Risk in the optical professions

Final report

General Optical Council

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Contents

Executive Summary

Introduction

This research report on behalf of the General Optical Council (GOC) is a review of risk in the optical professions of optometrists and dispensing opticians.

The GOC requires an up to date understanding of risk in the optical professions it regulates to inform its regulatory work and undertake any future interventions within the sector that are proportionate to the level of risk. The GOC last undertook a review of risk in 2010 and since then the optical sector has evolved in various ways.

This report aims to understand the main competency, conduct and contextual risks for optometrists and dispensing opticians, whether these risks have changed since 2010 and whether they are likely to change in the near future. As this research has been conducted on behalf of the GOC, whose remit is to regulate the optical professions and protect patients and the public, 'risk' is defined as the risks that may be posed to patients and the public by the optical professions.

The majority of findings of this research are based on the perceptions and experiences of GOC registrants and stakeholders in relation to risk, as there is limited empirical data concerning risk in the optical professions. Where empirical data has been analysed (previous research, GOC complaints data), this has been compared and contrasted with the perceptions and experiences of the profession.

This research was conducted by Enventure Research, an independent research agency.

Methodology

A phased mixed-method approach was employed, including primary and secondary research. The primary research included:

- An online survey of the optical sector to understand perceptions and experiences of risk
- Qualitative research in the form of focus groups and in-depth interviews with GOC registrants and key stakeholders to further explore perceptions and experiences of risk and better understand the results from the online survey

The secondary research included analysis of two existing data sources - GOC Fitness to Practise (FTP) data and the Optical Consumer Complaints Service (OCCS) data. Both datasets were extracted over the same two year period (April 2016 to April 2018) and were analysed to provide insight into concerns raised by patients and the public, highlight any patterns or trends, and to make comparisons with the findings of the primary research to understand how the data sits alongside perceptions and experiences of risk from within the sector.

Additionally, a review of relevant literature was conducted, which has been referenced where relevant throughout this report.

A more detailed description of the methodology for this research can be found in chapter 2 of this report.

Summary of the key findings

The following pages present some of the key findings from this research, following the structure of the report.

Perceptions of level of risk in current optical practitioner roles
Areas of practice for optometrists viewed to have the highest level of risk included independent prescribing, management of ocular disease, detecting ocular disease and referral decisions. By contrast, areas of practice related to contact lenses and the eye examination/sight test were viewed as having lower levels of risk. The research highlights the perception that areas of practice relating to the detection and management of ocular disease have potentially greater levels of severity in terms of the risk they pose to patients, combined with the fact that optometrists tend to have less experience in these areas of practice.

For areas of practice for dispensing opticians, detecting ocular disease and referral decisions are perceived as having the highest level of risk, in contrast to more routine areas of practice such as fitting spectacles and understanding the visual needs of patients. Dispensing opticians understand that their role involves less risk than optometrists, but still see some element of risk in their role, particularly in areas where they have less experience or scope.

In comparison to other healthcare professions such as nurses, pharmacists and dentists, it is widely accepted that the roles of optometrist and dispensing optician involve lower levels of risk to patients and the public. However, it is also acknowledged that these roles do pose some risk, particularly as roles develop and become more clinical, with professionals becoming more involved in the detection and management of ocular disease.

Risk factors perceived to be the most likely and most severe
The survey results show that contextual risks were viewed as most likely to occur in practice, including:

- Time constraints with patients
- Commercial and performance target pressure
- Poor or inadequate staffing
- Working as a locum

In contrast, conduct and competency risks were viewed as less likely to occur, including:

- Inappropriate behaviour towards patients or colleagues
- Not maintaining confidentiality
- Physical or mental health concerns
- Misdiagnosis or failure to detect disease

Competency and conduct risk factors were perceived to have the highest level of potential severity if they occurred in practice, including:

- Misdiagnosis or failure to detect disease
- Failure to refer or inappropriate referral
- Inappropriate behaviour towards patients or colleagues
- Not maintaining confidentiality

It is interesting to note that many risk factors that were viewed as more severe were also viewed as less likely to occur, and vice versa.

As presented in ***Figure 15*** on page 44, combining both likelihood and potential severity of risk factors together shows that the highest ranked risks were:

- Time constraints with patients
- Commercial or performance target pressure
- Misdiagnosis or failure to detect disease

- Failure to refer or inappropriate referral

A wide range of competency, conduct and contextual risk factors were covered as part of this research in both the quantitative and qualitative phases. Further analysis of these factors can be found in chapters 6, 7 and 8 of this report.

FTP and OCCS data analysis

The secondary data analysis, conducted on data extracted between 1 April 2016 and 30 April 2018 following the introduction of the GOC's new Standards of Practice for Optometrists and Dispensing Opticians, comprised of 376 FTP cases and 2,911 OCCS complaints.

Analysis of the allegations received for each FTP case highlights that the most common allegations related to:

- Incorrect or missed diagnosis
- Inappropriate or missed referrals
- Failure to conduct appropriate tests or examinations
- Incorrect/inappropriate/incomplete prescriptions provided
- Inaccurate/inadequate advice provided
- Poor record keeping

As the majority of FTP cases related to optometrists, the allegations listed above are reflective of this role. However, the most common allegations for dispensing opticians related to police charges, investigations, arrests, cautions or convictions, and dishonesty.

Almost half of allegations (45%) were categorised as clinical in nature, with 40% categorised as non-clinical and 16% as both. A larger proportion of clinical allegations related to optometrists in comparison to dispensing opticians, and likewise a larger proportion of non-clinical allegations related to dispensing opticians. Allegations were additionally categorised by the type of risk they related to, which highlighted that cases were almost equally split between allegations related to competency, conduct or both, with optometrists more likely to face allegations related to competency only and dispensing opticians more likely to face allegations relating to conduct only.

The most common standard breached as a result of the allegations was Standard 5 – *Keep your knowledge and skills up to date*. This was closely followed by Standard 7 – *Conduct appropriate assessments, examinations, treatments and referrals* and Standard 17 – *Do not damage the reputation of your profession through your conduct*.

Analysis of the OCCS data shows that the largest proportion of complaints received related to 'goods and service' (43%), which includes errors in prescription, dispensing, outcomes of laser eye surgery and prescriptions prescribed in one practice and dispensed in another. A significant proportion (28%) related to 'customer care', including complaint handling, attitude, delays in supply and failure to deal with concerns/complaints.

Over half of FTP cases related to multiple/chain practices (51%), followed by 37% from independent practices. Although the origin of a large proportion of OCCS complaints was unknown, 26% related to multi-site corporations and 18% to franchises.

Whilst this secondary data analysis represents real-life empirical data, it can only be indicative of risk within the optical professions. Consideration of this data alone does not provide a truly representative picture of risk in the sector, as these cases and complaints are likely the result of the poor management of risk, as opposed to other risks in the profession which are well managed and do not reach FTP or result in a complaint.

Changes in the optical sector and the impact on risk

The majority of survey respondents agreed that the level of risk associated with optometrists is changing. This contrasts to the proportion who agreed that the level of risk associated with dispensing opticians is changing which was lower. A wide range of factors are seen to have changed the way optical services are delivered.

The changing scope of optical professionals

- There is a perceived increased risk to patients as a result of changes to optical practitioner roles as more clinical roles and responsibilities are undertaken
- However, some feel the risk to patients has not changed or is being managed effectively via education and training
- Others believe that the level of risk to patients is actually reduced as a result of changes to optical professional roles, as access to optical care is improving and optical practitioners are often better qualified to deal with certain conditions
- There are risks posed to patients by the use of non-registered optical assistants, especially when some tasks should be performed by dispensing opticians

Development of technology and artificial intelligence

- Some believe that developments in technology reduce risk to patients as optical conditions and disease can be much more easily diagnosed, and electronic patient records can increase accuracy
- However, some see increased risk, particularly in the interpretation of the results generated by technology (possibly by artificial intelligence), increased automation resulting in less interaction between professionals and patients, and over-reliance on technology and potential de-skilling of professionals

Population changes

- Population changes focused almost exclusively on the ageing population and the impact this was having on the NHS, with many optical services moving from secondary care to community optical practice as a result
- This means there is increased likelihood that optical professionals will encounter more complex needs, including potentially higher risk eye conditions such as glaucoma and age-related macular degeneration

Changes to the NHS

- High levels of awareness that the NHS is under increasing strain in terms of capacity and resources, driven by an ageing population and funding
- This has led to the movement of optical services from secondary care to the community setting, meaning that optical professionals are being required to upskill and take on more clinical roles and responsibilities, thereby potentially increasing the risk the professions pose to patients and the public

Changes in consumer expectations and behaviour

- Perception that patients have increasingly high standards, and are also becoming increasingly litigious
- Some patients are now more likely to visit different opticians over a number of years, rather than returning to the same location, thereby increasing potential risks in relation to continuity of care
- The public is slowly becoming more aware that they can visit an optician if they have a problem with their eyes, meaning that optical professionals are more likely to encounter more complex, and therefore potentially higher risk conditions and patients
- The online sale of spectacles and contact lenses was perceived to pose a significant risk to patients and the public, particularly due to the reduced involvement of optical professionals and for patients with complex needs. It was also suggested that there needs to be improved regulation of online sales, with a focus on contact lenses, where the risk was seen to be greater due to the type of product and the increasing number of unregulated companies operating outside the UK

Future risk

The most common suggestions for the main risks to patients and the public in the next five years were commercial pressures, targets and time constraints, pressure on hospital services, the quality of education and training, and unregulated online sales.

It is generally viewed that, in the near future, the sector will continue to change in the same ways that it has in the last ten years, including the changing scope of optical professionals, developments in technology and artificial intelligence, population changes, changes to the NHS, and changes to consumer expectations and behaviour. The main concerns expressed in relation to risk to patients included:

- As optical professional roles continue to change, the services delivered will continue to expand and become more clinically focused, particularly for optometrists
- The use of non-registered optical assistants may increase, potentially placing patients at risk and also devaluing the dispensing optician role
- The population will continue to get older, continuing to place more pressure on the NHS, resulting in more services moving into primary care
- Undergraduate education and training needs to adapt to the recent and future changes to ensure newly qualified optical professionals are adequately prepared for practice
- Continuing education and training (CET) also needs to adapt to help registrants manage risk in the near future, possibly moving to a system of continuing professional development to prevent practitioners maintaining a basic skill and knowledge level
- As technology and artificial intelligence continue to develop, this could lead to increased automation and reduction in the role of optical professionals, which could increase the level of risk to patients
- Online sales are likely to continue to increase, and therefore there is a need for improved regulation in this area, as well as increased communication to the public about the potential risks

Conclusions

This research has provided a wealth of insight into risk in the optical professions which will help to inform future interventions within the optical sector employed by the GOC, ensuring that they are proportionate to the level of risk. The main conclusions drawn from the research by Enventure Research, based on both the primary research (online survey, focus groups, in-depth interviews) and secondary research (analysis of FTP and OCCS data) are as follows:

- Potential risks have changed since 2010, but the sector has adapted to manage them
- Optometrists and dispensing opticians continue to be viewed as low risk
    - Increased risks are managed through education, training and a culture of risk aversion
    - There are differences in levels of risk due to professional role and workplace setting
    - The optical professions are viewed as low risk in comparison to other healthcare professions, such as dentistry, pharmacy and nursing
- The sector will continue to change in the same ways in the near future, and can continue to adapt if appropriate action is taken
- Competency risks related to ocular disease are viewed as potentially more severe
    - The riskiest areas of common practice are perceived to be those related to ocular disease
    - Competency risk factors related to ocular disease are viewed as having potentially high levels of severity, but as less likely to occur in practice
    - Mitigating the risk of missed referrals through cautious practice is increasing inappropriate referrals, which is impacting on other risks
    - Competency risks related to more routine areas of practice are viewed as less severe
- The conduct risks of poor communication with patients and not being honest when things go wrong could be better managed
    - The risk of poor communication with patients may become more severe in the future
    - Whilst awareness of duty of candour has increased, professionals are still fearful of admitting mistakes
- Contextual risks are perceived to be more likely to occur in practice and can impact on other risks

    - Contextual risks are perceived as more likely to occur in practice compared to competency and conduct risks
    - Time constraints with patients can exacerbate other risks
    - Perceptions of locum working are changing, but it is still seen to be higher risk than permanent employment
    - The risk of remote or isolated practice has been significantly mitigated through changes to CET
- Systems risks also have an impact on the level of risk posed to patients
- Levels of risk can vary for certain patient groups
- Education and training needs to evolve to help manage risk in the future
    - Undergraduate education and training needs to evolve to prepare newly qualified practitioners for a changed optical sector
    - The current system of CET needs to develop, possibly into CPD, to foster development within the sector
- There is a need to develop clearer definitions for optical professional roles
- Management of the future risk posed by online sales may be required
- Improvements could be made to the recording and communication of FTP data and the sharing of optical insurance data

1. Introduction

1.1 Background

1.1.1 The General Optical Council (GOC) is the regulator for the optical professions of optometry and dispensing optics in the UK, with a mission to protect and promote the health and safety of the public. To inform regulatory policies and interventions, the GOC needs to understand the risks that the optical professions pose to patients and members of the public, now and in the near future.

1.1.2 Previous research into risk in the sector was conducted by the GOC in 2010. This research did not identify any major risks in the optical professions, but found those identified, were limited to practitioners not conducting all appropriate eye health tests or not eliciting full patient symptoms, and issues around communication. There was no evidence of high risk due to mismanagement or misdiagnosis of eye health conditions.[1]

1.1.3 However, since then the sector has evolved in various ways, including an increasingly ageing population, advances in technology, and changes to the NHS, which have had an impact on the way that optical services are delivered across the UK. As a result, the work optometrists and dispensing opticians carry out has diversified, with many expanding their skill set to deliver a range of eye care services in community or hospital settings as part of multi-disciplinary teams.

1.1.4 The GOC therefore requires an up to date understanding of risk in the optical professions it regulates. This information will enable the GOC to undertake any future interventions within the sector that are proportionate and effective to the level of risk.

1.2 The research questions

1.2.1 This research was designed to address the following primary research questions:

- What are the main competency, conduct and contextual risks for optometrists, including those in general clinical practice and those that undertake specialty independent prescribing?
- What are the main competency, conduct and contextual risks for dispensing opticians, including those in general clinical practice and those who undertake specialty contact lens dispensing?

1.2.2 Secondary research questions that were also to be addressed by this research included:

- Have the risks changed since 2010?
- Are risks likely to change over the next five years?
- Are there any other risks identified outside competency, conduct and contextual risks (e.g. systems risks)?

[1] Europe Economics. (2010). *Risks in the Optical Profession: Final Report*, p.ix

1.3 The professions regulated by the GOC

1.3.1 An optometrist examines eyes, tests sight and prescribes spectacles or contact lenses for those who need them. They also fit spectacles or contact lenses, give advice on visual problems and detect any ocular disease or abnormality, referring the patient to a medical practitioner if necessary. Optometrists may also share the care of patients who have chronic ophthalmic conditions with a medical practitioner. Once qualified, optometrists can undertake further training to specialise in prescribing therapeutic drugs for chronic eye conditions.

1.3.2 A dispensing optician advises on, fits and supplies the most appropriate spectacles after taking account of each patient's visual, lifestyle and vocational needs. Dispensing opticians play an important role in advising and dispensing low vision aids to those who are partially sighted as well as advising on and dispensing to children where appropriate. They are also able to fit and provide aftercare for contact lenses after undergoing further specialty training. On completion, practitioners are placed onto a specialty register. Career opportunities also exist to develop business skills in marketing and practice management.

1.4 The definition of risk

1.4.1 As this research was conducted on behalf of the GOC, whose remit is to regulate the optical professions and protect patients and the public, when understanding 'risk', this is defined as the risks that may be posed to patients and the public by the optical professions.

1.4.2 This research focusses on the competency, conduct and contextual risks that the optical professions may pose to patients and the public. Each type of risk is defined below:

- Competency risks – Risks resulting from practitioners lacking the necessary skills or knowledge to diagnose and manage diseases and conditions, or to use appropriate equipment
- Conduct risks – Risks stemming from the behaviour of practitioners, either through negligence or inappropriate behaviour
- Contextual risks – Features of the environment in which a practitioner operates that may increase the scope for risk, or influence the severity or likelihood of clinical and competency risks; for example, isolated practice

1.4.3 The majority of findings of this research are based on the perceptions and experiences of GOC registrants and stakeholders in relation to risk, as there is limited empirical data concerning risk in the optical professions. Where empirical data has been analysed (previous research, GOC complaints data), this has been compared and contrasted with the perceptions and experiences of the profession.

2. Methodology

2.1 Overview

2.1.1 A phased mixed-methodology approach, including both quantitative and qualitative methods, was taken to deliver this research, including:

- An online survey of the optical sector, including all GOC registrants and key stakeholders
- Focus groups and in-depth interviews with GOC registrants
- In-depth interviews with key stakeholders from the optical sector
- Analysis of secondary data sources, including Fitness to Practise data, Optical Consumer Complaints Service data, and a review of relevant literature

2.2 Risk in the optical professions survey

2.2.1 A questionnaire was designed by Enventure Research and the GOC which took respondents approximately 10 minutes to complete. It was designed to allow completion by a range of audiences, including GOC registrants and various optical sector stakeholders. For reference, a copy of the questionnaire can be found in **Appendix A**.

2.2.2 The survey was designed to collect data in relation to perceptions of risk within the optical sector based on direct or indirect experience. Specifically, questions were asked to explore:

- Which common areas of practice for optometrists and dispensing opticians were perceived to carry the greatest level of risk
- How likely certain risks were to occur in practice, and if so, how severe those risks might be for patients and the public
- What factors most influenced the way that optical services are delivered, and to what extent the level of risk associated with optometrists and dispensing opticians was changing
- What the main risks to patients and the public may be in the next five years
- Characteristics of respondents (e.g. profession, qualifications, workplace setting, demographics etc.)

2.2.3 As this was a piece of research, rather than a consultation, stakeholders were encouraged to take part in the survey with their individual views, rather than on behalf of any organisation that they may work for or represent, in order to collect open and honest views. Respondents were assured that the data they provided would be treated in confidence and that they would remain anonymous in the research.

2.2.4 In total, 2,610 response to the survey were received. The majority of respondents took part as individual GOC registrants (87%), 4% as optical business registrants, 4% as optical employers, and the remaining 5% as some form of optical stakeholder. This represents a response rate of approximately 8% of individual GOC registrants and 4% of optical business registrants. ***Figure 1*** overleaf presents the breakdown of survey respondent types.

Figure 1 – Survey respondent type
Base: All respondents (2,610)

Respondent type	Number	% of all respondents
Individual GOC registrant	2,275	87%
Optical business registrant	107	4%
Optical employer	95	4%
Employee of an optical professional body	59	2%
Employee of an education/training provider	31	1%
Employee of a healthcare regulator	12	0%
Employee of an optical defence/representative organisation	5	0%
Employee of an optical insurer	2	0%
Commissioner of optical care	1	0%
Other	23	1%

2.2.5 Of those who responded to the survey as individual GOC registrants, 64% were optometrists and 29% were dispensing opticians. A total of 7% indicated that they were a student optometrist or dispensing optician. A more detailed profile of survey respondents can be found in **Appendix B**.

2.2.6 The table at ***Figure 2*** below shows where survey respondents mainly worked.

Figure 2 – Country
Base: All respondents (2,610)

Country	Number	% of all respondents
England	2085	80%
Scotland	242	9%
Wales	160	6%
Northern Ireland	67	3%
Outside the UK	56	2%

2.2.7 A more detailed profile of survey respondents, including additional workplace information and demographics, can be found in **Appendix B**.

2.3 Qualitative research with registrants

2.3.1 A series of focus groups was conducted with GOC registrants, split between optometrists and dispensing opticians to take into account the differences in role and potential level of risk. Nine focus groups were held in total, stratified across the country. In-depth interviews were conducted over the telephone with optometrist and dispensing optician registrants in Northern Ireland, and with dispensing opticians in Wales, where recruitment for full focus groups proved difficult. The table in ***Figure 3*** overleaf shows the stratification of the qualitative research with registrants.

