings of other regulators regarding EDI is sufficient? 4. How we can enhance EDI practice within GOC-approved qualifications, whilst avoiding being prescriptive?
	Andrew Logan left the meeting at 12pm
	CPD update
9.	Head of Education Development provided an update on the first year of the new CPD cycle. Completion rates were in line with previous years but there was a poor uptake of self-directed learning and feedback on any action the GOC could take was invited. The Committee commented that there was an incentive to use the many provider-led options for CPD courses as these were already GOC-approved. More guidance, including case studies and templates on what would be acceptable self-directed learning, could be helpful and could result in improved uptake.
10.	The Committee discussed how registrants may be resistant to change but it was still early days and self-directed learning needed more time to embed. It was suggested there may still be confusion regarding peer reviews and support that having a mix of registrants could be positive in bringing a richness to discussions, rather than the current single-profession peer review requirement which also brings about considerably logistical challenges for CPD providers. It was also suggested that reflective learning was still a struggle for registrants but getting into this habit would improve self-led CPD uptake. The Committee commented there could be shared learning to be gained between CPD providers, which could also determine consistency with other CPD providers.
11.	Education Committee **noted** the paper and provided feedback regarding the CPD cycle. **Action: The Committee recommended further consideration be given on how to encourage a higher proportion of self-directed learning.**
	Approval and QA update - Timetable for Education over the coming months/ SPOKE/ ETR implementation update/SSISG
12.	The Committee noted the team was fully now resourced. Education Operations Manager outlined the education visit schedule for 2023/24. A provider had been removed from the serious concerns review. Annual monitoring and reporting submissions had been received from all providers and the team was working on its quantitative and qualitative analysis. A sector report would be published in the summer 2023.
13.	Education Development Manager provided an update on 'adaptations' - providers suppling evidence of how they meet the new requirements of the Education and Training Requirements (ETR). All providers were progressing well through the process. The Committee discussed how there was initial nervousness on migration

	to ETR amongst providers 12 months ago, but providers were now fully engaged. Regular discussions with providers are alleviating any concerns.
	Alicia Thompson left the meeting at 12.30pm
14.	Education Manager provided an update on the Sector Strategic Implementation Steering Group (SSISG), which continued to discuss implementation of ETR requirements. There was continued progress between its workstreams, including a funding workshop to develop a shared understanding of funding options. SPOKE had been commissioned to establish a knowledge hub for independent therapeutic prescribing and contact lens optics. Other networking events had been held at the University of Warwick. There were no unexpected issues other than resourcing to bring in new requirements, but providers had planned mitigation measures.
	Any Other Business
	Future Education Committee Agenda Item
15.	The Committee suggested a future item of discussion around dispensing opticians' scope of practice and how the syllabus could be adapted to the new standards.
	The meeting closed at 12.50pm

STRICTLY CONFIDENTIAL
C14(23)

General Optical Council

GENERAL OPTICAL COUNCIL

DRAFT Minutes of the meeting of the Registration Committee held on Friday 10 March 2023 at 11:30am via Microsoft Teams

Present: Lisa Gerson (Chair), Geraldine Birks, Peter Black, Lynn Emslie, Louise Gow, Anthony Harvey, Ali Sansome, Roshni Samra and Catherine Viner.

Apologies: None.

GOC Attendees: Yeslin Gearty (Director of Corporate Services), Nadia Patel (Head of Registration) and Andy Spragg (Head of Governance) *Minutes*.

	Welcome and Apologies
1.	The Chair welcomed everyone to the meeting.
2.	There were no apologies.
	Minutes from break out session held on 14 October 2023.
3.	It was noted that paragraph nine, bullet point three should have included reference to "issues on validating overseas references". Subject to this minor amendment, the minutes from the breakout session held on 14 October 2022 were approved an accurate record of the meeting.
	Update on renewals
4.	The Director of Corporate Services provided a summary of progress with the current renewal cycle. The Committee discussed possible delays in providing receipts after payment. It was explained that this principally impacted registrants paying via direct debit and related to the underlying banking processes. The Head of Registration indicated that she would review the website guidance to make this clearer to registrants and proposed an alternative means by which registrants could obtain proof for the purpose of reclaiming the cost from their employer.
	International Registration
5.	The Director of Corporate Services provided an update. It was noted that the larger multiples had shared projections as to how they were supporting overseas applicants in order to manage regional workforce shortages. The Committee discussed these shortages, and it was highlighted that these were specific to certain parts of the country. The underlying causes included cultural and regional variations, and it was noted that the GOC had begun considering how it could support businesses and commissioners with understanding workforce planning data related to the register.
6.	The Committee discussed what changes might be required in the current processes to deal with the larger volume of international applicants to the register. It was noted that costs were met through charges to the applicant. There was a suggestion that costs could be reviewed to reduce the number dropping out through the process, however this was not felt by Registration to be a significant area of concern.