Figure 3 – Stratification of qualitative research with registrants

Location	Format	Role	Additional stratification
England (North)	Focus group	Optometrist	Mix of practice settings, number of years registered, gender, age, ethnicity
	Focus group	Dispensing optician	
England (Midlands)	Focus group	Optometrist	
	Focus group	Dispensing optician	
England (South)	Focus group	Optometrist	
	Focus group	Dispensing optician	
Scotland	Focus group	Optometrist	
	Focus group	Dispensing optician	
Wales	Focus group	Optometrist	
	In-depth interview x 3	Dispensing optician	
Northern Ireland	In-depth interview x 4	Optometrist	
	In-depth interview x 2	Dispensing optician	

2.3.2 A discussion guide was designed to revisit some areas covered in the survey in order to stimulate discussion and explore the reasons behind the results in greater depth, as well as other areas that were not suitable to be covered in an online survey format. A copy of the registrant discussion guide can be found in **Appendix C**.

2.3.3 Between five and eight participants attended each focus group, and further in-depth interviews were conducted one-on-one (62 participants in total). Qualitative research fieldwork with registrants took place in April 2019.

2.4 Qualitative research with stakeholders

2.4.1 A wide range of stakeholders from the optical sector took part in qualitative research via in-depth interviews, which allowed the topic of risk to be covered in significant depth in a one-on-one scenario.

2.4.2 The GOC produced a list of key stakeholders and organisations for potential participation in the in-depth interviews to ensure a representative spread of stakeholders across the sector was achieved.

2.4.3 ***Figure 4*** below and overleaf lists all the stakeholders who took part in the research and gave their consent to be identified in this research. Verbatim quotations have been used where relevant from these interviews as evidence of certain viewpoints, but these have only been attributed to organisations or individuals where consent was provided and quotations were approved.

Figure 4 – Optical stakeholder interview participants

	Organisation	Name	Title	Stakeholder category
1	Association for Independent Optometrists and Dispensing Opticians	Christian French	Chairman	Professional association
2	Association of Optometrists	Peter Hampson	Clinical Director	Professional association
3	Association of British Dispensing Opticians (ABDO)	Barry Duncan	Deputy Chief Executive	Professional association
4	College of Optometrists	Dr Mary-Ann Sherratt	Chair of the Board of Trustees	Professional association
5	Federation of Ophthalmic and Dispensing Opticians (FODO)	Harjit Sandhu	Managing Director	Professional association
6	Federation of Ophthalmic and Dispensing Opticians (FODO)	David Hewlett	Group Director for Leadership, Transformation and Strategic Partnerships	Professional association

	Organisation	Name	Title	Stakeholder category
7	British Contact Lens Association (BCLA)	Cheryl Donnelly	Chief Executive Officer	Professional association
8	Royal College of Ophthalmologists	Mike Burdon	President	Professional association
9	Boots Opticians	Claire Slade	Director of Professional Services	Large employer
10	Asda Opticians	Paul Milligan	Deputy Superintendent Optometrist	Large employer
11	Vision Express	Meena Ralhan	Optical Compliance Officer	Large employer
12	Individual views	Mike Horler	Ophthalmic Director	Large employer
13	Anonymous	Anonymous	Anonymous	Large employer
14	University of Hertfordshire	Richard Hollingsworth	Senior Lecturer	Educational institution
15	Wales Optometry Postgraduate Education Centre (WOPEC)	Nik Sheen	Director	Educational institution
16	ABDO Exams	Alicia Thompson	Director of Professional Examinations	Awarding Body
17	Individual views	Liam Kite	Course Leader	Educational institution
18	Anonymous	Anonymous	Anonymous	Educational institution
19	SeeAbility	Lisa Donaldson	Head of Eye Health	Charity/patient organisation
20	Royal National Institute of Blind People (RNIB)	Helen Lee	Policy and Campaigns Manager	Charity/patient organisation
21	Patient Safety Learning	Helen Hughes	Chief Executive	Charity/patient organisation
22	Macular Society	Cathy Yelf	Chief Executive	Charity/patient organisation
23	Blind Veterans UK	Paul Hartley	Lead Rehab. Officer for People with Visual Impairment	Charity/patient organisation
24	Optometry Wales	Sali Davis	Chief Executive	National organisation
25	Welsh Government	David O'Sullivan	Chief Optometric Advisor	National organisation
26	Optometry Scotland	Frank Munro	Clinical Advisor	National organisation
27	Scottish Government	Janet Pooley	Optometric Advisor	National organisation
28	Moorfields Eye Hospital	Sarah Canning	Head of Optometry	Secondary care commissioner/provider
29	Individual views	Holly Higgins	Optometrist	Secondary care
30	Individual views	Rachel Pilling	Consultant Ophthalmologist	Secondary care
31	Individual views	John Sparrow	Consultant Ophthalmologist	Secondary care
32	NHS England and NHS Improvement	Carol Reece	Head of Dental & Optical Services Commissioning	Optical commissioner
33	NHS England (London Region)	Poonam Sharma	Lead Optometry Advisor	Optical commissioner
34	Health and Social Care Board	Raymond Curran	Head of Ophthalmic Services	Optical commissioner
35	Primary Eyecare Services	Dharmesh Patel	Chief Officer	Optical commissioner
36	Optical Consumer Complaints Service (OCCS)	Jennie Jones	Head of OCCS	Other
37	Vision UK	Matt Broom	CEO	Other

2.4.4 In-depth interviews followed a specifically designed interview guide to allow all relevant topics to be covered, some of which were tailored for each stakeholder group. As with the registrant focus groups, results from the survey were used as talking points to generate discussion. A copy of the in-depth interview guide can be found in **Appendix D**.

2.4.5 In total, 37 optical sector stakeholders were interviewed between April and June 2019.

2.5 Analysis of secondary data sources

Fitness to Practise data

2.5.1 To provide additional insight into risk in the optical professions, an analysis of the GOC's Fitness to Practise (FTP) data was conducted in order to highlight any patterns or trends in the types of cases raised in recent years. This data is based on complaints received and processed by the GOC through its Fitness to Practise procedures, where each case is reviewed by a panel of case examiners to decide whether there is a realistic prospect that the allegations raised against the registrant impaired their fitness to practise to a degree that justifies action being taken against their registration. If so, the case is referred to the Fitness to Practise Committee (FTPC) to consider further and take action if required. If not, a warning or remediation may be issued, or alternatively no action may be taken.

2.5.2 It is important to note that this analysis is based on cases opened as a result of complaints received, and not on the outcomes of FTP proceedings, in order to highlight concerns raised by patients and the public and provide further insight into potential areas of risk. Analysis of the outcomes of FTP proceedings is already conducted by the GOC and can be found in its Annual Reports, published on the GOC website.

2.5.3 Conducting an analysis of the GOC's current FTP database would provide basic topline information, as currently limited information is collated and recorded for each case within the database for case tracking purposes (full case information is contained on separate case files for each complaint and the outcome reports for each complaint case which is resolved by a case examiner or FTP panel). For example, in the database, a case allegation is only assigned a single category of allegation, when in reality there may be multiple allegations. Furthermore, administratively it is currently only possible to record two breached Standards to a case on the current database system, when in reality the case may be considered against three or more, and it is also not possible to know whether the information recorded refers to the latest Standards of Practice (April 2016) or the previous Code of Conduct for Individual Registrants (pre April 2016). Therefore, additional categorisation of the FTP database was required to enable a greater level of analysis.

2.5.4 A process of categorisation was developed between the GOC and Enventure Research, where redacted case examiner reports would be read to allow new data to be categorised and a new database developed for analysis. This included the categorisation of:

- Whether the individual has a history of FTP proceedings
- All GOC Codes or Standards that have been breached
- Detailed allegation(s)
- Whether the allegations were clinical, non-clinical or both
- The outcome of the process (whether allegations passed or failed the 'realistic prospect test' at stage 1, stage 2, or whether the case was referred to FTP)
- Any remediation/learning advised
- Any warnings issued

2.5.5 A specification for the range of FTP cases to export for analysis was agreed. This included all closed cases raised between 1 April 2016 and 30 April 2018, following the introduction of the GOC's new Standards of Practice for Optometrists and Dispensing Opticians, which came into effect on 1 April 2016. This extract included cases raised against the latest version of the Standards, as well

as the previous Code of Conduct for individual registrants (pre April 2016), Code of conduct for Business Registrants and Standards for Optical Students (from 1 April 2016), as this depends on the date of the allegation, which may have been prior to April 2016. In total, 376 FTP cases were redacted and exported for analysis.

2.5.6 The case reports were categorised accordingly and a list of categories for each area of data (e.g. allegations, warnings etc.) was developed, creating a new database ready for analysis.

2.5.7 Analysis of this data can be found in chapter 11.1 of this report. It is also referenced where relevant throughout other chapters to support the quantitative and qualitative primary research.

Optical Consumer Complaints Service data

2.5.8 The Optical Consumer Complaints Service (OCCS) is an independent and free mediation service for consumers (patients) of optical care and the professionals providing that care, funded by the GOC. All opticians and optometry practices have their own internal complaints procedure to deal with any complaints raised by consumers and most concerns are normally resolved informally. If a consumer and practitioner cannot resolve the complaint, either can refer the complaint to the OCCS, who then review the complaint and help to find an impartial and fair resolution. The OCCS will refer the complaint to the GOC if it considers that the complaint raises fitness to practise issues.

2.5.9 To complement the research and support the analysis of the Fitness to Practise data, data supplied by the OCCS has also been analysed to assess any patterns or trends in the types of complaints that have been raised by patients.

2.5.10 To provide consistency, the OCCS data analysed included all cases received between April 2016 and April 2018, following the introduction of the GOC's new Standards of Practice for optometrists and dispensing opticians, which came into effect on 1 April 2016. This totalled 2,911 cases.

2.5.11 Analysis of this data can be found in chapter 11.2 of this report. It is also referenced where relevant throughout other chapters to support the quantitative and qualitative primary research.

Optical insurance data

2.5.12 To provide further insight and context for this report, optical insurance data was sought out from the main providers within the sector. The Association of Optometrists provided statistics on the number of cases per year between 2012 and 2018, along with the condition types between 2017 and 2018. However, no further insurance data was collected, as other organisations were unable to provide this information at this time due to commercial sensitivity or lack of available data, meaning that no analysis has been conducted in this area for this report.

2.5.13 In the conclusions drawn in chapter 12 it is recommended that the sharing of optical insurance data across the sector could be potentially beneficial to help better understand patient concerns and complaints in order to improve patient care.

2.6 Literature, publications and other research

2.6.1 To help inform the research, including design of the questionnaire, discussion and interview guides, and to provide additional insight and context to this report, a number of publications have been reviewed.

2.6.2 Previous GOC research and consultation reports have been included within this review, as a number of topics related to risk within the optical professions have been touched upon in recent years and have provided additional insight and context for this research. Other sources including articles, journals and consultation and research reports, primarily found via online searches, have also been reviewed. In general, most sources related to specific clinical risks within optometry, with only a few being related to competency, conduct or contextual risks. Relevant findings from these sources have been referenced throughout this report to help provide context to the research and to support or contrast with the findings where appropriate.

2.6.3 In total, 37 sources have been utilised. A list of sources referenced can be found in the bibliography in chapter 13.

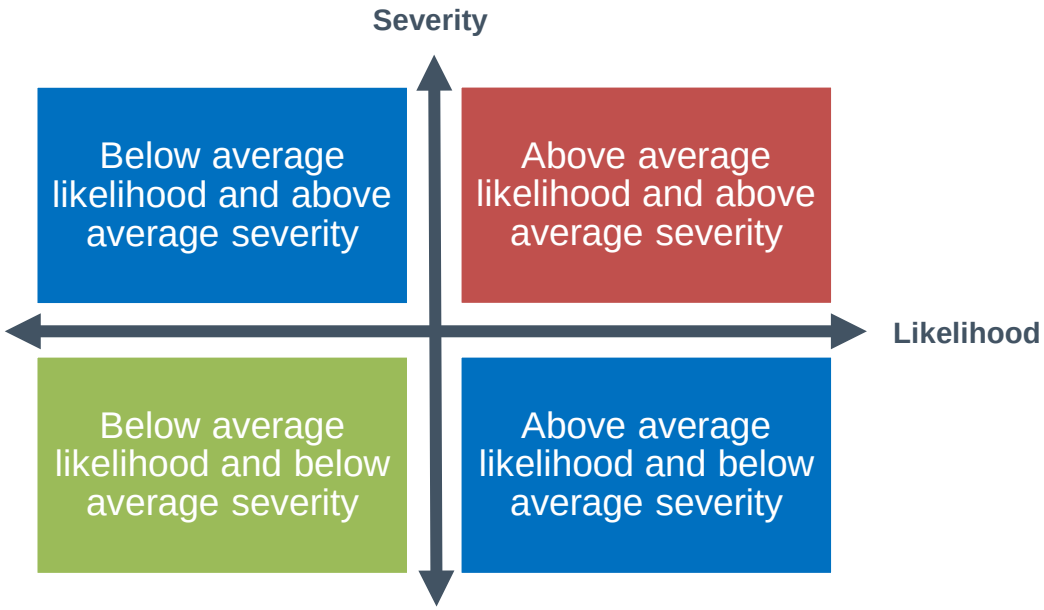
3. Reading this report

3.1 Interpreting survey data

3.1.1 For many questions in the online survey, respondents were able to provide their response on a scale of one to five, where the numbers related to degrees of a scale. For example, respondents were asked to indicate their perceived level of risk for certain aspects of practice, where one was no risk and five was a high level of risk. Similarly, respondents were able to indicate likelihood of risk occurring in practice, where one was never and five was frequently. Where these scales are used, mean scores have been generated for analysis. For example, where respondents were able to indicate how likely a risk could be, a higher mean score would indicate a higher level of risk.

3.1.2 The calculated mean scores for these questions are visually presented in charts. In some cases, these are presented in quadrant charts to present combined perceptions of likelihood and severity of risk factors. Risk factors that fall towards the right of the vertical axis were perceived to be more likely to occur in practice, whereas those towards the left were perceived to be less likely to occur. Risk factors that are above the horizontal axis are perceived to be more severe to patients if they occurred in practice, whereas those below are perceived to be less severe. The axes lines on these charts present the average likelihood and severity for all risk factors included in the survey. ***Figure 5*** below shows how to interpret these charts.

Figure 5 – How to interpret quadrant charts used in this report



3.1.3 This report contains a number of tables and charts used to display survey data. In some instances, the responses may not add up to 100% or the base size may differ between questions. There are several reasons why this might happen:

- The question may have allowed each respondent to give more than one answer
- A respondent may not have provided an answer to the question, as questionnaire routing allowed certain questions to only be asked to specific groups of respondents (e.g. registrants, other stakeholders)
- Only the most common responses may be shown in the table or chart
- Individual percentages are rounded to the nearest whole number so the total may come to 99% or 101%

- A response of less than 0.5% will be shown as 0%

3.1.4 Where possible, analysis has been undertaken to explore the survey results by different subgroups, including (but not limited to) respondent type (registrant or stakeholder), professional role (optometrist or dispensing optician), workplace setting, length of registration and country. This analysis has only been carried out where the sample size is seen to be sufficient to enable confident statistical analysis. Where sample sizes were not large enough, subgroups have been combined to create a larger group. Differences have been calculated as statistically significant according to a statistical test (the z-test) at the 95% confidence level.

3.2 Interpreting qualitative feedback

3.2.1 When interpreting the qualitative research data collected via focus groups and in-depth interviews, the findings differ to those collected via a quantitative methodology because they are not statistically significant. They are collected to provide additional insight and greater understanding based on in depth discussion and deliberation, not possible via a quantitative survey. For example, if the majority of optometrist participants hold a certain opinion, this may or may not apply to the majority of all optometrists. Qualitative findings are collected by speaking in much greater depth to a smaller number of individuals (in this case, 62 registrants and 37 stakeholders).

3.2.2 Focus group and in-depth interview discussions were digitally recorded and notes made to draw out common themes and useful quotations. Verbatim quotations have been used as evidence of qualitative research findings where relevant throughout the report. In some cases, these are attributed to the organisation that the stakeholder represented based on the participant's agreement. Some respondents preferred to provide their feedback as individuals, rather than on behalf of an organisation, and therefore have been named accordingly in this report. A small number of participants preferred to remain completely anonymous. Feedback from all individual registrants who took part in the qualitative research is also anonymous.

3.3 Terminology and clarifications

3.3.1 Throughout this report, those who took part in the online survey are referred to as 'respondents'.

3.3.2 Those who took part in qualitative research (focus groups or in-depth interviews) are referred to as 'participants'.

3.3.3 In some verbatim quotations, the term 'optom' has been used to refer to an optometrist and 'DO' to refer to a dispensing optician.

3.3.4 The term 'stakeholder' refers to those who took part in the research, either via the online survey or an in-depth interview, as a representative of the wider optical sector. In the survey, stakeholders were asked to respond anonymously as individuals. In the in-depth interviews, many stakeholders represented a particular organisation, but some took part as individuals.

3.3.5 When referring to 'community' optometry or practice, this refers to high street optical practices including both independent and regional or national chain opticians. It is also sometimes referred to as primary optical care, in contrast to secondary care.

3.3.6 A list of common abbreviations used throughout this report can be found in **Appendix E**.

4. Perceptions of levels of risk in current optical practitioner roles

This chapter assesses current common areas of practice for both optometrists and dispensing opticians in terms of the level of risk they pose to patients and the public. This includes results from the survey and feedback from registrant focus groups and stakeholder interviews. The results and feedback collected are based on perceptions of risk based on experience of working in the optical sector.

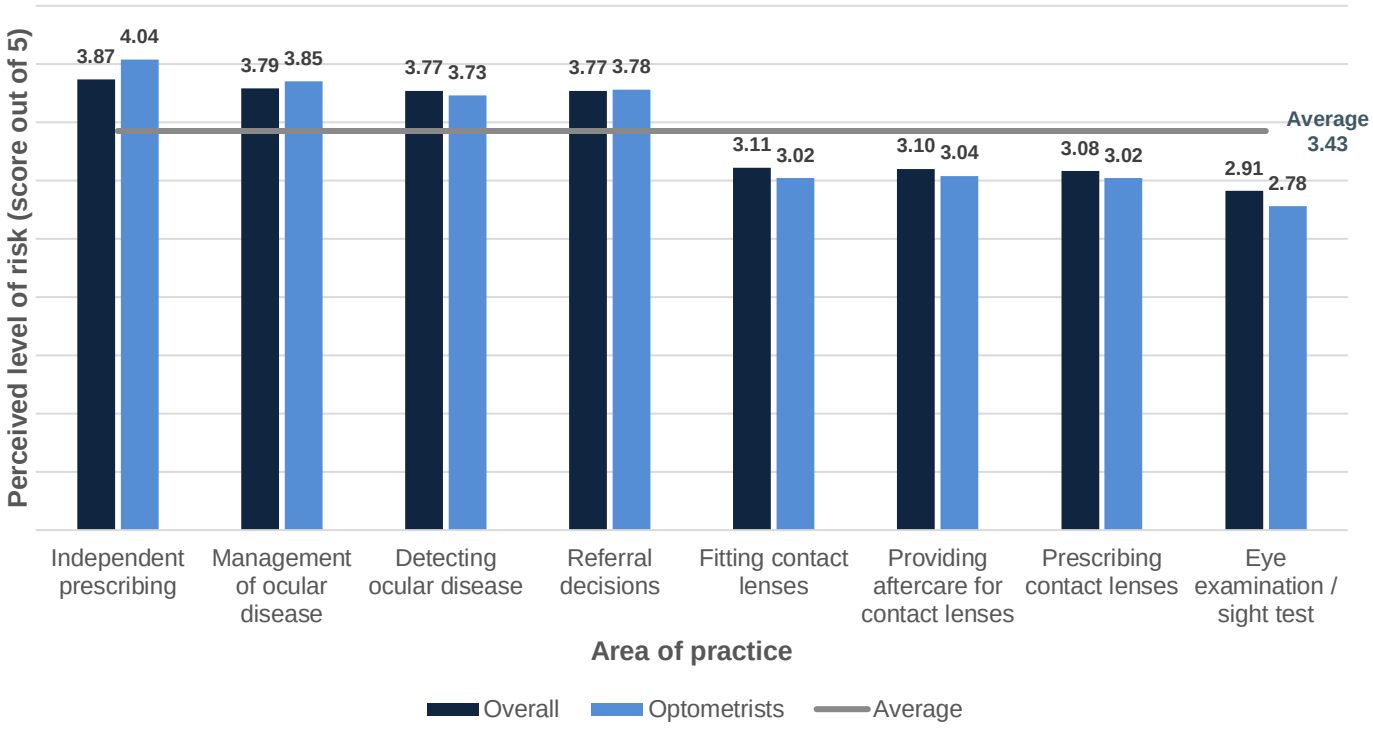
4.1 The current level of risk in practice for optometrists

4.1.1 Survey respondents were provided with a list of some of the most common areas of practice for optometrists and asked to indicate the potential level of risk to patients and the public, based on their experience. The chart at ***Figure 6*** below presents the results to this question at an overall level for all survey respondents and also for those who responded as optometrists. Respondents scored each area on a scale of one to five. Areas of practice perceived to be a higher level of risk have been given a higher score. The average line represents the average perceived level of risk for all areas of practice included in this survey question at an overall level.

4.1.2 Four areas were seen as having above average levels of risk to patients and the public, with independent prescribing and management of ocular disease scoring the highest. By contrast, four areas of practice were seen as having below average levels of risk, with the eye examination/sight test scoring the lowest.

4.1.3 Looking at the results specifically from optometrists, these respondents perceived independent prescribing to be a higher level of risk and the eye examination/sight test to be a lower level of risk when compared with the overall results.

Figure 6 – Perceptions of risk in common areas of practice for optometrists
Base: All respondents (2,610), Optometrists (1,452)

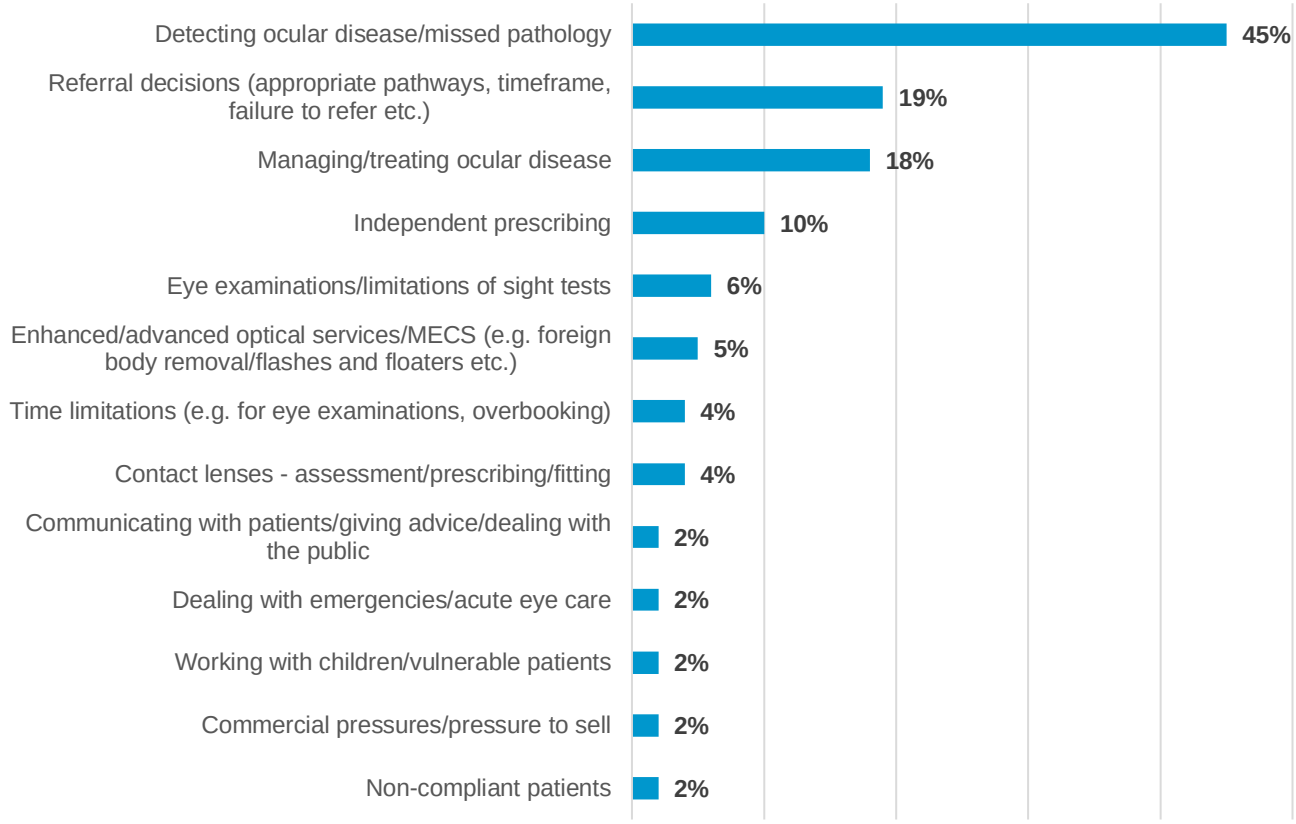


4.1.4 Survey respondents were able to suggest what they thought was the riskiest area of work carried out by optometrists. Free text responses have been coded for analysis, and the most common suggestions are presented in the chart below.

4.1.5 By far the most frequently suggested riskiest area of work was detecting ocular disease/missed pathology, followed by referral decisions and managing/treating ocular disease.

4.1.6 The chart at ***Figure 7*** below highlights a number of other areas of work perceived to be the riskiest that were not included in the previous question, including enhanced/advanced optical services, time limitations, communicating with patients, dealing with emergencies and working with children/vulnerable patients.

Figure 7 – Suggested riskiest areas of work carried out by optometrists
Base: All respondents who provided an answer (2,037)



Independent prescribing

4.1.1 Independent prescribing was perceived as the riskiest area of practice for optometrists by survey respondents, with an overall score of 3.87 out of five. However, it is interesting to note that, whilst the highest rated in terms of risk, it is still not that close to the highest possible score of five. Subgroup analysis of the survey results highlights that independent prescribing is perceived to be a higher level of risk by optometrists (4.04) when compared with dispensing opticians (3.67), and also higher by those working in hospital (4.18) when compared with other settings.

4.1.2 Registrant focus group participants generally agreed that independent prescribing was one of the riskiest areas of practice for optometrists, as this qualification meant that the practitioner was more regularly dealing with the treatment of eye conditions and ocular disease, which were inherently risker areas of practice due to the potential for misdiagnosis and mismanagement. It was also

suggested that independent prescribing required optometrists to rely more heavily on their own professional judgement, which therefore increased the level of potential risk.

I'd say it's riskier because you have to decide on the actual disease and that determines how you're going to manage and independently prescribe if necessary. You're having to make definite decisions rather than passing the buck.

Optometrist, Leeds

4.1.3 However, a common suggestion raised by registrant focus group participants was that independent prescribing may be perceived as a riskier area of practice for optometrists because only a small proportion have this qualification. The GOC's register shows that the number of optometrists with an independent prescribing qualification has increased from 308 in 2015 to 775 in 2019,[2] highlighting that whilst the number of optometrists with this qualification is increasing, it is still relatively small proportion of the optometrist population (approximately 5%). As a result, participants explained that the level of risk associated with this area of practice may not be widely understood, resulting in an assumption that it is riskier than it is in reality. This assertion is not borne out in the survey results, where those who had an independent prescribing qualification actually viewed this area of practice as a higher level of risk (4.04).

There are a lot of people who aren't independent prescribers who think that's really scary.

Optometrist, Edinburgh

4.1.4 Some participants viewed independent prescribing as a lower risk area of practice because the scope of the qualification was limited to the treatment of minor eye conditions. It was also suggested that the level of training required to obtain the independent prescribing qualification was so thorough that any risk posed to the patient was very well managed, and that optometrists would not be working outside their own level of competency. This perception is reinforced by the fact that all nonmedical prescribers (NMPs), which includes optometrists with an independent prescribing qualification, may prescribe only within their area of competence, such as specific ocular conditions for optometrists,[3] meaning that they are not permitted to work outside their area of competence. Previous research into risk conducted by the GOC also supports this perception, as it was found that independent prescribing had potential for more severe risk if optometrists work beyond their competence when they have access to a range of medicines.[4] [5]

I think optometry is very low risk really. We're not doing heart surgery…we're not going to kill anybody. The independent prescribing is done for minor optical conditions, and it's stressed so many times that you shouldn't go beyond your competency…Even the access to the drugs – the most dangerous thing they would probably have is a steroid, and the guidelines for it are really fierce.

Optometrist, Northern Ireland

I don't think there's a big level of risk to the patient, purely because of the amount you have to go through to get that independent prescribing status. For me, that mitigates a degree of risk. If it was being done by optometrists across the country with no extra training it would be a huge risk, but the amount you've got to know to get that qualification is huge.

Optometrist, Leeds

[2] General Optical Council register 2019
[3] Cope, L., Abuzour, A., and Tully, M. (2016). Nonmedical Prescribing: Where Are We Now? *Therapeutic Advances in Drug Safety*, Vol.7(4), p.167
[4] Europe Economics. (2010). *Risks in the Optical Profession: Final Report*, p.v
[5] For reference, the College of Optometrists 'Optometrists' Formulary' can be found at the following link - http://loc-net.org.uk/media/3891/college-formulary.pdf

4.1.5 The survey results highlight that independent prescribing was recorded as a higher level of risk by those working in Scotland (4.09), particularly when compared with those working in England (3.83). This difference may be the result of the regional differences in the NHS, where there is funding to support the training of independent prescribing optometrists in Scotland, as well as the issuing of NHS prescribing pads to optometrists in 2013[6], meaning that the proportion of independent prescribing optometrists in Scotland is likely to be greater than the rest of the UK. This assertion is found in various data, including a report from the Scottish Government which states that 35% of independent prescribers in the UK are based in Scotland,[7] and the most recent GOC registrant survey, which found that 15% of respondents from Scotland had an independent prescribing qualification (compared with 3% in England, 1% in Wales and 3% in Northern Ireland).[8] Additionally, the results of this survey found that 36% of optometrists respondents working in Scotland had this qualification (compared with 7% in England, 5% in Wales and 11% in Northern Ireland).

4.1.6 In relation to national differences, focus group participants in Wales suggested that those working in Wales may feel more confident about independent prescribing due to the additional training they receive as part of the Welsh Eye Care Services (WECS).

I wonder if you'd asked us about IP before we had the WECS rating whether we'd feel as confident. I doubt it. I'm not IP trained but I've been trained through the WECS and I feel a bit more confident to deal with all those risks.

Optometrist, Cardiff

Detection and management of ocular disease

4.1.7 The detection of ocular disease and management of ocular disease by optometrists scored very similarly in the online survey in terms of the potential level of risk to patients and the public (3.77 and 3.79 out of five respectively). A similar result was found in the GOC's recent consultation into Continuing Education and Training, where detection of disease/missed pathology was recorded as the riskiest area of practice, particularly by optometrists.[9]

4.1.8 Qualitative feedback from registrants generally supported the view that the detection and management of ocular disease were risker areas of practice for optometrists, as anything related to ocular disease was perceived to entail a higher level of risk for the patient. Detection of ocular disease was often seen as involving a higher level of risk than management. The risk of misdiagnosis and failure to detect disease is covered in greater depth in chapter 6.2.

Anything that involves disease is always going to be more risky…There's always a risk that you're going to miss or misdiagnose with disease.

Optometrist, Northern Ireland

I would say that there's more risk in detecting ocular disease than there is in managing it. Missing it is when there's more risk to the patient.

Optometrist, Leeds

[6] College of Optometrists. (2019). *How UK Eye Care Services Are Delivered: Scotland*. Retrieved from College of Optometrists: https://www.college-optometrists.org/the-college/how-uk-eye-care-services-are-delivered/scotland.html
[7] Scottish Government. (2017). *Community Eyecare Services Review*, p.18
[8] Enventure Research. (2016). *Registrant Survey 2016*, raw survey data
[9] Enventure Research. (2018). *Fit for the Future: Lifelong Learning Review - Continuing Education and Training Consultation*, pp.21-22

4.1.9 It was suggested that, because encountering ocular disease can be infrequent for many optometrists, their confidence in detecting may be low as a result of a lack of experience. In contrast, focus group participants in Wales suggested that optometrists in Wales may be more prepared to detect and manage ocular disease due to the standardised and regular training they receive as part of WECS, as well as shared care schemes, which they suggested may have boosted skills and confidence in this area. This feedback is reinforced by subgroup analysis of the survey results, where respondents who worked in Wales scored detecting ocular disease lower in terms of risk at 3.59 when compared with respondents who worked in England at 3.80.

We as optometrists don't see a lot of eye disease, particularly when we are training so as a profession we are always slightly on the back foot with disease. Is it glaucoma? Is it serious?

Optometrist, London

In Wales we have the shared care scheme, so we have training on referrals decisions and managing and detecting ocular disease. Most people in Wales are qualified, but in other parts of the country they don't have the same training. People in other parts of the country might be less sure about some of the diagnostic issues.

Optometrist, Cardiff

4.1.10 Subgroup analysis indicates that the management of ocular disease was scored as a higher level of risk by those working in hospital (4.02) when compared with other settings. However, there was a perception amongst some registrant participants that the detection and management of ocular disease in hospital may be a lower risk to the patient, as optometrists working in hospitals encounter ocular disease on a more regular basis when compared with a community setting, and therefore view detection and management as more routine. It was also suggested that the level of risk may be lower due to the presence of ophthalmologists in the hospital setting, providing optometrists with the ability to check symptoms and results before making a diagnosis.

The management of glaucoma for most hospitals is a pretty straightforward process.

Optometrist, London

4.1.11 As found with independent prescribing, some focus group participants suggested that the detection and management of ocular disease was not a particularly high risk for optometrists because of the mandatory training provided when working in these areas, coupled with the propensity of optometrists to refer in cases where they are unsure.

Generally training is quite good. You are taught everything that can possibly go wrong. We are taught about a lot of things that can happen even though we're not going to be dealing with a lot of it…But there are always those diseases that you will see maybe once in a lifetime. Most optoms will just refer if they don't know.

Optometrist, Birmingham

Referral decisions

4.1.12 Referral decisions recorded a potential risk score of 3.77 out of five, the same as detecting ocular disease. This view was generally reflected across registrant focus groups, with a higher level of risk associated with referral decisions because it was linked with the detection of ocular disease, something which most participants viewed as inherently riskier for patients. The main risks associated with referral decisions were missing a referral or incorrectly referring a patient. The risks of failure to refer or inappropriate referral are covered in greater detail in chapter 6.2.

It could be critical if it's a serious condition and it's not been referred. There could be a serious outcome.
Optometrist, Cardiff

4.1.13 Subgroup analysis shows that those working in a hospital perceived a higher level of risk for referral decisions at 3.93 when compared with those working in other settings. It was highlighted during focus group discussions that communication links between community practice and hospitals were often in need of improvement, presenting an additional element of risk for the patient.

There's not much link between the hospital and the practice to confirm that the referral has been received, so there's a risk there.

Optometrist, Leeds

Prescribing, fitting and providing aftercare for contact lenses

4.1.14 Areas of practice for optometrists relating to contact lenses all scored very similarly for their potential level of risk to patients and the public. Fitting contact lenses recorded a potential risk score of 3.11 out of five, almost the same as providing aftercare for contact lenses at 3.10 out of five and prescribing contact lenses at 3.08 out of five.

4.1.15 Optometrists participating in the qualitative research generally accepted that areas of practice relating to contact lenses could be risky, but discussions tended to focus on other areas of practice that they perceived to be higher risk such as the detection and management of ocular disease, referrals and independent prescribing. It was generally suggested that there was a greater level of risk to the patient associated with contact lenses due to the involvement of patients in the management of their own care, where risks are increased if they do not use or look after their contact lenses or use them correctly. This risk is discussed in greater depth in chapter 6.4 which investigates perceptions of the risk of poor contact lens fitting and aftercare.

I'd say fitting contact lenses is higher risk. It's much more likely to happen as patients abuse their contact lens wear.

Optometrist, Edinburgh

Eye examination and sight test

4.1.16 The eye examination and sight test recorded the lowest level of potential risk to patients and the public with a score of 2.91 out of five. It is, however, important to note that although this was the lowest scoring area of practice, the score itself is still relatively high and close to the average level of risk recorded for all areas of practice, a finding noticed by a number of registrant participants who were surprised by this result. They had expected a lower score to be recorded as they felt that there was little risk to the patient associated with an eye examination and sight test, and viewed this area of practice as routine for a qualified optometrist.

In the straightforward eye exam, I wouldn't imagine there is much risk to the public. It's nearly up at 3, and I don't know why that would be like that. If everything's straightforward I really don't feel there's much risk.
Optometrist, Northern Ireland

4.1.17 The survey data highlights that the eye examination and sight test was perceived to be riskier by those who had been registered for a shorter length of time when compared with those who had been registered for many years. For example, a score of 2.98 was recorded for those with two years of registration or less, compared with 2.78 for those with 21 years of registration or more. Feedback from the registrant focus groups supports this result, where participants suggested that

such a high risk score may have been recorded due to a higher perception of risk from newly qualified practitioners.

When you're newly qualified you might perceive the risk to be higher.

Optometrist, Cardiff

4.1.18 However, some registrant participants felt that the risk score for the eye examination and sight test was justified because it incorporated many other areas of practice, including the detection of ocular disease, which was viewed as higher risk, understanding and recording patient history and symptoms.

It's even simple things like history and symptoms…if you don't pay attention to what someone's complaint is during the sight test, then there's risk to the patient.

Optometrist, Birmingham

Paediatric optometry

4.1.19 A common suggestion for other areas of practice of optometrists which posed potential risks to patients and the public was paediatric optometry, which was not listed in the survey question. Many registrant participants explained that any areas of practice that related to children were automatically a higher level of risk because eyesight is still in development at this stage. Therefore, any mistakes made during even potentially low risk areas of practice such as a sight test could have long-term negative impacts on a child's sight and development.

Paediatric optometry is a potentially riskier area of practice because their eyesight is still developing. If you haven't done it correctly it can have a big impact on their vision long-term.

Optometrist, Leeds

4.1.20 Paediatric optometry was also perceived as potentially risky because it can be harder to conduct accurate sight tests with children due to the self-reporting nature of the process, where optometrists are reliant on children to explain how well they can see, and even to sit still during examinations. Some focus group participants indicated that they typically referred children elsewhere as a result to avoid this risk.

It's harder to get reliable information and you might miss something because of lack of compliance, so it's quite risky I'd say.

Optometrist, Cardiff

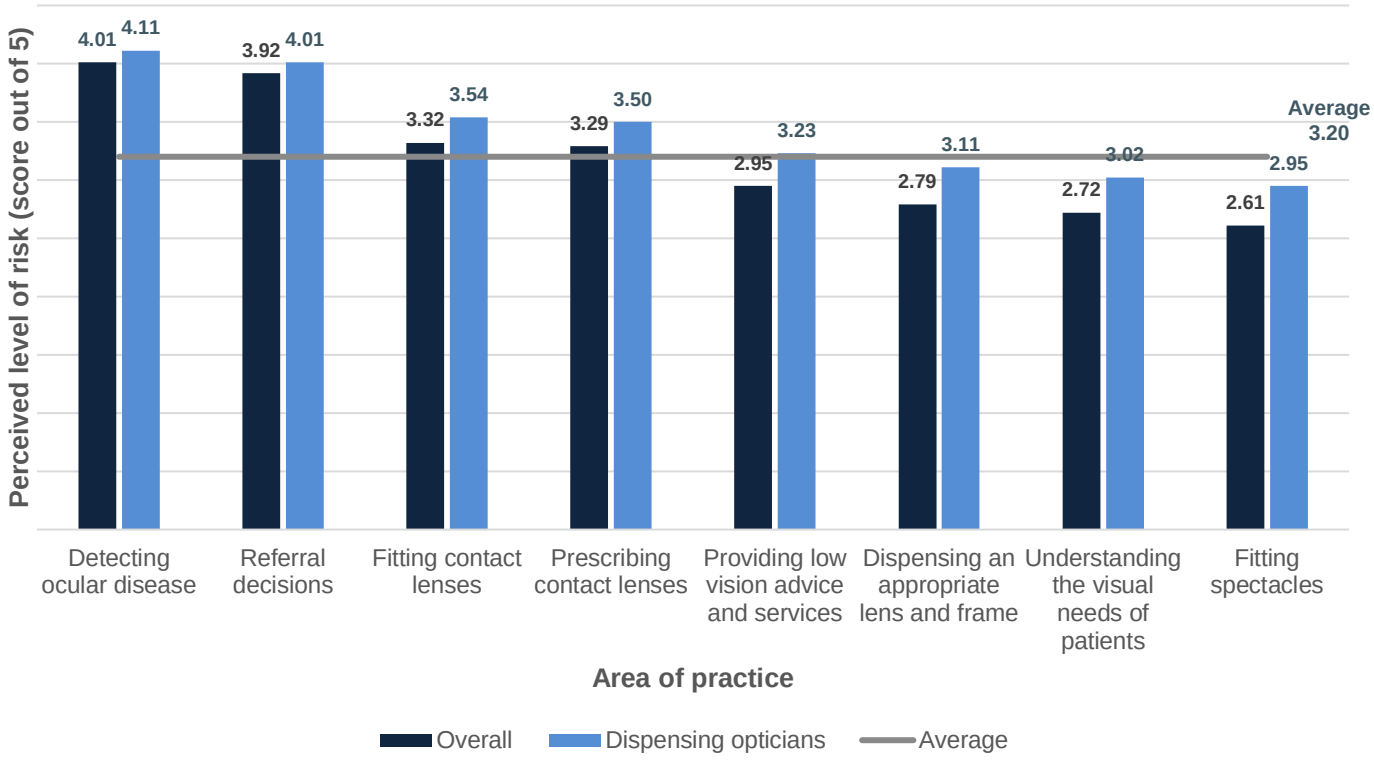
4.2 The current level of risk in practice for dispensing opticians

4.2.1 Survey respondents were given a list of some of the most common areas of practice for dispensing opticians and asked to indicate the potential level of risk to patients and the public, based on their experience. The chart at ***Figure 8*** overleaf presents the results to this question at an overall level for all survey respondents and also for those who responded as dispensing opticians (including contact lens opticians). Respondents scored each area on a scale of 1 to 5. Areas of practice perceived to be a higher level of risk have been given a higher score. The average line represents the average perceived level of risk for all areas of practice included in this survey question at an overall level.