7.	The Committee discussed how the increased demand had led to the GOC seeking to engage more international assessors.
	DBS checks for registrants
8.	The Head of Governance presented the report and asked the Committee to note the current GOC policy position as well as the consultation response to the Professional Standards Authority (PSA) proposed strategy for 2023-26.
9.	The Committee, in considering the paper, highlighted several concerns. It was felt that there was a public perception that a regulator should establish that DBS checks are undertaken as part of its role in protecting the public. The Committee referenced the existing standards for registrants, specifically citing standard 12 “Ensure a safe environment for your patients”. Committee members commented that they felt there was limited assurance in requiring registrants to self-declare they were of good standing.
10.	The Committee commented that it would like to see more extensive DBS checks undertaken, including non-registrants in optical service settings, and was concerned that there was a lack of consistent understanding across businesses as to the need to assess and manage safeguarding risks. It was also highlighted that there were areas where this was felt particularly necessary, such as domiciliary care and special schools eye care services.
11.	The Committee expressed the view that there was a range of options in respect to the GOC assuring itself that DBS checks were done. It was suggested that the figures in the paper overestimated the cost of implementation, noting that not all registrants would require the full DBS check.
12.	The Head of Governance noted the comments and highlighted that the GOC position did not suggest DBS checks were not necessary, but that the employer and registrant were best placed to assess the risk in respect to their specific duties. It was noted that the Committee was able to advise Council if it felt that the policy regarding DBS checks needed further review.
13.	The Committee **agreed**: To formalise its advice to Council regarding a review of whether the GOC should require proof of DBS checks for registrants. It was suggested that this would be formally considered by Council at its meeting on 28 June 2023.
	Any Other Business
14.	There was no other business.
	Meeting Close
15.	The meeting closed at 12.43pm.

STRICTLY CONFIDENTIAL
C14(23)

General Optical Council

DRAFT minutes of the meeting of the Standards Committee held on Friday 10 March 2023 at 11:30am via MS Teams

Present: Kay Bagshaw, Josie Forte (Chair), Haseena Lockhat, Joy Myint, Chloe Robson, Nilla Varsani and Marcus Weaver.

Rukaiya Anwar (Council Associate)

Apologies: Nigel Best

GOC Attendees: Rebecca Chamberlain (Standards Manager), Jenny Hazell (Governance and Compliance Manager, minutes), Elisha Lindsay (Standards Officer). Leonie Milliner (Chief Executive and Registrar) and Charlotte Urwin (Head of Strategy, Policy and Standards).

	Welcome and Apologies
1.	The Chair opened the meeting and welcomed those present.
2.	Apologies were received from Nigel Best.
	Minutes from breakout session held on 14 October 2022
3.	The minutes of the breakout session held on 14 October 2022 were **approved** as a true record of the proceedings.
	Standards Review discussion, 'test conversation' and feedback
4.	The Head of Strategy, Policy and Standards introduced a report on a review of the GOC's Standards which would be focusing on the Standards of Practice for Optometrists and Dispensing Opticians and the Standards for Optical Students. The Committee was invited consider issues surrounding social media usage and online conduct, and how they related to the standards set by the GOC. This was in view of the possible need to strengthen the GOC's standards in this area. The Standards Manager facilitated the discussion by sharing a slide presentation which posed several questions to the Committee. The Committee then had a wide-ranging discussion in which a number of points were raised: <u>Use of social media</u> • There were positive ways in which registrants were using social media, including seeking and sharing advice regarding patient issues, educating other colleagues and using it for training or recruitment. • It could help create an easy interface with primary and secondary care. • It helped engage harder to reach groups.