4.2.2 The areas of practice seen as having the highest level of risk were detecting ocular disease and referral decisions, both recording high above average scores. A number of areas were seen as lower risk, including fitting spectacles, understanding the visual needs of the patient and dispensing an appropriate lens and frame.

4.2.3 Looking at the results specifically from dispensing opticians, a number of areas of practice were viewed as having a higher level of risk when compared with the overall result, most notably fitting spectacles (2.95 compared with 2.61).

Figure 8 – Perceptions of risk in common areas of practice for dispensing opticians
Base: All respondents (2,610), Dispensing opticians (670)



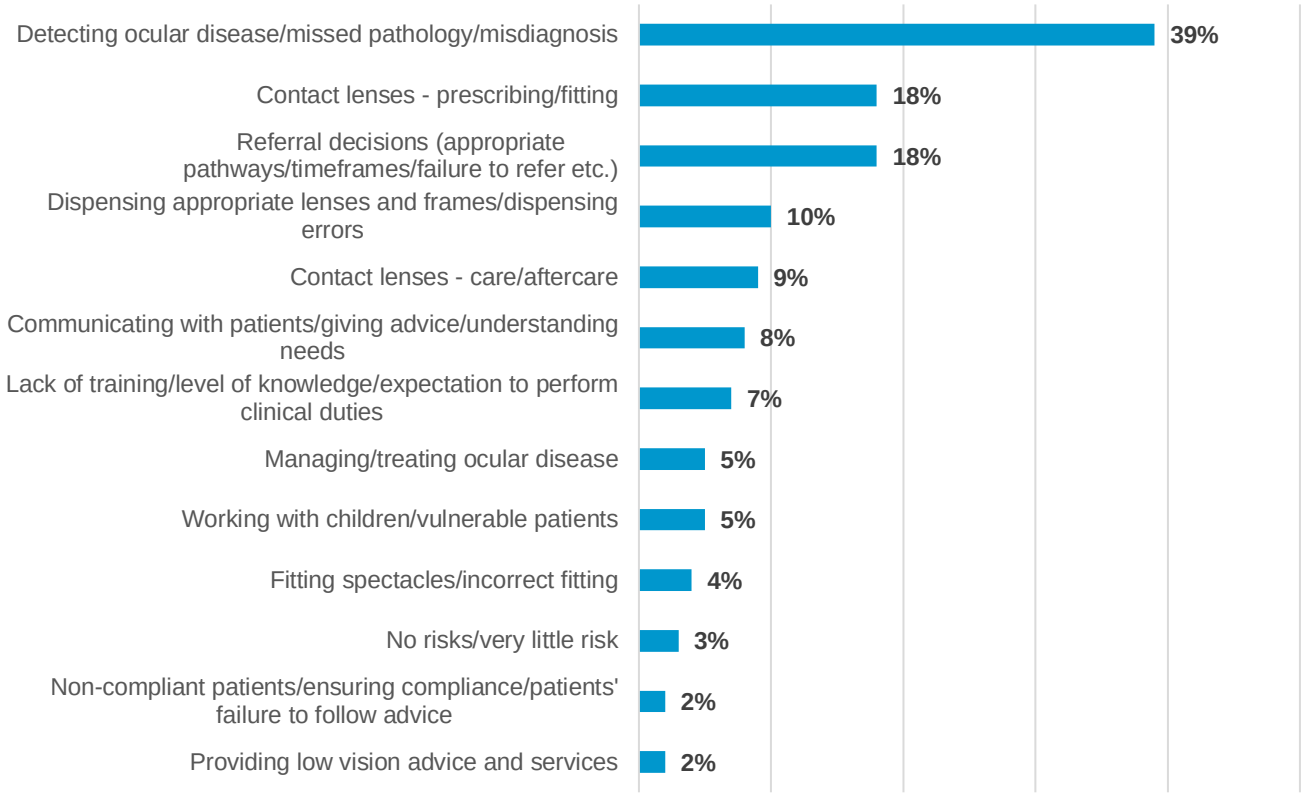
4.2.4 Survey respondents were able to suggest what they thought was the riskiest area of work carried out by dispensing opticians. Again, free text responses have been coded for analysis, and the most common suggestions are presented in the chart at ***Figure 9*** overleaf.

4.2.5 In line with the riskiest area of work carried out by optometrists, the most common suggestion was also detecting ocular disease, missed pathology and misdiagnosis. This was followed by large proportions who suggested contact lens prescribing/fitting and referral decisions.

4.2.6 Risks highlighted in the chart which were not rated in the previous question include communicating with patients, lack of training, level of knowledge, expectation to perform clinical duties, working with children or vulnerable patients, and providing low vision advice and services.

4.2.7 A small proportion of respondents stated that they thought there was no risk or very little risk in the work carried out by dispensing opticians, which was not the case for areas of practice associated with optometrists.

Figure 9 – Suggested riskiest areas of work carried out by dispensing opticians
Base: All respondents who provided an answer (1,714)



Detecting ocular disease

4.2.8 Detecting ocular disease was the area of practice for dispensing opticians which recorded the highest level of potential risk at 4.01 out of five, higher than any areas of practice for optometrists. Subgroup analysis highlights that dispensing opticians themselves perceived this to be even riskier at 4.11 when compared with optometrists who provided a score of 3.96. Those who worked in a hospital also rated detecting ocular disease as a higher level of risk at 4.21, particularly when compared with those working in national chains (3.97), regional chains (3.99) or independent opticians (3.97).

4.2.9 Many dispensing opticians agreed that detecting ocular disease was a high risk area of practice, particularly within their role, based on the potential impact for the patient if they missed something. It was suggested that failing to detect ocular disease would be something that many dispensing opticians feared, and that this explained why it was viewed as high risk.

Detecting ocular disease, I would say is the greatest risk because that has the most dangerous impact on the health of the patient.

Dispensing optician, London

4.2.10 Dispensing optician participants highlighted that detecting ocular disease was not key to their role, and was more the responsibility of the optometrist. They explained that the confidence and experience of dispensing opticians to detect ocular disease was still in development and was not something they often had to deal with in everyday practice, meaning that they therefore perceived this area of practice as high risk.

When I qualified, it wasn't necessarily part of the DO's role then to determine external disease and conditions. That has come along as things have changed. Because it's not a common thing, it's a confidence thing from a DO perspective.

Dispensing optician, Birmingham

4.2.11 Some participants, however, suggested that detecting ocular disease was not a particularly high risk area of practice for dispensing opticians because it was rare that they were the sole practitioner responsible for this, and that usually they could easily refer to an optometrist, removing the requirement of clinical decision making. The risk factor of misdiagnosis and failure to detect disease is covered in more detail in chapter 6.2.

It's not something that we are that involved with as normally we would refer it onto the optometrist.

Dispensing optician, London

Referral decisions

4.2.12 As with detecting ocular disease, referral decisions was another area of practice that survey respondents scored as a high risk for dispensing opticians at 3.92 out of five. Again, dispensing optician respondents viewed this as a higher risk at 4.01 when compared with optometrists at 3.88, as did those working in a hospital at 4.05 when compared with other practice settings.

4.2.13 Qualitative feedback from registrants suggests that dispensing opticians do not see referral decisions as a particularly risky area of practice. They explained that they rarely required to refer, usually because of the presence of an optometrist, and that when they are required to refer, the process is simple.

Most us will work in practices where there are always optometrists, so whilst you may triage someone, we rarely have to make any decision at all.

Dispensing optician, Edinburgh

Referral decisions at the moment are so easy. ABDO give you a form, it's written out for you and you just fill out the words and that's it, off it goes. But I've only ever referred two people in 19 years as a DO.

Dispensing optician, Leeds

4.2.14 Stakeholder participants echoed this view, stating that it was rare for dispensing opticians to be solely responsible in practice for referrals, as they could pass queries on to optometrists or other colleagues. However, it was also highlighted that, in certain circumstances or settings, dispensing opticians were required to make referral decisions, and therefore there was some element of risk. Furthermore, this risk may be greater due to how infrequently it occurred in practice, as dispensing opticians may be less confident in this area of practice.

In an optical practice set up, dispensing opticians are very rarely ultimately responsible for the patient that walks through the door as they can refer directly to an optometrist or contact lens optician colleague. However, there are still areas and circumstances where the dispensing opticians are the only registrant in the practice, therefore they are responsible and have a duty to refer where appropriate.

ABDO Exams (awarding body)

Prescribing and fitting contact lenses

4.2.15 Prescribing and fitting contact lenses were perceived to be of a similar level of risk for dispensing opticians by survey respondents at 3.29 and 3.32 out of five respectively. Subgroup analysis

highlights that dispensing opticians with a contact lens specialty recorded lower risk scores for both prescribing (3.39) and fitting contact lenses (3.39) when compared with dispensing opticians without this qualification (3.57 and 3.62 respectively).

4.2.16 Qualitative feedback supports this result, as focus group participants suggested that prescribing and fitting contact lenses were risky areas of practice for dispensing opticians without a contact lens specialty, as they were less qualified to manage patients in these areas. It was suggested that contact lens opticians would see less risk in these areas of practice because they were specifically trained and qualified to deal with them. This was also supported by some stakeholders, who suggested that contact lens opticians were lower risk when prescribing and fitting contact lenses when compared with optometrists. As with optometrists, dispensing optician participants also highlighted the increased level of risk associated with contact lenses caused by the involvement of patients within their care and potential for non-compliance. The risk of poor contact lens fitting and aftercare is covered in more detail in chapter 6.4.

Fitting and prescribing contact lenses, I'm not qualified to do that. If I was a contact lens practitioner that wouldn't actually be an issue. The patient needs to have a level of adherence, so that is a possible risk.

Dispensing optician, Cardiff

Contact lens opticians have more specialist knowledge and experience than their optometry colleagues at fitting contact lenses and providing aftercare. Therefore, there is minimal risk, on the basis that contact lens opticians have gone through a very comprehensive contact lens course that goes into extensive detail and the assessment is extremely rigorous.

ABDO Exams (awarding body)

Providing low vision advice and services

4.2.17 Providing low vision advice and services recorded a score of 2.95 out of five, just below the average across all areas of practice for dispensing opticians. It was scored as a higher level of risk by dispensing opticians (3.23) when compared with optometrist respondents (2.77). It was also scored higher by respondents working in national (3.05) and regional chains (3.08) when compared with independent opticians (2.83) and hospital (2.80).

4.2.18 Registrant participants tended to view providing low vision advice and services as a risky area of practice, with some suggesting that this was because of the potential impact that incorrect advice or services could have on patients, such as accidents and injuries.

If you don't have the correct low vision aid supplied, you could have a critical injury from a burn because someone has tipped hot water over themselves. People could have a resulting fall.

Dispensing optician, Cardiff

4.2.19 It was suggested that this was a riskier area of practice for dispensing opticians due to inexperience, with some participants explaining that they did not regularly come across patients with low vision needs and therefore did not develop their skills in this area. It was also highlighted that, whilst CET is available in this area, low vision advice and support is often dealt with separately by charities such as the Royal National Institute for the Blind.

I think providing low vision advice is actually quite high risk…Although there is CET out there for low vision, I still feel I am lacking any real experience or knowledge of it.

Dispensing optician, Edinburgh

4.2.20 Some participants also highlighted other potential risks to patients related to low vision that could occur if the condition was undiagnosed or overlooked, or if the incorrect advice was provided, such as isolation and depression.

The low vision side of things is often overlooked. We like to think it isn't but sometimes it's assumed they are going somewhere else when actually there is a huge proportion that are just being left. There are lots of patients in that position without the right aids.

Dispensing optician, Birmingham

There is the additional low vision qualification…But very often these patients get lost in the follow up and are never encouraged to come back by the optometrist, who will need to refer them into secondary care to receive the certificate of visual impairment. That gets them access to benefits and access to low vision support – an assessment that can help provide low vision equipment, lighting, adaptations around the home, magnifiers…A lot of patients disappear into the system, sit quietly and go blind, lonely and depressed at home. They need to be signposted to low vision clinics, emotional support and charities like ours who can provide all this.

Macular Society

4.2.21 However, some dispensing optician participants viewed low vision advice and services as a lower risk area of practice because of the additional qualifications and training required to work in this area, meaning that many dispensing opticians would refer to those who were qualified. It was also suggested that low vision was a lower risk area as it was not a type of condition that was common in practice.

As for providing low vision advice and services, again you wouldn't really be able to do that unless you were properly qualified. We refer on to a low vision practitioner.

Dispensing optician, Cardiff

I'm surprised that low vision is so high to be honest. It's generally rarer…Normally I find they go to low vision specialists, low vision practices rather than just normal practices.

Dispensing optician, Birmingham

Dispensing an appropriate lens and frame

4.2.22 Dispensing an appropriate lens and frame recorded a risk score of 2.79 out of five. Again, this was an area of practice that dispensing opticians perceived to be a higher level of risk at 3.11 when compared with optometrists at 2.60.

4.2.23 Registrant participants generally viewed dispensing an appropriate lens and frame as a lower risk area of practice. As seen with the eye examination and sight test for optometrists, dispensing optician participants viewed dispensing as the routine aspect of their role, and that therefore it came with little risk. Some participants also indicated that they were surprised this area of practice had scored so highly, despite being towards the bottom of the list.

I'm surprised dispensing an appropriate lens and frame is rated as high as it is. I would have rated is as no risk. If an optical assistant can get it right, then you'd hope a dispensing optician could.

Dispensing optician, Leeds

4.2.24 A small number of dispensing opticians highlighted some risks related to poor dispensing, such as providing lenses which did not meet the Driver Vehicle Licensing Agency (DVLA) visual guidance

for driving or leading to problems with posture or accidents caused by poor vision, particularly if more complex dispensing is involved including bifocal or varifocal lenses. It was also suggested that dispensing was a higher level of risk to patients if not carried out by a qualified dispensing optician, something which some participants indicated happened in their practice. The risk of poor dispensing is covered in more detail in chapter 6.9.

Dispensing appropriate lens and frame is an art and it can turn out shockingly bad. I've heard some horror stories in places where they were poorly trained and got it horrifically wrong. If you get something like a bifocal or a varifocal wrong, then that person might go out and drive and it causes a crash. It is a risk, definitely. My gripe is that dispensing is undertaken by unqualified people who have no idea about what they are doing.

Dispensing optician, Cardiff

4.2.25 Dispensing with certain types of patients was perceived to involve a higher level of risk. Children and older people were both mentioned as higher risk. Paediatric dispensing was viewed in the same way as paediatric optometry, with the potential risk for long-term sight damage as a result of poor dispensing. Dispensing to older people often involved more complex dispensing, which if done incorrectly based on their mobility, could lead to the risk of falls. A report by the College of Optometrists into falls recommended that there needs to be increased awareness among the optometry profession of the causes of falls, such as the need for cautious prescribing of multifocal lenses to older people,[10] highlighting the risk associated with this area of practice.

If you don't dispense a child effectively, including advising the child and parent/guardian on how to wear their spectacles and that child looks over the top of their spectacles during the critical period of their visual development, it can potentially have a detrimental effect on their vision for the rest of their life. ABDO believe that's a huge risk…For the elderly, the risk is the falling. There's been a lot of research conducted on patients who have falls which can be down to not having an eye test at all, overdue an eye test or being poorly dispensed. Poor and inappropriate dispensing to the elderly, when you don't take into consideration other aspects of their general health such as their mobility is going to result in a higher risk of falls.

ABDO Exams (awarding body)

Dispensing children is so risky, the impact we can have on their sight is massive.

Dispensing Optician, Edinburgh

Understanding the visual needs of patients

4.2.26 Understanding the visual needs of patients was another area of practice that scored a below average level of risk for dispensing opticians at 2.72 out of five, although dispensing opticians respondents viewed this as a higher risk (3.02) when compared with optometrist respondents (2.56). This area of practice was also viewed as a higher level of risk by those who had been registered with the GOC for less time when compared with those who had been registered for longer. For example, those who had been registered for less than two years recorded a score of 2.85, compared with those who had been registered for 21 years and over at 2.65.

4.2.27 Whilst there was general agreement that this area of practice was low risk for dispensing opticians, some participants highlighted that it still carried potentially severe risks to both the patient and the optometrist if a patient is not happy with the product they have been given.

[10] College of Optometrists. (2019). *Focus on Falls*, p.19

Understanding the visual needs of the patient. I would have thought that would have been ranked higher. People might come back and say they are not happy about something that you have provided.

Dispensing optician, Birmingham

Fitting spectacles

4.2.28 Fitting spectacles was the area of practice for dispensing opticians that was perceived to have the lowest level of risk at 2.61. As seen with other areas of practice, it was viewed as a higher level of risk by dispensing opticians (2.95) when compared with optometrists (2.43), and by those who had been registered for a shorter period of time (2.82 for those registered for less than two years) when compared with those who had been registered for longer (2.47 for those registered for 21 years and over).

4.2.29 Feedback from registrant participants mirrored this result, with the majority of dispensing optician participants explaining that there was limited risk associated with the fitting of spectacles, and that any patient risk was of low impact.

It [fitting spectacles] *doesn't have a major impact if it is wrong on the patient.*

Dispensing optician, Leeds

4.3 Level of risk in comparison with other roles

Within the optical profession

4.3.1 Almost all participants felt that the level of risk posed to patients and the public by the roles of optometrists was higher when compared with dispensing opticians, citing the increased involvement of optometrists in the detection and management of disease, which increased their level of risk, particularly if mistakes are made.

Because of the disease issue, we probably do pose more of an issue than a DO.

Optometrist, Northern Ireland

The risk to the public from a dispensing point of view is not big compared with an optometrist. If I get a measurement wrong for example, the patient might get a headache. If an optom misses some pathology, it's much more serious.

Educational institution stakeholder

4.3.2 Furthermore, it was suggested that dispensing opticians typically worked in partnership with an optometrist, meaning that areas of practice which carried greater level of risk should be deferred to the optometrist, resulting in a higher level of risk in comparison to the dispensing optician.

We're usually working in partnership with an optometrist, so the risk is less for us because they're more responsible.

Dispensing optician, Leeds

The likelihood of DOs making the wrong decision is actually much smaller, because they tend to have the backup of the optometric professional in the practice. So if they have a problem, they immediately have a referral point in the optometrist.

University of Hertfordshire

4.3.3 However, not all agreed that the risk posed by optometrists was always higher than dispensing opticians. The survey results highlight that dispensing opticians view more risk in all aspects of their role when compared with the overall results. Some registrant participants also said that the risk can be higher for dispensing opticians when they are not working in partnership with an optometrist, which can happen infrequently in practice, where the dispensing optician may be required to work up to or outside their scope of practice. It was also suggested that, although not formally part of their role, dispensing opticians might lack confidence to be able to successfully detect ocular disease and make clinical decisions due to the infrequency that they came into contact with these conditions, especially if they qualified a long time ago, therefore increasing the level of risk.

I think we are more likely to miss it [ocular disease]*. A lot of it comes down to confidence level. I sat my ABDO exams quite recently, so I've got the symptoms in my head still, but even now coming up to two years on, half of that is gone. If someone was to present symptoms to me, I would probably have to go double check with an optom unless the symptom is clear cut. A lot of it comes down to confidence and how often we are using that skillset.*

Dispensing optician, London

4.3.4 Workplace setting appears to have an impact on the level of risk posed by optometrists and dispensing opticians. For example, some participants suggested that patients in secondary care may be more likely to need riskier treatment, making the level of risk posed by optical professionals working in secondary care automatically higher when compared with those working in a community setting. However, it was suggested that, due to the presence of ophthalmologists in the hospital setting, the level of risk could be seen to be lower because optometrists and dispensing opticians could more easily refer to them.

Patients presenting in secondary care probably need a riskier level of treatment compared with those presenting in the community.

Optometrist, Leeds

It depends on how autonomous you are. In the hospital, even though I might see patients with more problems, I've got access to ophthalmologists and people at a higher level who I can go and ask. If you're a solo optometrist, sometimes you have to make decisions that might benefit from some support.

Optometrist, Leeds

In comparison to other healthcare professions

4.3.5 Focus group participants widely agreed that the level of risk posed by optometrists and dispensing opticians was lower than that posed by other healthcare professions, comparing their roles to doctors, nurses, dentists and pharmacists. One of the main reasons suggested was because the roles of optometrist and dispensing optician were typically not as involved in clinical areas of healthcare, including prescribing medication and invasive procedures such as injections. The view that optometry is overall relatively low risk when compared with other healthcare professions was mirrored in the GOC's 2010 risk research.[11]

On the whole, what we do is less risky than a doctor who might be practising surgery or a dentist doing something invasive. Absolutely we have a critical role in healthcare, but on a day to day basis it's more routine and less able to generate the same level of risk as people like doctors and nurses.

Optometrist, Leeds

[11] Europe Economics. (2013). *Optical Business Regulation*, p.30

4.3.6 Participants also discussed how the potential problems and conditions which optometry patients could present with were less complex when compared with other healthcare professions, and that if a risk was to occur, the impact would generally be less severe in comparison.

People don't present with the same level of problems as they might do to a doctor. It's that they can't see properly, so it's functional. They need a new pair of glasses. And if you get a prescription incorrect it's relatively small risk to the patient.

Optometrist, Leeds

4.3.7 In both discussions with registrants and stakeholders, there was a general agreement that, although there are some potentially severe risks, optometry could be perceived to be a low risk profession. Not only were the potential risks associated with optometrists and dispensing opticians seen as low in terms of likelihood and severity, but many participants felt that the profession was very risk averse, as practitioners often referred to senior colleagues or other healthcare professionals when they were unsure, avoiding working outside their knowledge and competency, and undertook education and training to further mitigate any risk. Again, this perception was highlighted in the previous research conducted by the GOC into risk in 2010, where a common theme that ran throughout the consultation with optometrists, opticians and professional and educational bodies was one of risk aversion in the optical profession.[12]

The perception within the sector is that the risks are low, however the perception of risk is often different to the actual risk.

College of Optometrists

I think it's fair to say that we are a low risk profession…Dispensing opticians have a history of practising safely, and it's evident that not many dispensing opticians in the grand scheme of things are brought before the GOC on Fitness to Practise cases.

Association of British Dispensing Opticians (ABDO, professional association)

4.3.8 However, a small proportion of participants felt that the level of risk posed by the optical profession, including both optometrists and dispensing opticians, was increasing and becoming more comparable with other healthcare professions due to the changing scope of roles, particularly amongst optometrists who were taking on more clinical roles as a result of changes within the NHS, where services were moving from secondary care to the community. The changing scope of the role of optical professionals is discussed in greater detail in chapter 9.3 of this report.

It's becoming more high risk because of things that we're being passed from GPs, like people with headaches or blurred vision.

Optometrist, Leeds

We've had a contract change in the last year that we are now officially the first port of call.

Dispensing optician, Edinburgh

[12] Europe Economics. (2010). *Risks in the Optical Profession: Final Report*, p.66

5. Likelihood and severity of all risks

Survey respondents were provided with a list of potential risks which, if they occurred in practice, may place patients and the public at risk. Respondents were able to rate each risk in two ways:

1. How likely they thought it was to occur in practice
2. If the risk did occur, how severe the risk would be to patients and the public

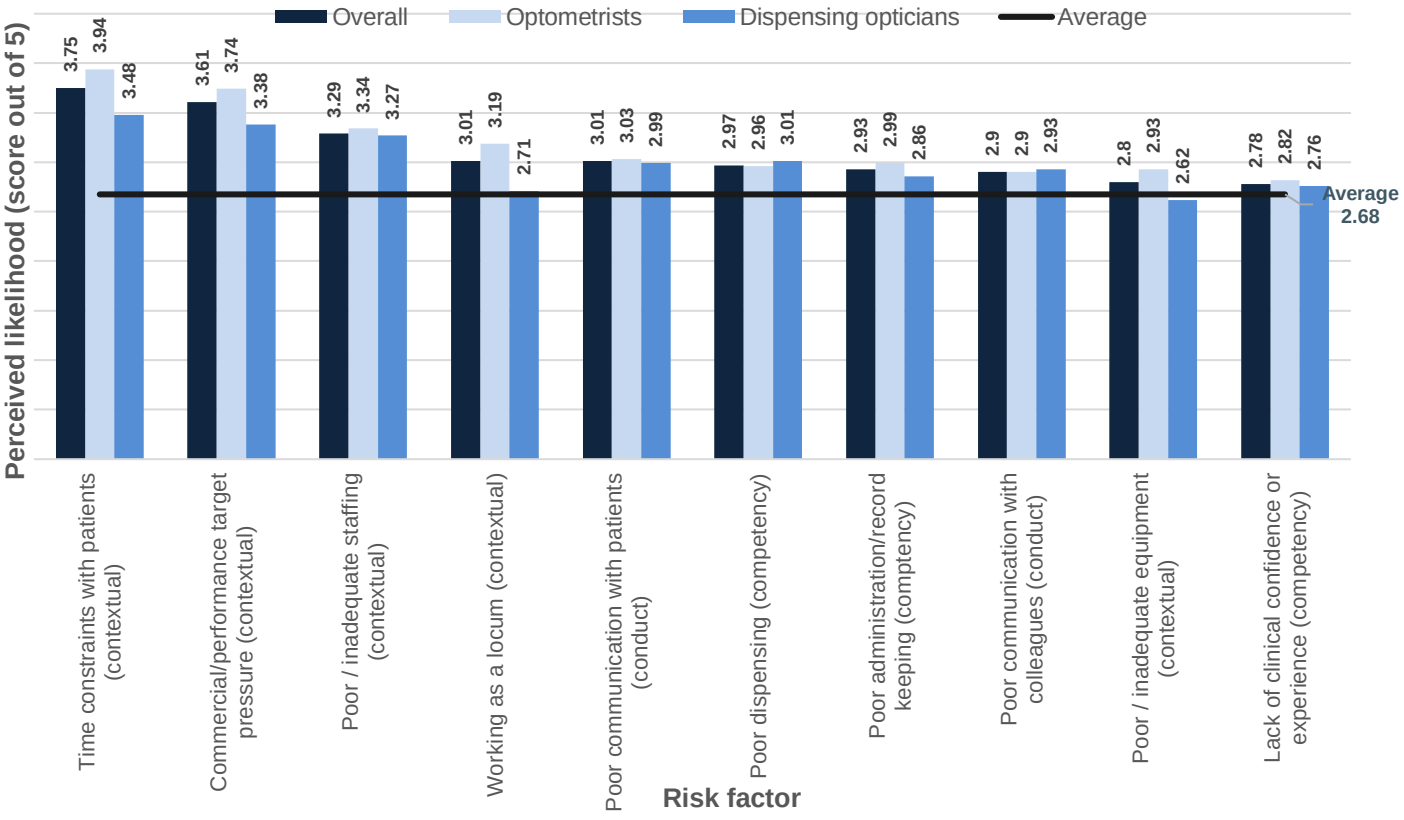
Both ratings were on a scale of one to five, where one was very unlikely or of no impact to patients or the public, and five was very likely or very high severity.

Risks were split into three categories of competency, conduct and contextual. This chapter of the report presents an overview of all types of risk together, in order to provide comparison and highlight which were perceived to be the most, and the least, likely and severe. The three categories of risk are then explored in greater detail in the following chapters.

5.1 Perceived likelihood of all risk factors

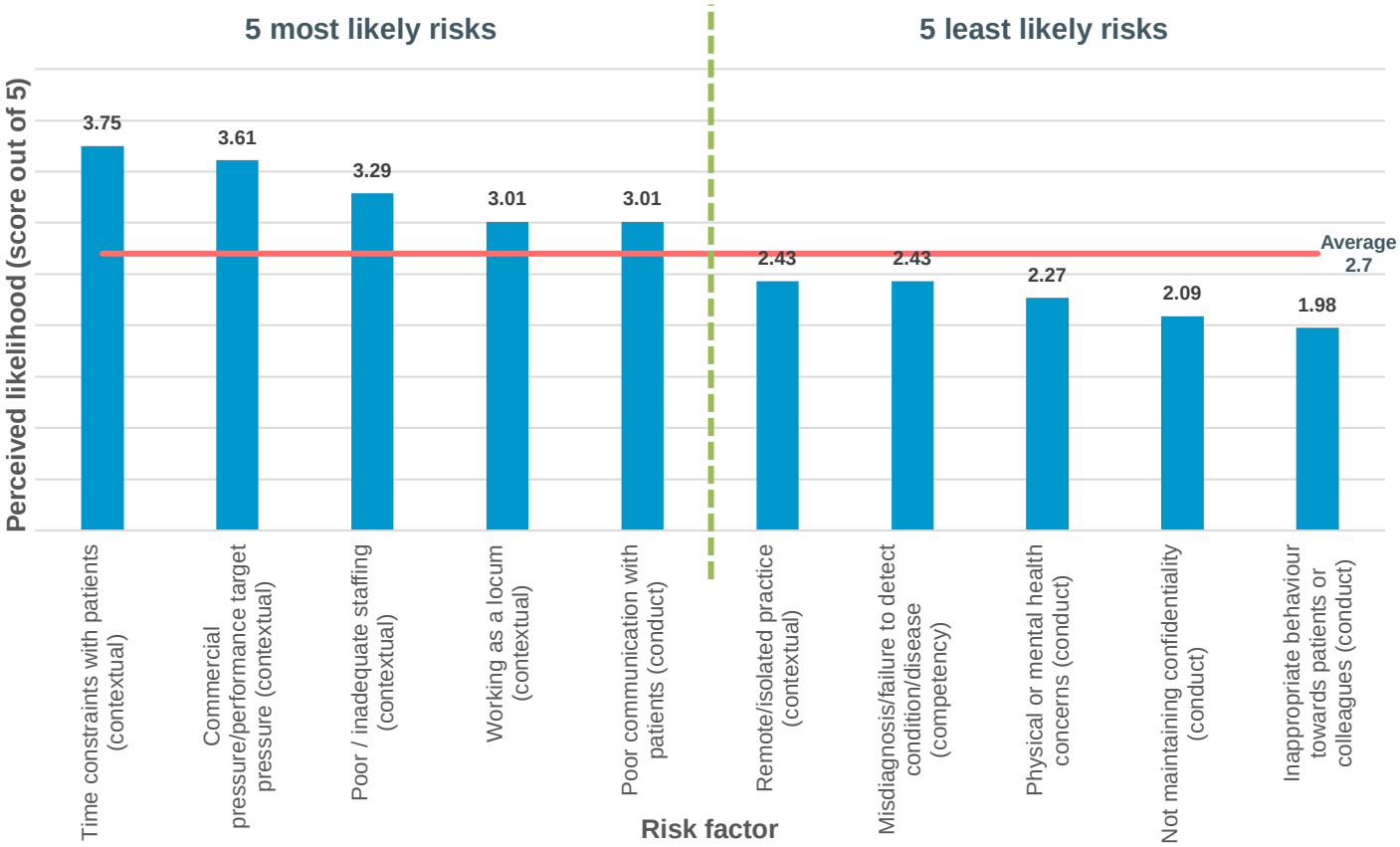
5.1.1 The chart at ***Figure 10*** below presents ten risk factors perceived by those who completed the survey to be most likely to occur in practice, split by overall (all respondents), optometrists and dispensing opticians. Time constraints with patients and commercial/performance target pressure were perceived to be the two most likely risks to occur, both of which were contextual in nature. All these risk factors were perceived to be above average likelihood (above the average line in the chart below, which represents the average perceived likelihood across all the risks factors included in the survey).

Figure 10 – Top ten risk factors perceived to be most likely to occur in practice
Base: All respondents (2,610), Optometrists (1,452), Dispensing opticians (670)



5.1.2 To understand the perceived distribution of the likelihood of risk, the chart at ***Figure 11*** below presents the top five and bottom five risk factors in terms of their perceived likelihood to occur in practice. It is interesting to note that the bottom three risk factors are all related to conduct risks, including inappropriate behaviour, not maintaining confidentiality and physical or mental health concerns. Again, the average line in the chart represents the average perceived likelihood across all the risks factors included in the survey.

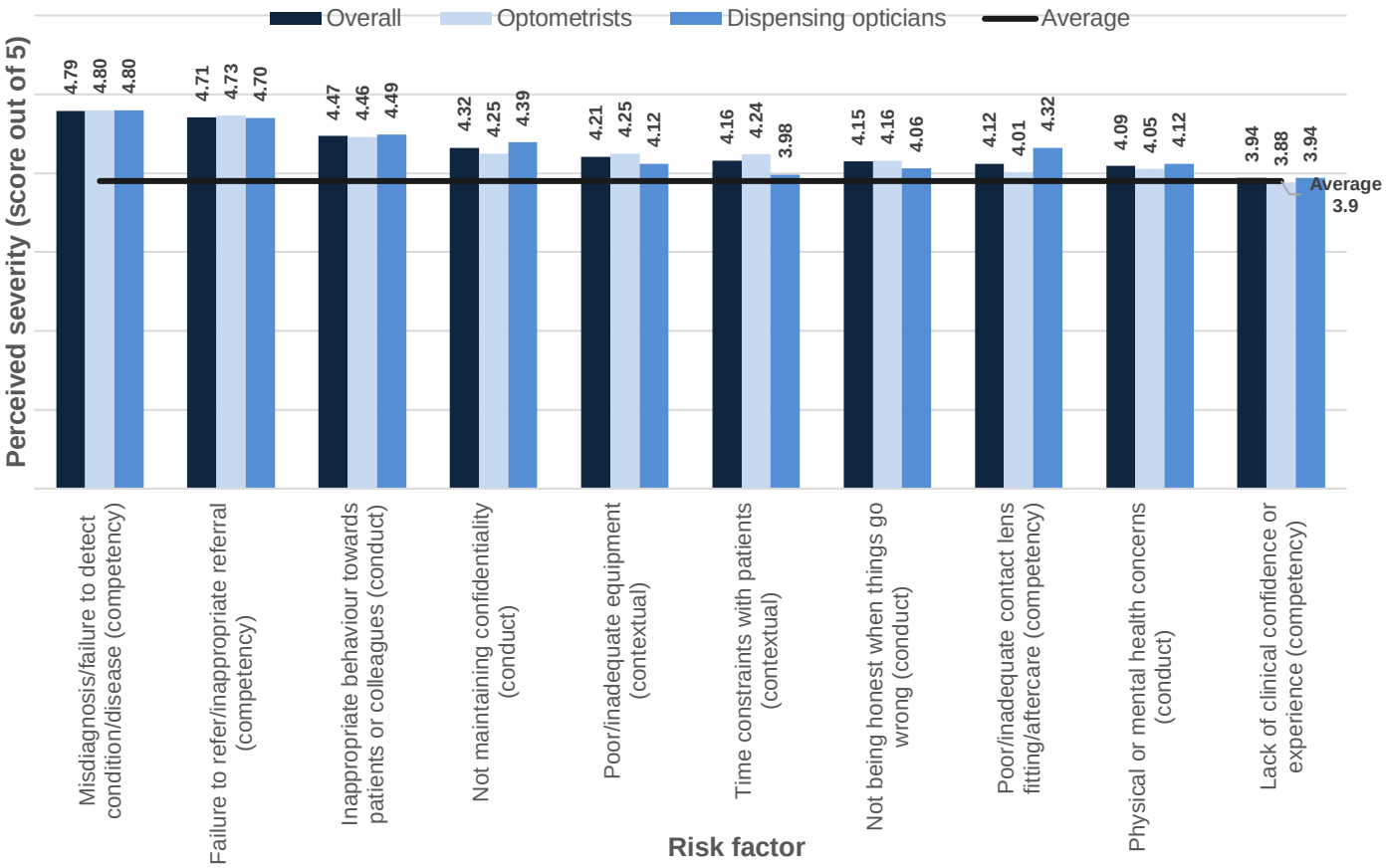
Figure 11 – Perceptions of the most and least likely risk factors
Base: All respondents (2,610)



5.2 Perceived severity of all risk factors

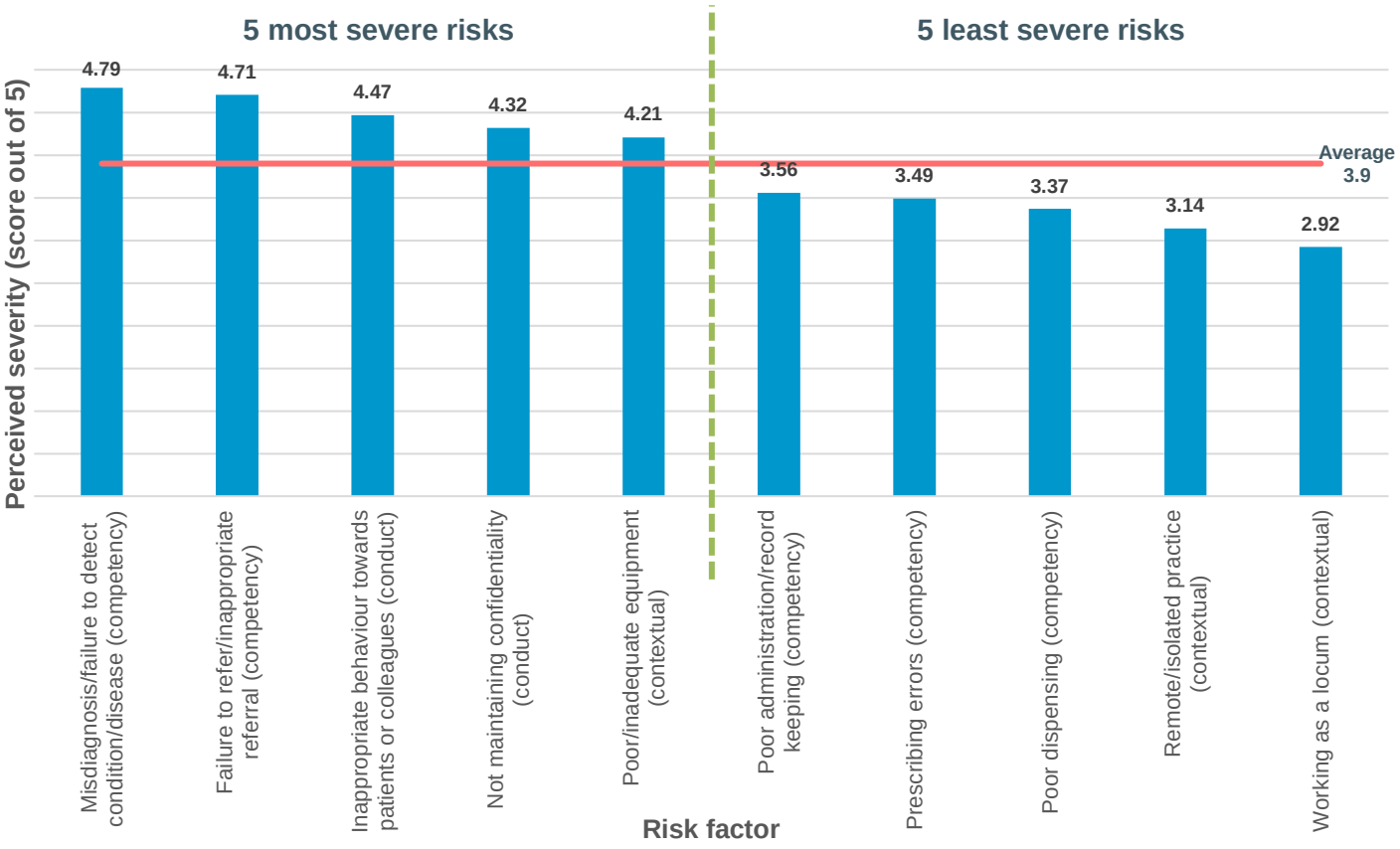
5.2.1 The chart at ***Figure 12*** below presents ten risk factors perceived by those who completed the survey to be most severe to patients and the public if they occurred in practice, split by overall (all respondents), optometrists and dispensing opticians. Misdiagnosis or failure to detect disease and failure to refer or inappropriate referral were perceived to be the risk factors with the highest potential level of severity, both of which were competency risks. Most of these risk factors were perceived to be above average severity (above the average line in the chart below, which represents the average perceived severity across all the risks factors included in the survey).