	Issues • Patient consent – anonymised photographs of patients may be used - how much does the patient know as to what is being shared and does GDPR cover that information sharing? • The implications for using temporary online platforms such as TikTok/Snapchat. • Use of social media and different online platforms is increasing and becoming more complex – how can standards reflect the pace of change? • Users might think that the site they are using is secure, but this might not necessarily be the case. • The lines between using social media for professional reasons as opposed for personal reasons can be blurred. • Different groups of registrants may have different risk profiles, depending on their employment situation -i.e. some registrants might work for employers who have social media policies whereas others might work for employers who do not have social media policies; some registrants might be locums and some might be sole practitioners. Social media, online conduct and fitness to practise • The data for online conduct related cases (July 2022 to January 2023) – 11% of the 27 substantive hearings – is lower than expected. • Some registrants may not be aware that they can report issues relating to inappropriate social media usage at an earlier stage before it became a serious issue. • The difficulties of 'policing' inappropriate social media usage. • Some of the larger businesses have a social media policy and others do not. • Including a standard in business standards on having a social media policy could be helpful for the business sector. • Registrants may not recognise that inappropriate use of social media in their private lives may impact on their registration and fitness to practise with the GOC. Existing GOC Standards • Concern that some registrants may think that they can use social media inappropriately and not suffer any adverse consequences or be held accountable for their behaviour. • The standards need to make it clear that use of social media can include not just professional postings but personal postings as well. • Inappropriate use of social media overlaps with other standards such as harassment and discrimination. • Having separate GOC guidance on use of social media would be helpful and would also endorse the GOC's standards. • It would be helpful to include a positive duty for a registrant to take action when they see concerning behaviour of other registrants.
	Any Other Business
5.	It was agreed that the following topics relating to the GOC's standards be discussed at the next meeting in June 2023: • Supervision • Sustainability • Equality, Diversity and Inclusion

6.	**The meeting closed at 12:42pm.**

Council Catch-up 25 April 2023
-
Council Catch-up 23 May 2023
-
Council Meeting (Strictly Confidential) 27 June 2023
For decision - **For discussion** - Strategic risk discussion - Legislative / Regulatory Reform **For noting** - Corporate Policies - Governance Review Progress Report - Committee updates - Council papers for the public session
Council Meeting (Public) 28 June 2023
For decision - **For discussion** - FtP Improvement Programme Update - PSA performance review - Legislative Reform - Public perceptions survey - Registrant survey - Q4 financial and performance reports - Balanced Scorecard - Business Plan Assurance Report Q4 **For noting** - Chair / CEO report - OCCS Annual Report - Advisory Panel minutes
Council Catch-up 11 July 2023
-
Council Catch-up 5 September 2023
-
Council Meeting (Strictly Confidential) 26 September 2023
For decision - **For discussion** - Strategic risk discussion - Legislative / Regulatory Reform **For noting** - Corporate Policies - Governance Review Progress Report - Committee updates - Council papers for the public session
Council Meeting (Public) 27 September 2023

For decision - Annual report and financial statements - ARC annual report - Equality, Diversity and Inclusion: monitoring report **For discussion** - Regulatory Reform and Call for Evidence Update - Council member appointments - Q1 financial and performance reports - Balanced Scorecard - Business Plan Assurance Report Q1 **For noting** - Chair / CEO Report -
Council Catch-up 3 October 2023
-
Council Catch-up 14 November 2023
-
Council Meeting (Strictly Confidential) 12 December 2023
For decision - **For discussion** - Strategic risk discussion - Legislative / Regulatory Reform **For noting** - Corporate Policies - Governance Review Progress Report - Committee updates - Council papers for the public session
Council Meeting (Public) 13 December 2023
For decision - **For discussion** - H&S assurance report - FTP Update - Council's Trustee Duty responsibilities and PSA regulatory responsibilities assessment review - Q2 financial and performance reports - Balanced Scorecard - Business Plan Assurance Report Q2 **For noting** - CEO / Chair Report - Advisory Panel minutes
Council Catch-up 9 January 2024
-
Council Catch-up 20 February 2024
-
Council Meeting (Strictly Confidential) 12 March 2024

For decision
-

For discussion
- Strategic risk discussion
- Legislative / Regulatory Reform

For noting
- Corporate Policies
- Governance Review Progress Report
- Committee updates
- Council papers for the public session

Council Meeting (Public) 13 March 2024

For decision
-

For discussion
- Accreditation and quality assurance
- Balanced Scorecard
- Council's Trustee Duty responsibilities and PSA regulatory responsibilities assessment review
- Q3 financial and performance reports
- Business Plan Assurance Report Q3
- FTP Audit of decisions
- Budget and Business Plan for 2023/24

For noting
- Chair / Chief Executive Report
-