Figure 12 – Top ten risk factors perceived to be most severe if they occurred in practice
Base: All respondents (2,610), Optometrists (1,452), Dispensing opticians (670)



5.2.2 To understand the perceived distribution of the potential severity of risk, the chart at ***Figure 13*** below presents the top five and bottom five risk factors in terms of their perceived severity if they occurred in practice. The range of perceived severity is similar to the range of perceived likelihood, as shown in the previous chart. The two risk factors perceived to have the lowest level of severity, working as a locum and remote/isolated practice, were both contextual in nature. The average line in the chart below which represents the average perceived severity across all the risks factors included in the survey.

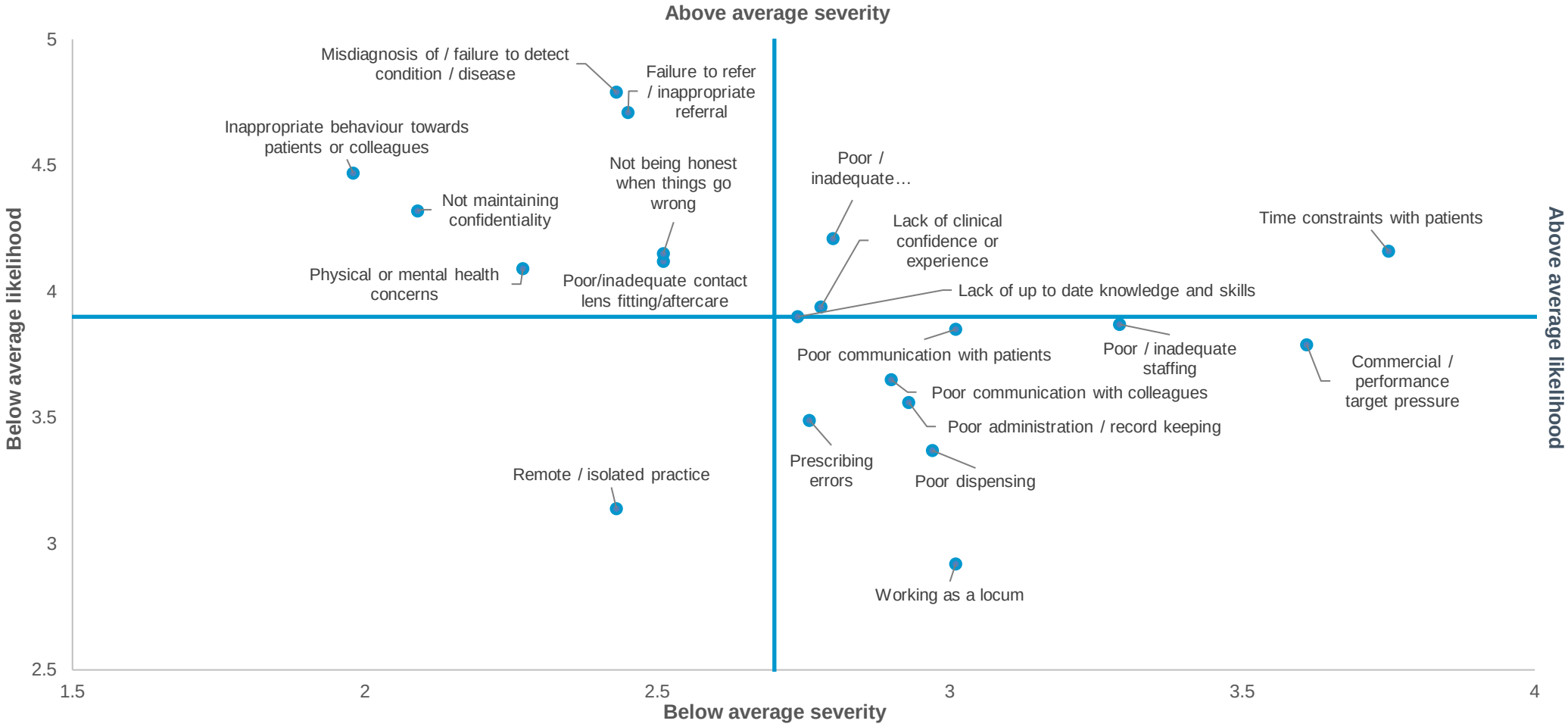
Figure 13 – Perceptions of the most and least severe risk factors
Base: All respondents (2,610)



5.3 Perceived likelihood and severity of all risk factors

5.3.1 The chart at ***Figure 14*** below provides a visual presentation of all risk factors covered in the survey in terms of both their perceived likelihood and level of severity (both scored out of 5). Most risk factors were perceived to be either below average likelihood but above average severity (see the top left quadrant), or above average likelihood but below average severity (see the bottom right quadrant). Each area of risk is covered in greater detail in chapters 6, 7 and 8.

Figure 14 – Perceived likelihood and severity of all risk factors
Base: All respondents (2,610)

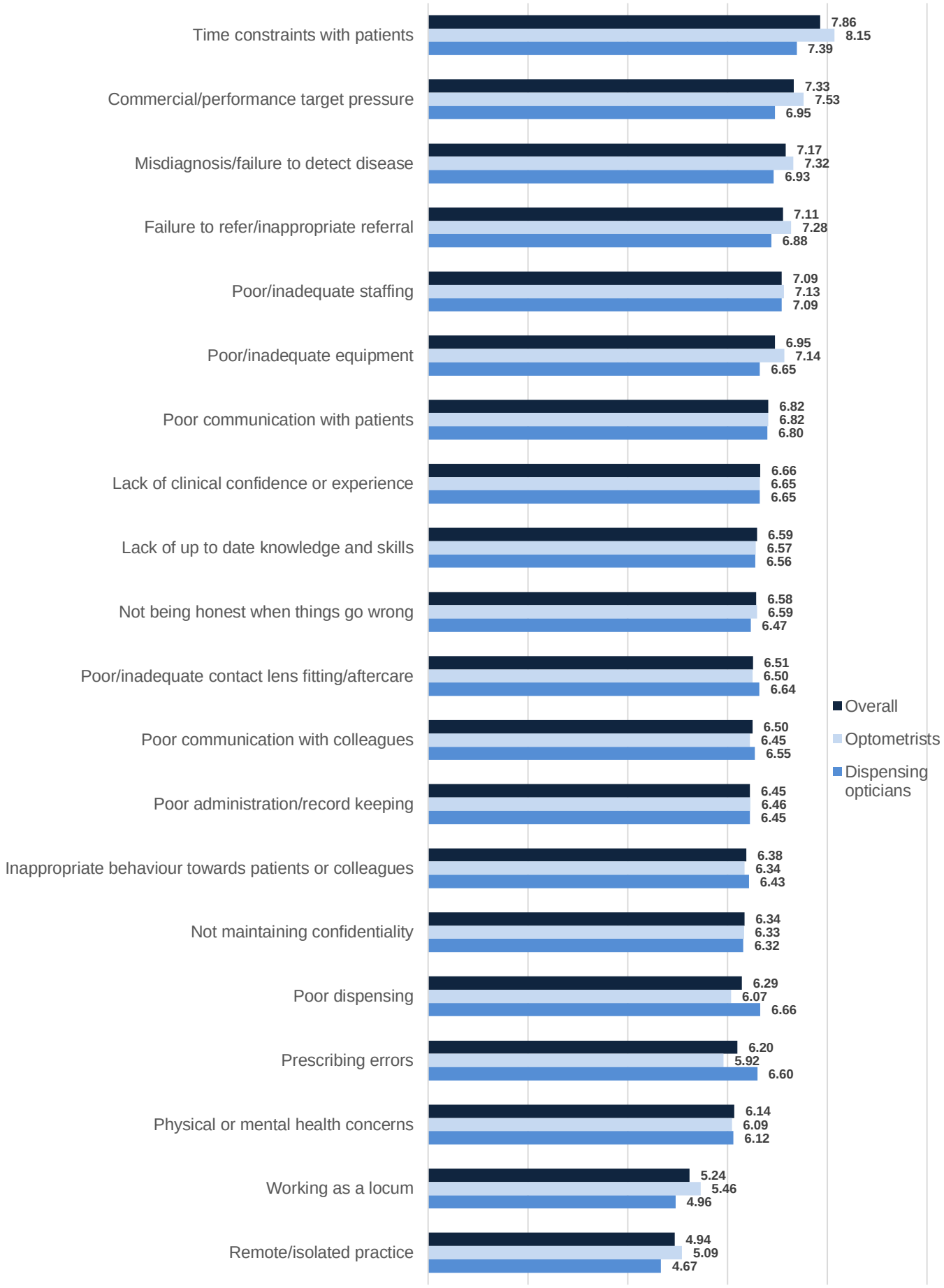


5.3.2 To be able to rank all risk factors, likelihood and severity scores for each have been added together to create a combined score. These scores are presented in the chart at ***Figure 15*** overleaf, showing results for all respondents at an overall level, and separately for optometrists and dispensing opticians.

5.3.3 *Time constraints with patients* was ranked as the most likely and severe risk factor, followed by *commercial/performance target pressure*, both of which are contextual risk factors. The next highest ranked risk factors were misdiagnosis/failure to detect disease and failure to refer, both of which are competency risk factors.

5.3.4 The ordering of optometrists results generally follows the overall results and is also very similar for dispensing opticians. However, some differences can be seen for dispensing opticians, where *poor/inadequate staffing* is ranked higher in second place, compared with fifth for optometrists, and higher scores are recorded for *poor dispensing* and *prescribing errors* (which related to errors as a result of the sight test, rather than errors when prescribing drugs).

Figure 15 – Ranking of all risk factors (combined likelihood and severity score)
Base: All respondents (2,610)



6. Competency risks

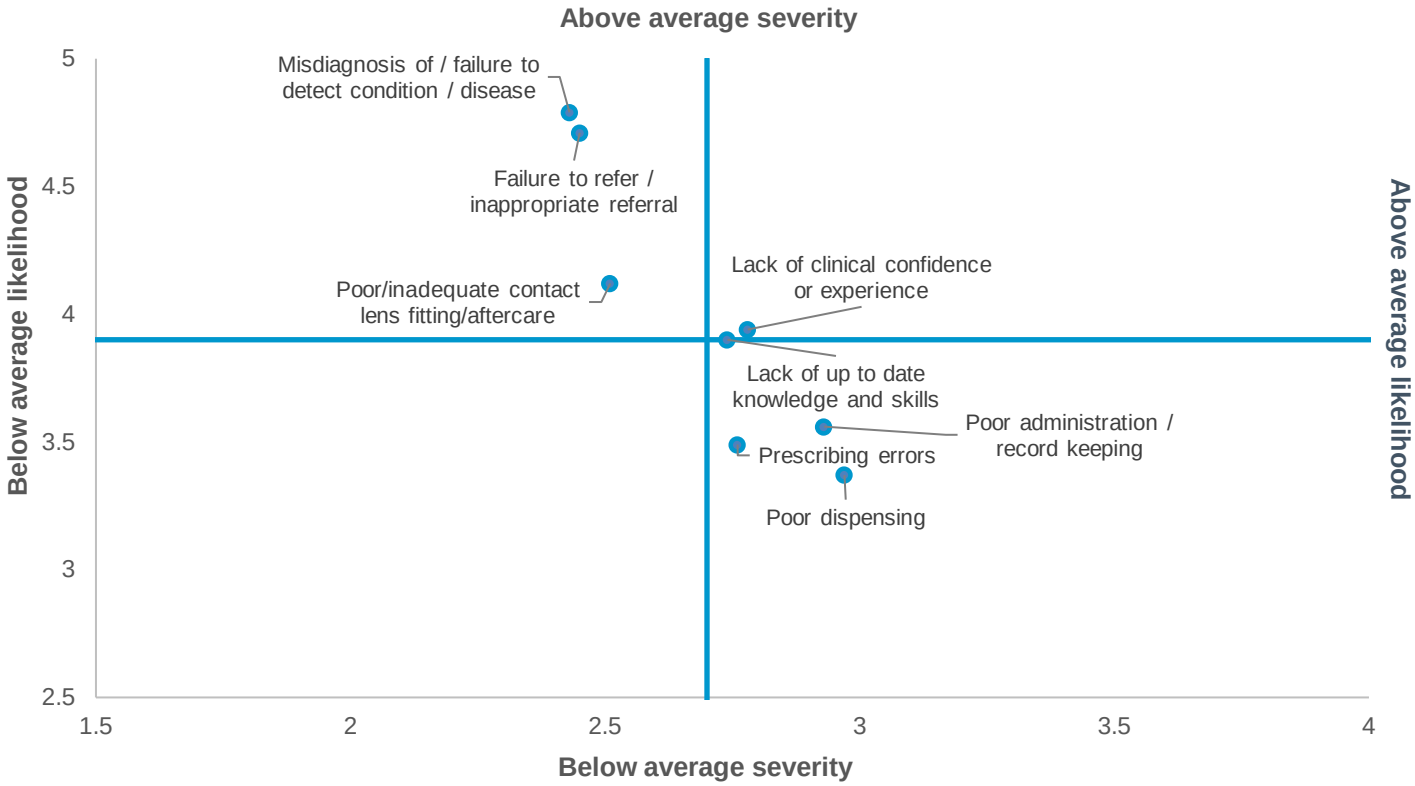
The following three chapters investigate perceptions of the three types of risk factor in greater detail using results from the survey, qualitative feedback from registrants and optical sector stakeholders, and analysis of Fitness to Practise and Optical Consumer Complaints Service data.

Competency risks are those resulting from practitioners lacking the necessary skills or knowledge. For example, a lack of knowledge to diagnose and manage disease or a lack of skill to use appropriate equipment.

6.1 Likelihood and severity

6.1.1 Survey respondents were provided with a list of potential risks related to competency which, if they occurred in practice, may place patients and the public at risk. The chart at ***Figure 16*** plots the results from all respondents to the survey, combining the perceived likelihood and severity of each potential risk.

Figure 16 – Perceived likelihood and severity of competency risks
Base: All respondents (2,610)



6.1.2 Overall, there is little difference in the levels of likelihood between risks considered less and more likely, from *misdiagnosis of/failure to detect condition/disease* (2.43) to *poor dispensing* (2.97). However, there is a greater range in the perceived levels of severity, from *poor dispensing* (3.37) to *misdiagnosis of/failure to detect condition/disease* (4.79).

6.1.3 *Misdiagnosis of/failure to detect condition/disease, failure to refer/inappropriate referral* and *poor/inadequate contact lens fitting/aftercare* recorded scores of above average severity,

compared with *poor dispensing, prescribing errors and poor administration/record keeping* which recorded scores below average severity.

6.1.4 The competency risks of *lack of clinical confidence or experience* and *lack of up to date knowledge and skills* were recorded as approximately average likelihood and severity. No risks were recorded as both above average likelihood and significantly above average severity.

6.2 Misdiagnosis and failure to detect disease

6.2.1 The risk of misdiagnosis and failure to detect disease was ranked the lowest in terms of likelihood (2.43 out of 5), but the highest in terms of severity (4.79 out of 5). Optometrists viewed this risk as more likely (2.56) when compared with dispensing opticians (2.21).

6.2.2 In general, qualitative feedback supports the survey result, with most participants in agreement that misdiagnosis and failure to detect disease was unlikely to occur in practice, but that the potential severity of the risk was high, with sight loss mentioned as the risk in extreme cases. This highlights continuity with previous research conducted by the GOC, which found that the adverse event of an optometrist missing or misdiagnosing an optical disease or condition could have very severe consequences, including the permanent loss or damage of sight, and even death in extreme cases.[13]

I don't think that misdiagnosis is a common issue, but I think if it did occur then there is a possibility that the consequences could be significant.

Optometry Scotland

If you haven't detected the condition, they're going to lose their sight, or their sight could be affected. It could affect their driving, their lifestyle.

Optometrist, Northern Ireland

6.2.3 A number of participants suggested that the profession may be much more aware of this risk following the high-profile R v Rose (Honey Maria) [2017] EWCA Crim 1168 case of optometrist who was convicted of gross negligence manslaughter in relation to a child's death, which may have led practitioners to think more about the consequences of misdiagnosis or failure to detect an ocular condition. Although the Court of Appeal has now overturned this conviction, the only case of its kind involving an optometrist, it still remains on the minds of many optical practitioners.[14] This included awareness of both the risk to the practitioner in terms of their livelihood and potential litigation, as well as the risk posed to the patient. It was suggested that, as a result of this increased awareness, the profession was practising more defensively, and was therefore less likely to attempt to diagnose eye disease and instead more likely to refer, meaning that the risk of misdiagnosis was lessened to some extent.

I think that [R v Rose 2017] *shocked the profession, because I don't think anyone really ever thought that anyone would go to prison…I think that perception of risk is a lot higher in the industry now than it was before.*

Vision UK

[13] Europe Economics. (2013). *Health Risk Assessment of Illegal Optical Practice*, p.10
[14] Hardiman-McCartney, D. and Mullin, J. (2018). *The Law of Gross Negligence Manslaughter*. Retrieved from The College of Optometrists: https://www.college-optometrists.org/the-college/blogs/the-law-of-gross-negligence-manslaughter.html

This [R v Rose 2017] *has resulted in a huge number of optometrists now feeling not confident to diagnose whether a patient's optic disc is truly swollen or not, and has led to a very high false negative referral basis into hospital eye services.*

Royal College of Ophthalmology

6.2.4 Subgroup analysis of the survey results highlights that those working in a hospital setting viewed this risk as more likely to occur (2.82), particularly when compared with those working in an independent optical practice (2.41). However, qualitative feedback suggests that the risk of misdiagnosis may be less likely in secondary care due to the increased frequency of encountering eye conditions and disease, which results in practitioners working in hospitals being more experienced, knowledgeable and confident, and therefore less likely to misdiagnose. It was also suggested that the training provided to optometrists in hospital settings helped to mitigate this risk, coupled with the fact that there is easier access to more senior and experienced colleagues or ophthalmologists.

In primary care…if somebody comes in with something reasonably rare that you've not come across in the last five years it is hard to maintain that knowledge and skills, but in a hospital setting such as Moorfields that is very different because you'd be working week after week in a clinical service such as glaucoma, and you're very regularly maintaining that knowledge. That's our bread and butter – we're doing that three or four sessions a week, every week, so it becomes the norm, whereas in primary care it's more of a screening process, where you're expected to pick up any condition that a patient might present with.

Moorfields Eye Hospital

6.2.5 In line with the survey result, some participants said that the risk of misdiagnosis or failure to detect disease was less likely than other risks due to the amount of training practitioners receive if they are involved in this area of practice, coupled with the requirement to stay up to date via Continuing Education and Training (CET), meaning that they are well qualified in this area. Again, this perception was noted in the GOC's previous research, which found that risks are mitigated by the availability of information and guidance on the diagnosis and management of diseases, including the requirement for registered optometrists to remain up to date through CET.[15]

Optoms who are involved in detecting disease will be well trained to do so and have to keep that knowledge and skill up to date. The more we get involved in these kinds of areas, the more training comes with it.

Optometrist, Birmingham

6.2.6 Some participants felt that misdiagnosis and failure to detect disease was perhaps more likely than the survey results suggested, explaining that certain conditions, such as glaucoma in its early stages, are difficult to detect. It was also suggested that many eye diseases are not acute, and therefore even though it may be likely to be missed, the risk of failure to detect is perhaps not as severe.

Your level of ability to determine whether you have diagnosed a disease or not can in fact be very poor. Glaucoma is actually notoriously difficult to diagnose in its early stages so the likelihood of that happening is actually quite high in my opinion.

Optometrist, London

6.2.7 Analysis of the GOC's Fitness to Practise database shows that, between 2016 and 2018, allegations received relating to incorrect or missed diagnosis occurred in 27% of cases (98 cases), which was the most common type of allegation raised in cases that were investigated. This

[15] Europe Economics. (2013). *Health Risk Assessment of Illegal Optical Practice*, p.10

suggests that the likelihood of this risk is perhaps greater than the current perceived levels found in the survey.

6.3 Failure to refer and inappropriate referral

6.3.1 The risk of failure to refer and inappropriate referrals was also viewed as below average likelihood of occurring in practice (2.45 out of 5), but above average severity (4.71 out of 5). This risk was seen as more likely to occur in practice by optometrists (2.59) when compared with dispensing opticians (2.24). This was reflected in the qualitative research, where dispensing optician participants again explained that, whilst they were aware of the severity of the risk, referral was not a common part of their role, and therefore the risk was less likely for them.

We're rarely in a situation we're the only person responsible for it [referral].

Dispensing optician, Leeds

6.3.2 It was highlighted that there is a difference between failure to refer and inappropriate referral. Typically, failure to refer was viewed as a greater risk than inappropriate referral, as the potential consequences for patients could be very severe, including sight loss in the most extreme cases. It was often suggested that optometry is a risk averse profession, as it is commonplace for optical practitioners to err on the side of caution and refer patients to other healthcare professionals, something which is encouraged during their education and training. Therefore, many participants felt that failure to refer was unlikely to occur in practice.

Inappropriate referral is not as risky as a failure to refer because inappropriate referral is still a referral, so hopefully somebody would still pick something up.

Dispensing optician, Cardiff

I think that optometrists as a group, as a profession, are really quite risk averse. Generally speaking, they don't take chances.

Optometry Scotland

6.3.3 However, it was suggested that this attitude towards referrals can lead to inappropriate referrals, where patients are directed to secondary care unnecessarily when they could be managed in a community setting. The immediate risks to patients of inappropriate referral were discussed, including causing unnecessary stress and anxiety, but greater focus was given to the indirect risks to patients of increasing pressure on the NHS and secondary care, exacerbating waiting times and rationing of referrals due to patients being unnecessarily referred to hospital. As evidence of this view, the British Medical Journal quoted a false-positive rate from optometric referrals of approximately 30% of new ophthalmology activity and stated that the NHS must find a solution to the waste generated by unnecessary referrals from unregulated, scattergun screening of patients attending for NHS sight tests.[16] Participant feedback may explain the survey finding that those working in a hospital setting viewed this risk as more likely (2.90) when compared with other practice settings, as they may have experience of encountering inappropriate referrals in secondary care.

If you over-refer then you increase the burden in secondary care, which means that they have pressures in their own capacity for dealing with complex cases.

Optometry Scotland

[16] Clarke, M. (2014). NHS Sight Tests Include Unevaluated Screening Examinations That Lead to Waste. *British Medical Journal (Clinical Research ed.)*, Vol.384, p.2084.

I can only see so many patients in a clinic, and that means that the person with the real symptoms is shoved further back.

Secondary care stakeholder

6.3.4 Some participants suggested that inappropriate referrals and false-positives were more likely to occur now, particularly when practitioners want to avoid risk to the patient and themselves whenever possible. It was suggested that the number of inappropriate referrals has increased significantly since the previously mentioned R v Rose 2017 court case, as practitioners are now practising much more cautiously and defensively in order to mitigate any potential risk, both to patients and themselves.

The impact it [of the R v Rose 2017 case] *has had on hospitals is huge. We get between ten and fifteen referrals every single week just to have a look at an incidental finding from a patient after a routine visit to an optometry service with no headaches and no other symptoms. But people are really anxious and second guessing themselves, and referring in.*

Secondary care stakeholder

In some ways, when they were challenged by the fact that one of them missed something, they have slightly retreated and become more defensive in their practice. So, the failure to refer has gone down, but we're getting more inappropriate referrals because they are false-positives.

Royal College of Ophthalmology

6.3.5 Analysis of the GOC's Fitness to Practise database shows that, between 2016 and 2018, allegations received related to inappropriate or missed referrals occurred in 24% of cases (87 cases), which was the second most common type of allegation raised. Again, this suggests that the likelihood of this risk occurring in practice could be greater than it is currently perceived to be by the profession.

6.4 Poor contact lens fitting and aftercare

6.4.1 The competency risk of poor/inadequate contact lens fitting/aftercare was perceived to be below average likelihood (2.45) and just above average severity (4.12). This risk was seen as more likely by optometrists (2.58) when compared with dispensing opticians (2.45), but a larger proportion of dispensing opticians viewed this risk as more severe (4.32) when compared with optometrists (4.01).

6.4.2 Previous research conducted by the GOC has found that the main non-clinical risk associated with contact lenses was incorrect/inappropriate fitting and supply, including lenses being too loose or too tight, or failure of the practitioner to provide sufficient information to the patient about care and hygiene.[17] However, this risk was not given as much focus by registrants and stakeholders during the qualitative research, with more focus given to other risks which were perceived to be a higher level of likelihood or severity. Some participants stated that the potential risks associated with fitting contact lenses had reduced in recent years due to improvements in the materials that they are made from, and a wider range of options in terms of fitting.

I think contact lenses have become safer because of technology, but also because clinicians have so much choice about what they fit.

Federation of Ophthalmic and Dispensing Opticians (FODO)

[17] Europe Economics. (2013). *Health Risk Assessment of Illegal Optical Practice*, p.20

6.4.3 As noted previously when analysing the risk levels in areas of practice, some participants explained that the risk to patients related to contact lenses was often the patients' ability to follow the advice provided by the practitioner, and even their failure to attend at aftercare appointments. It was suggested that this risk was also related to the ability of the practitioner to communicate with the patient effectively to ensure they understand how to use and look after their contact lenses.

The aftercare element is more likely to be that patients aren't attending the aftercare appointment rather than people actually doing a bad job when they are there…The aftercare is more about the patient interaction.

Dispensing optician, Birmingham

6.4.4 Analysis of the GOC's Fitness to Practise database shows that, between 2016 and 2018, allegations related to problems with fitting contact lenses occurred in just 1% of cases (5 cases), suggesting this may be a less likely risk for patients to occur in practice.

6.5 Lack of clinical confidence or experience

6.5.1 The risk of lack of clinical confidence or experience was recorded as just over average likelihood (2.78 out of 5) and just below average severity (3.94 out of 5). In terms of severity, it was scored slightly lower by registrant survey respondents (3.92) when compared with stakeholder survey respondents (4.08).

6.5.2 Qualitative feedback suggested that the potential severity of this risk was perhaps greater than the survey results indicated. Participants explained that a lack of clinical confidence or experience was detrimental to the ability of practitioners to use their professional judgement and make decisions, which had the potential to place patients at risk.

For me it's the ability to solve problems, which for optometrists is very important. They get better in time, and use information to come to a judgement. I think it can have a big impact on risk.

Optometrist, Leeds

I think lack of clinical experience would lead to a much higher severity rating.

Welsh Government

6.5.3 The main risk to patients related to a lack of clinical confidence or experience was seen as inappropriate referrals. It was suggested that practitioners would be unable to confidently refer without the right level of clinical confidence or experience, and therefore may over-refer due to fear of missing something, or alternatively miss something due to lack of experience and fail to refer.

If you haven't got the clinical competence or experience then that's probably why you're not referring appropriately, or not referring at all, because you're not confident in what you're seeing or you haven't had the experience to know that's the right route.

Optometrist, Birmingham

I think lack of clinical confidence is huge…If you speak to the pre-regs they're very worried and they don't have the confidence. There's a huge amount of fearful referring.

Rachel Pilling, Consultant ophthalmologist, secondary care stakeholder

6.5.4 It was suggested that the likelihood of this risk factor varies heavily depending on workplace setting and the amount of supervision in place, particularly for newly qualified practitioners. For example, this risk is often mitigated in larger hospital departments where support from colleagues is available, but less so in smaller departments or practices where practitioners are required to work

alone on a more regular basis. Differences in workplace setting is reflected in the survey results, where those working in hospital suggested that a lack of clinical confidence or experience was more likely (3.22), particularly when compared with those working in independent opticians (2.74) and national chains (2.80).

Within the hospital setting lack of clinical confidence or experience is variable. The majority of departments will have very close consultant contact and be very heavily supervised, but in smaller departments potentially you're left a little bit more to your own devices. So I think there is a range of clinical experience and confidence which isn't terribly well standardised.

Moorfields Eye Hospital

6.6 Lack of up to date knowledge and skills

6.6.1 The competency risk of lack of up to date knowledge and skills was perceived to be just above average likelihood (2.74) of happening in practice and just below average potential severity (3.90).

6.6.2 A number of participants in the qualitative research highlighted that it can be difficult to keep up with the pace of change within the optical sector to ensure that they remain up to date with the latest knowledge and skills. Participants explained how quickly new information is available, including procedures, guidance and technology, and that as a result it can be easy to fall behind. The main risks to patients suggested were not providing patients with the latest best practice, not detecting more serious problems, or potentially working outside their scope of knowledge and skills.

Lack of up to date knowledge and skills…there are so many new things all the time and it's likely that people are not up to date.

Wales Optometry Postgraduate Education Centre (WOPEC)

The challenge for the professional is to keep their knowledge up to date. The risk to the patient is that, if that doesn't happen, there's a challenge for other things like diagnosing conditions.

Asda Opticians

6.6.3 However, it was also discussed that this risk should be less likely to occur due to the mandatory requirements of Continuing Education and Training (CET), where all registrants are required to keep their knowledge and skills up to date. Some participants also felt that, as they perceived that CET had improved in recent years by becoming easier to access, more relevant and interactive courses, this risk was now less likely than it may have been in the past.

Lack of up to date knowledge and skills, I don't see why that is likely. We have to keep up our CET. The GOC make us do it.

Dispensing optician, Birmingham

In the last few years there's been a real improvement in CET. It's far more engaging and interactive, and considerably more available. It's more targeted on areas that require education. Now it's actually helping them improve their skills.

Asda Opticians

6.6.4 Subgroup analysis of the survey results highlights that dispensing opticians were more likely to view the risk of lack of up to date knowledge and skills as more likely (2.82) when compared with optometrists (2.69), whereas optometrists were more likely to perceive the risk as more severe (3.93) when compared with dispensing opticians (3.77). Some participants suggested that it was more of a challenge for optometrists than dispensing opticians to keep up to date with the latest developments and ways of best practice due to the fast paced development of the sector, and that therefore the risk was in fact more likely for this type of practitioner.

If you look at how quickly how information is available and how quickly technology moves on, the responsibility of optometrists, not so much dispensing opticians, to keep up to date with all the latest information on certain eye conditions and health conditions, optical techniques, it's really difficult. Everything is constantly evolving and better pieces of equipment are always available. The challenge for us is to update learning and update equipment.

Asda Opticians

6.6.5 The survey sample also shows that the perceived likelihood of this risk decreases as the number of years registered with the GOC increases. For example, those who had been registered for less than two years perceived it as more likely to occur in practice (2.83) when compared with those who had been registered for 21 years or more (2.67). The risk was also perceived to be more severe by those working in hospital (4.15) when compared with other workplace settings.

6.6.6 Analysis of the GOC's Fitness to Practise database finds, between 2016 and 2018, allegations received which related to inaccurate or inadequate advice occurred in 20% of cases (74 cases), although it is not possible to determine how many were a specific result of lack of up to date knowledge or skills.

6.7 Poor administration and record keeping

6.7.1 Poor administration and record keeping was recorded as one of the more likely competency risks (2.93 out of 5), but below average in terms of severity (3.56 out of 5). Subgroup analysis highlights that this risk was perceived to be more likely by those working in a hospital (3.32), particularly when compared with independent opticians (2.82). Additionally, those working in a hospital were also more likely to view this risk as more severe (3.77) when compared with those working in independent opticians (3.41) and national chains (3.69).

6.7.2 Feedback from the qualitative research highlights that many practitioners and stakeholders view the risk of poor administration and record keeping as more likely than the survey results may suggest. A number of participants recalled experiences of poor administration and record keeping, or highlighted reasons why poor administration and record keeping can occur in practice, often as a result of poor management systems or time constraints. It was suggested that the prevalence of this risk varied considerably from practice to practice, particularly where handwritten notes were still used, rather than electronic records.

Record keeping can be a problem area. Clinicians can occasionally go into autopilot where they do things but don't write it down. That's always more risky. They're trying to do their best for patients, giving a lot of verbal advice, but not necessarily writing it all down. We tell them they're better off writing 'College leaflet given to patient' rather than trying to write it all down when giving advice. You don't have time to write down every single thing you've said, however a College approved leaflet also allows the patient to go home and review the information you've verbally given them.

Vision Express

Record keeping can vary according to your practice management system.

Dispensing optician, London

6.7.3 Participants also suggested that the potential risk to the patient of poor administration and record keeping could be more severe than the survey results indicate. It was explained that poor record keeping could result in many other problems, particularly when monitoring patients over time, where it was very important to maintain accurate records of results and measurements to correctly diagnose and manage ocular conditions. Previous research by the GOC also highlighted the

importance of accurate record keeping to maintain a clear audit of clinical quality should any complaints need to be investigated.[18]

It could be a risk to the public if you've got poor records. You won't be able to see if anything's changed on the next visit.

Optometrist, Birmingham

6.7.4 It was suggested that poor administration and record keeping could have a negative impact on the referral process, and also the sharing of patient records between practitioners, creating further risk for patients. It is interesting to note that this risk was viewed as more likely by those working as locums (3.09) when compared with those working full (2.92) or part time (2.93), potentially highlighting the problem of sharing patient notes between practitioners.

The repercussions of poor record keeping can be quite severe…You could have occurrences where someone has been referred to primary care and there's nothing on there about follow up…A new optom could pick it up and not be able to refer back to old records to looks at things like eye pressure changing. You can only track that with good record keeping. The risk to patients is higher if you're not recording properly.

Optometrist, Cardiff

6.7.5 Analysis of the GOC's Fitness to Practise database shows that, between 2016 and 2018, allegations related to poor record keeping occurred in 20% of cases (74 cases), making it one of the more common types of allegation raised and therefore more common than the survey results suggest, in line with qualitative feedback.

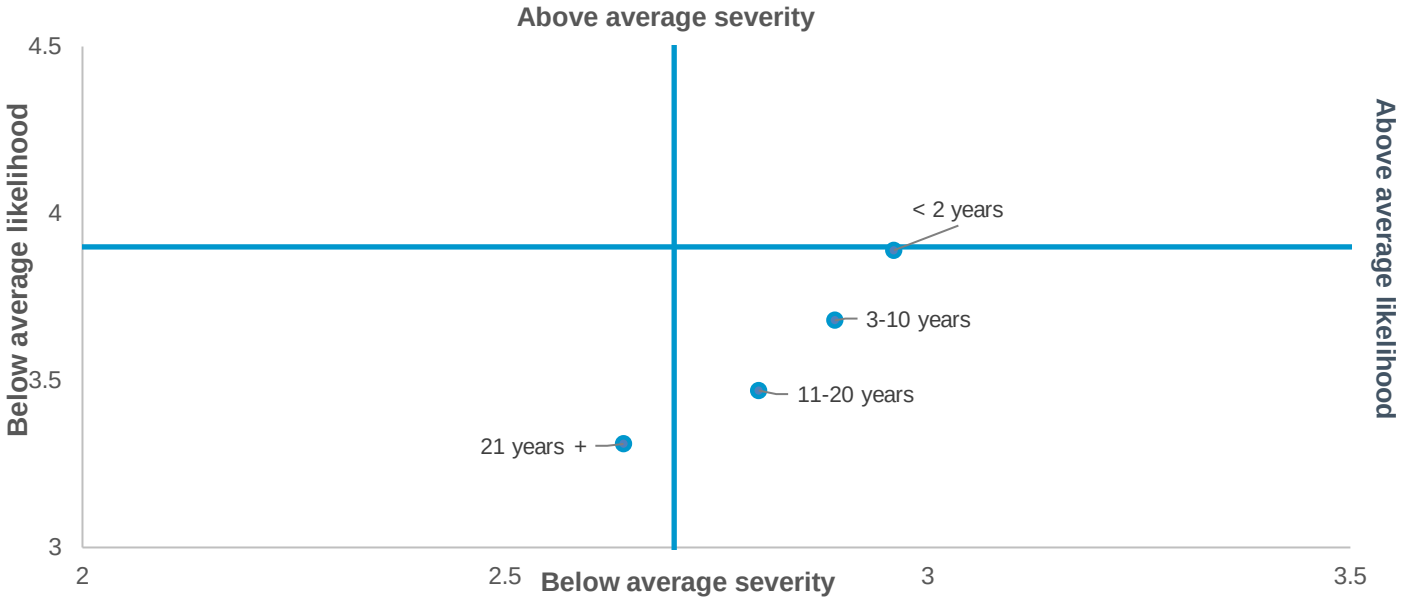
6.8 Sight test prescribing errors

6.8.1 When discussing perceptions of prescribing errors in the survey results and qualitative feedback, this relates to errors as a result of the sight test, rather than errors when prescribing drugs. The risk of prescribing errors was recorded as slightly above average likelihood (2.76) but below average severity (3.49). Subgroup analysis of this result shows a trend in perception based on the number of years a registrant has been registered with the GOC. Those who have been registered for a shorter period of time are more likely to view the risk of prescribing errors as both more likely to occur and more severe, compared with those who have been registered for longer. This is shown in the chart at ***Figure 17*** overleaf.

[18] Europe Economics. (2010). *Risks in the Optical Profession: Final Report*, p.38

Figure 17 – Perceived likelihood and severity of sight test prescribing errors by number of years registered

Base: All respondents (2,610)



6.8.2 This result was supported to some degree in the qualitative feedback, where some participants highlighted that sight test prescribing errors may be more commonplace amongst more newly qualified practitioners.

It would depend how 'off' the script was…I don't feel that that would usually happen. Maybe with a young optometrist it does, but I don't think that's a very regular thing.

Optometrist, Northern Ireland

6.8.3 Registrant focus group participants generally agreed that, whilst infrequent, prescribing errors did happen and were an inevitable part of practice due to the reliance on patients to accurately describe how a prescription affects their vision, something which they explained is subjective and may change depending on a number of factors.

The optom relies on the patient that day to give an opinion on what they perceive their best vision to be in that chair.

Dispensing Optician, Cardiff

6.8.4 Most participants also felt that the severity of the risk of prescribing errors was, in most cases, low, as problems could be easily rectified with little impact or harm coming to the patient. Previous research conducted by the GOC reinforced this view, as it found that spectacle non-tolerances do not constitute a serious risk to adults but are not uncommon and can have unwanted consequences, including headaches, blurred vision etc. and – more trivially – the time and inconvenience of returning to the optometrist for adjustments.[19]

The impact generally will be relatively small. Some differences in prescription can have very little impact and be quite insignificant.

Optometrist, Leeds

Patients get very upset by things like prescribing errors, but the actual impact upon them is low, they're very unlikely to come to harm. It's generally low risk to the patient.

Association of Optometrists

[19] Europe Economics. (2013). *Health Risk Assessment of Illegal Optical Practice*, p.10

6.8.5 However, the risk of prescribing errors was viewed as much more severe when made in relation to children. A number of participants highlighted the significant impact that the wrong prescription can have on a child due to the development of eyesight in early years of life. It was explained that not only could this have an impact on vision, but on other areas of life such as education and development, a finding echoed in previous pieces of research conducted by the GOC which highlighted the long-term impacts of incorrect prescriptions for children.[20]

If you're talking about a child prescribing error, that can have a massive severity impact. I'd actually put a prescribing error for a child right up there with misdiagnosis and failure to refer, because if you have a child in and fail to spot that they've got unequal vision, then the next time they go for an eye test in the next six to twelve months' time their vision could actually have deteriorated. And depending on that child's age, it could mean that their vision would struggle to recover from that.

Boots Opticians

A prescribing error to a three-year-old will have much more of a severe impact in terms of risk to them.

Optometrist, Leeds

6.8.6 Analysis of the GOC's Fitness to Practise database shows that, between 2016 and 2018, allegations received related to incorrect, inappropriate or incomplete prescriptions occurred in 21% of cases (79 cases), making it one of the more common types of allegation raised.

6.9 Poor dispensing of spectacles

6.9.1 The risk of poor dispensing of spectacles was viewed as the most likely of all competency risks listed in the survey (2.97 out of 5). At the same time, it was viewed as the risk with the lowest level of severity if it occurred in practice (3.37 out of 5).

6.9.2 Some of the feedback from the qualitative research supports the survey result that poor dispensing is more likely, but that its potential impacts to patients are less severe. It was suggested that poor dispensing may be something which patients feel more able to complain about, as they would be quickly aware that their spectacles were incorrectly dispensed, but that ultimately the risk of harm to the patient from poor dispensing was low.

Poor dispensing actually probably is more common and would be a thing that people are complaining about…But it's less likely to cause any harm to the patient.

Optometrist, Northern Ireland

Poor dispensing may just incur discomfort and annoyance for the patient and result in unnecessary retests.

ABDO Exams (awarding body)

6.9.3 However, a number of participants who were dispensing opticians, or stakeholders involved in dispensing, highlighted the potentially significant risks of poor dispensing to patients, including the impact that it could have on the ability of patients to drive safely. This feedback is reflected in the survey results, as those who responded to the survey as dispensing opticians were more likely to view this risk with greater severity (3.70) when compared with optometrist respondents (3.15).

If I do make a mistake, if we're talking about for example varifocal lenses, and I get that wrong, the risk associated with that, particularly if somebody was driving, would be significant. So whilst I don't anticipate getting it wrong, if I did there could be severe implications. The last thing you would want is a driver who's been dispensed incorrectly coming towards you at 70mph who can't see properly.

ABDO (professional association)

[20] Europe Economics. (2013). *Health Risk Assessment of Illegal Optical Practice*, p.36

6.9.4 The risk of poor dispensing was viewed as more severe in relation to children, vulnerable adults and those with disabilities, as conducting an accurate and successful dispense is heavily reliant on communication and feedback from the patient to indicate how the spectacles alter their vision. It was highlighted that the risk to these patients was not only being dispensed an incorrect pair of spectacles, but that if they were not correct, it would be more difficult for these patients to communicate the problem, which may cause further issues with their sight or cause them to stop wearing the spectacles altogether.

Often people with learning disabilities have got much higher prescriptions and it takes longer for them to cope with the sensory changes, particularly if it's with autism, for example. So you need to have a really well fitting, well dispensed pair of glasses.

SeeAbility

If you're a customer who might be vulnerable for some reason, because you have learning disabilities. A dispensing error for that person means that they might try and put up with their glasses or that they might not come back and complain that they're not seeing right in those glasses. So actually, dispensing errors can actually be quite significant, particularly if you are a vulnerable person.

Boots Opticians

6.9.5 No allegations were found that related specifically to poor dispensing during the analysis of the GOC's Fitness to Practise database between 2016 and 2018. However, in their most recent annual report, the OCCS stated that they have seen a reduction in the percentage of enquiries and complaints concerning varifocal/multifocal dispensing in their past three annual reports, which they attributed to their efforts to raise awareness of how to combat dispensing errors with the optical professions and industry.[21]

[21] Optical Consumer Complaints Service. (2018). *Looking Ahead: The Future of Optics, Complaint Mediation and Regulation (Annual Report 2017-18)*, p.21

7. Conduct risks

Conduct risks are those stemming from the behaviour of practitioners, either through negligence or inappropriate behaviour. For example, inappropriate behaviour towards patients or colleagues, poor communication with patients or colleagues, and not being honest when things go wrong.

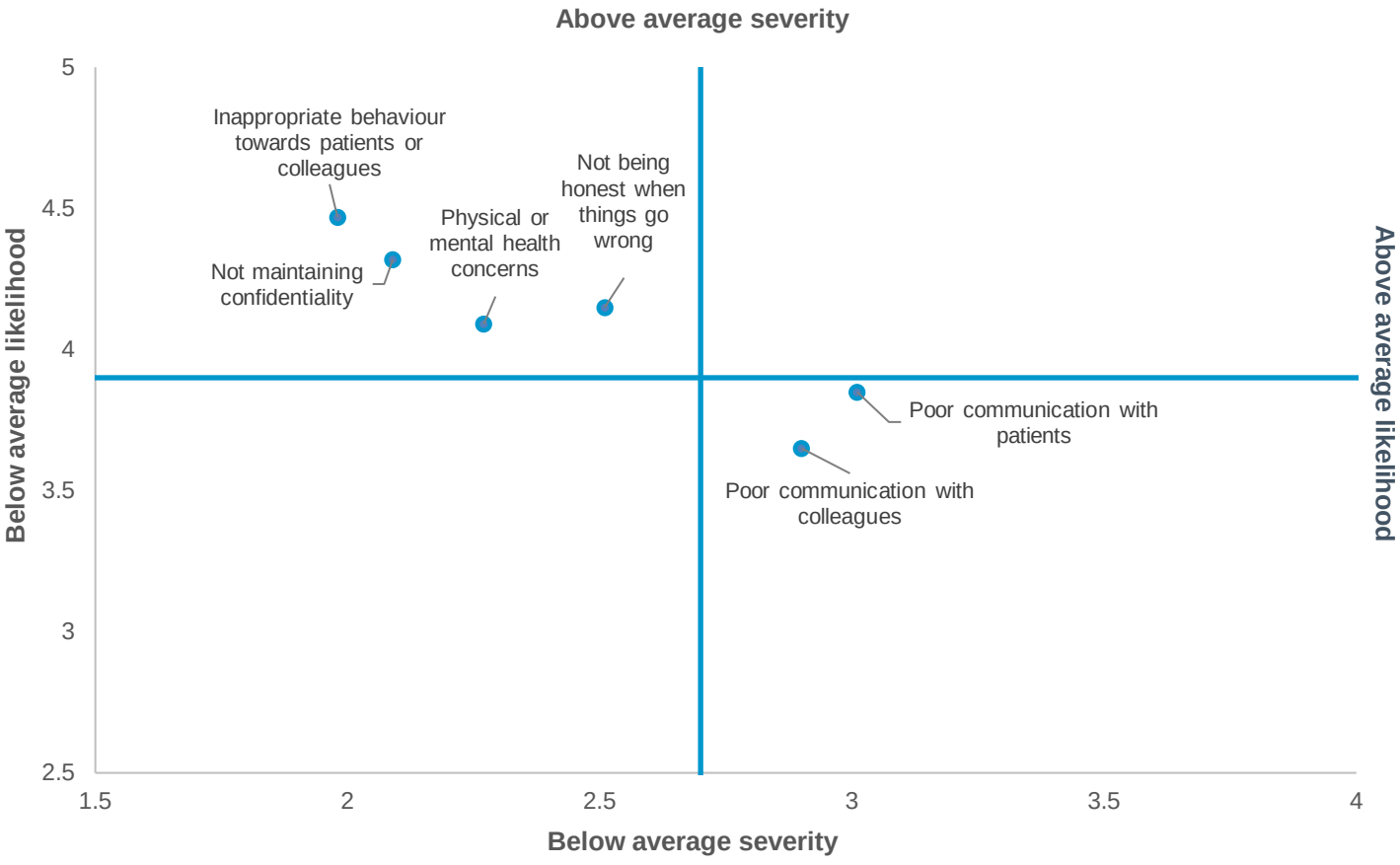
7.1 Likelihood and severity

7.1.1 Survey respondents were given a list of potential risks related to conduct which, if they occurred in practice, may place patients and the public at risk. The chart at ***Figure 18*** below plots the results from all respondents to the survey, combining the perceived likelihood and severity of each potential risk.

7.1.2 These risks have been plotted in a similar way to competency risks, with most risks being perceived as below average likelihood but above average severity, such as *inappropriate behaviour towards patients or colleagues*, or as below average severity but above average likelihood, such as *poor communication with patients.*

7.1.3 Both risks relating to communication, *poor communication with patients* and *poor communication with colleagues* were perceived to be above average likelihood but just below average severity if they occur in practice.

Figure 18 – Perceived likelihood and severity of conduct risks
Base: All respondents (2,610)



7.1.4 Analysis of the GOC's Fitness to Practise database shows that, between 2016 and 2018, 39% of allegations received related to conduct risks, a slightly greater proportion than those that related to competency risks (31%). A further 30% related to both competency and conduct risks.

7.2 Inappropriate behaviour towards patients or colleagues

7.2.1 The conduct risk of inappropriate behaviour towards patients or colleagues was perceived to be the least likely (1.98 out of 5), but the most potentially severe (4.47 out of 5). Subgroup analysis highlights that those who worked in a hospital setting saw this risk as more likely to occur (2.20), particularly when compared with those who worked in an independent opticians (1.89).

7.2.2 A number of registrant participants perceived that a large proportion of the GOC's Fitness to Practise cases are related to inappropriate behaviour or lack of professionalism on the part of the practitioner, rather than related to their competency. This contrasts with the survey results, where this risk was viewed as unlikely to occur in practice.

A lot of the complaints are more about inappropriate behaviour than they are about missing eye disease, which is what we always worry about, isn't it?

Optometrist, London

7.2.3 It was suggested that the risk of inappropriate behaviour towards patients could be more likely to be reported due to the nature of the role of optical professionals, who are required to get physically close to their patients to carry out eye examinations, something which some patients may find uncomfortable, or which may lend itself to misinterpretation or abuse. It was also mentioned that the fact that optometry spans both healthcare and retail can lead to issues around inappropriate behaviour towards patients, as the sales or retail element of the profession can sometimes cause problems between patients and practitioners.

It's a tricky area because optometrists are in close quarters with patients, especially if they're on their own. We try our hardest to keep everyone safe with lone working policies and chaperones. We don't get many of these issues, but it's a big risk and we take it very seriously.

Vision Express

Juggling sales and medical roles in chain opticians. It's a risk because half our job is medical and half of it is selling a service, selling glasses. We're being professional but also engaging to try and get them to buy specs.

Optometrist, Cardiff

7.2.4 Analysis of the GOC's Fitness to Practise database shows that, between 2016 and 2018, there were a number of different types of allegation which related to inappropriate behaviour towards patients or colleagues. However, the small percentages do not necessarily match the perception held by many participants that inappropriate or unprofessional behaviour occurred in a large proportion of GOC FTP cases. These allegations included:

- Unprofessional behaviour/rudeness – 11% of cases (41 cases)
- Discrimination – 1% of cases (4 cases)
- Inappropriate/sexual comments to patients – 1% of cases (3 cases)
- Assault of colleague – 0% of cases (1 case)
- Inappropriate behaviour towards/sexual harassment of colleague – 0% of cases (1 case)

7.3 Not maintaining confidentiality

7.3.1 Not maintaining confidentiality was perceived as having less than average likelihood (2.09 out of 5), but above average severity if the risk did occur in practice (4.32 out of 5). Subgroup analysis shows that those who worked in a hospital setting viewed this risk as more likely (2.38) when compared with those who worked in other settings, particularly independent opticians (2.02).

7.3.2 Analysis of the GOC's Fitness to Practise database shows that, between 2016 and 2018, allegations received which related to data security breaches, failure to protect data and confidentiality occurred in just 4% of cases (13 cases).

7.3.3 Qualitative research participants focused on the introduction of the General Data Protection Regulation (GDPR) in 2018. It was widely agreed that, due to these new regulations, there is increased awareness about data protection and confidentiality amongst practitioners, employers and patients, with many registrant participants indicating that they had undergone additional training to ensure they were compliant with GDPR. It was therefore suggested that this heightened awareness may explain why this risk scored so highly in terms of severity. However, it was also felt that the awareness of registrants of the requirements of GDPR and appropriate training may have reduced the likelihood of this risk occurring.

Confidentiality is a really hot topic with the new GDPR, and patient confidentiality is really important…There is a risk of complacency, but I think we are all aware of it and we all take steps. We cover each other by saying that piece of paper shouldn't have been left on the printer, that kind of thing. We just check each other constantly.

Dispensing optician, Cardiff

Awareness of data protection is a bit greater, probably due to GDPR. It's on their radar more.

Optical Consumer Complaints Service

7.3.4 When considering the risk posed to patients by not maintaining confidentiality, participants struggled to think of direct risks or risks which would cause harm to the patient. Instead focus was given to the risks posed to the practitioner, including allegations of misconduct and potential litigation. Some participants also discussed the risk to practitioners about the lack of clarity around when they should report a patient's condition to the DVLA if they do not believe they have done so, when they believe it to be in the interest of the public. The GOC has recently consulted and will be issuing guidance for registrants over the next few months on disclosing confidential information about patients, including where patients may not be fit to drive. The guidance will highlight that GOC registrants have a duty to notify the DVLA/Driver and Vehicle Agency in Northern Ireland (DVA) themselves if the patient cannot or will not do so and there is a concern for the safety of the patient and wider public. Based on the quotation below, it appears awareness of what optical professionals should do in this scenario is currently unclear. This issue is clearly seen as a risk by the profession, as 83% of GOC registrants who took part in a survey in 2017 did not think the current system for assessing fitness to drive adequately protects the public.[22]

There's definitely a risk to the practitioner, but I don't know if there's a risk to the patient as such.

Optometrist, Birmingham

Where medical conditions can affect when driving, this can be a grey area where the duty of care responsibility is. A patient tells you they have a certain condition and you tell them they're supposed to inform the DVLA, but this doesn't happen. A GP has a duty to report this, but we don't. All we can do is tell them to do it. But we have a duty to inform a GP if we think they pose a risk to the public. We still have to

[22] Enventure Research. (2017). *Vision and Driving*. p.12

prove that the patient hasn't taken our advice so it's a difficult one, it's not clear when or if we breach confidentiality. I've had occasion to call a person's GP to highlight a sight issue to make sure the public were being protected. You could look at this as a breach but because he was a bus driver, I wasn't prepared to put the public at risk.

Optometrist, Cardiff

7.4 Physical or mental health concerns

7.4.1 The risk of physical or mental health concerns of the professional was viewed as below average likelihood (2.27 out of 5) and as above average severity in relation to other conduct risks (4.09 out of 5). The likelihood of this risk was rated higher by those who worked in a hospital (2.65) when compared with other workplace settings, particularly independent opticians (2.18).

7.4.2 Both the likelihood and severity of this risk were scored as higher for those who had been registered for a shorter length of time when compared with those who had been registered for longer. For example, those who had been registered for less than two years recorded a likelihood score of 2.47 and a severity score of 4.24, when compared with those who had been registered for 21 years and more at 2.20 and 4.03 respectively.

7.4.3 When discussing this risk, a number of qualitative research participants indicated that optometry could be a stressful profession to work in and that could impact the physical and mental health of practitioners. More focus was given to mental health concerns, with some participants explaining that the level of stress they feel from their role can have an impact on their ability to practise, therefore posing an element of risk to patients. Some participants highlighted that their workplace was aware of this risk, and as a result had implemented policies and procedures to ensure the wellbeing of their staff.

The role has got a lot more stressy…With lack of sleep the night before you can make more mistakes.

Dispensing optician, Birmingham

We have lots of policies in place where they can talk confidentially to trained counsellors. The wellbeing of our practitioners is a priority.

Vision Express

7.4.4 Analysis of the GOC's Fitness to Practise database shows that, between 2016 and 2018, allegations received related to physical or mental health concerns occurred in 2% of cases (9 cases), in line with the survey results and qualitative feedback.

7.5 Not being honest when things go wrong

7.5.1 The conduct risk of not being honest when things go wrong was perceived as above average likelihood (2.51) and below average severity (4.15) by survey respondents.

7.5.2 Qualitative feedback in relation to the likelihood of this risk was mixed. Some participants felt that it was more likely that practitioners were not honest when they made mistakes, explaining that they were aware of occasions when colleagues had covered up mistakes or not reported them to patients. However, other participants felt that this risk was uncommon, and that in the main, the profession is open and honest with patients when mistakes are made.

I would say that not being honest when things go wrong should be higher up the scale in terms of likeliness. Obviously, you're not going to put it [the mistake] *in the worst light possible, but if you're actually hiding information from the patient then that can mean there is mismanagement of the patient.*

Optometrist, Birmingham

I think most optometrists are fairly straightforward and honest when they've made a mistake. They're horrified and want to make it right.

Association of Optometrists

I can't think of many times where something has been actively concealed from a patient. It's very important, but I don't think it's happening very often.

Optometrist, Leeds

7.5.3 A number of participants who represented secondary care suggested that this risk may be more likely to occur in community practice, explaining that hospital optical practitioners are encouraged to be honest when mistakes are made, and that there is a culture of openness and transparency in place to facilitate this, which they perceived to be different to community practice. This perception, however, differs from the survey results, where those who worked in a hospital setting were more likely to indicate that the risk of not being honest when things go wrong was more likely to occur (2.80) when compared with other workplace settings, particularly independent opticians (2.40).

In terms of likelihood, not being honest when things go wrong in a community setting is more likely than in a hospital setting. There's the duty of candour that is drummed into us, if something goes wrong you are open and honest about it. We see consultants being like that all of the time. I've not worked full time in a practice, only as an optical assistant and doing dispensing when I was at university, but you see a lot more covering up. Someone might say that a patient's glasses have come back from glazing broken and they've had to be sent back and there is a delay when they haven't even been ordered. Things like that. I would say there is a lot more lack of honesty in the community than in hospital.

Secondary care stakeholder

I think because of the governance that we work under in a secondary NHS setting, we've got huge compliance with the governance of data handling, transparency, being very open and not blame conscious. We're actually very well set up in secondary care for not having much risk around those sorts of things.

Moorfields Eye Hospital

7.5.4 It was also suggested that the ability to be honest when things go wrong was something which developed over time with experience, and that the risk of not being honest may be more commonplace amongst newly qualified practitioners who do not feel confident enough to admit to mistakes. This perception is supported in the survey results, as those who had been registered with the GOC for less than two years were more likely to view this risk as more likely to occur (2.75) and more severe (4.28) when compared with those who had been registered for 21 years and over (2.44 and 4.09 respectively).

If we take apprentices on, they are really scared about owning up when they have done something wrong. That might be experience though. I know that if I have done something wrong with a customer, you're likely to be going to be found out at some point so the best course of action is to apologise. When you are used to doing that, even if it is something as simple as the wrong order, the customer very rarely calls you an idiot and instead they say don't worry about it. It's people's natural tendency to not admit when they have done something wrong. Especially when you are young because you are worried about people thinking you are no good, but when you are older it's easier to say you've done something wrong.

Large employer stakeholder

7.5.5 A view widely shared amongst participants was that the risk of not being honest when things go wrong is more likely to occur because optical practitioners are worried about the repercussions to themselves if they admit to a mistake, suggesting that it is a risk related to practitioners rather than to patients. Many participants highlighted the increasingly litigious environment in which they and other healthcare professionals now worked, meaning that they were conscious that mistakes could

lead to being sued by a patient. They therefore felt that this discouraged practitioners from being honest when things go wrong, and that they would be more inclined to cover up mistakes.

In optometry, because of the retail element of it, and people being afraid of litigation, I think if things do go wrong, people aren't likely to be candid about it because there's an element of personal protection. If it's costly, they're more likely to cover them up. In terms of the risk to patients, I'd say it's more likely than we might think.

WOPEC

Because people don't want to be sued. And when you open up and maybe confess to something, you potentially open yourself up to being sued. And that is why people are saying that it is above average likelihood and severity. They're trying to fix something or they're potentially trying to cover a mistake.

Optometrist, Northern Ireland

7.5.6 Linked to the fear of litigation, several participants also highlighted the fear amongst optical practitioners of Fitness to Practise and the General Optical Council, as this could remove their ability to practise and take their livelihood away. Again, it was felt that awareness of having potential mistakes investigated in this way, placing their registration at risk, would discourage practitioners from being honest when things go wrong, making this risk more likely to occur.

I think that clinicians will have a fear of facing a Fitness to Practise investigation at the GOC, facing an investigation at NHS England.

Head of Dental & Optical Services Commissioning, NHS England

The heavy hand of the regulatory bodies can maybe lead to a breakdown in the patient-practitioner relationship, this can lead to defensive practice and perhaps challenge the clinician's duty of candour. It should not happen, but I can understand why people might want to protect themselves, rather than being open and transparent. Within the NHS system openness is encouraged and the culture is more supportive of practitioners, we are all human and we can all make mistakes, I would doubt that anyone has intent on harming patients, but errors can happen. The matter is dealt with as a system issue within the NHS rather than any single individual being blamed unless there are obvious reasons to consider otherwise.

Optometry Scotland

7.5.7 It appears that awareness of the requirement of optical professionals to be honest when things go wrong has increased recently amongst the profession, linked to the attention given to duty of candour by the GOC in recent years. Some participants felt that this was leading to an improved culture within the profession where practitioners could be more honest when mistakes are made and encouraged to learn from them. Therefore, the perception was held by some that not being honest when things go wrong was less likely to be a risk in practice.

It's the newest flag-up from the GOC. We are now accepting that it's ok to be honest about things… we are not perfect and we can grow from our mistakes.

Optometrist, Edinburgh

The duty of candour has very helpful. We would be very surprised about people not being fully aware of that. We know that people are now more open with patients than they would have been ten years ago.

FODO

7.5.8 Linked to the increased awareness of duty of candour, some organisations explained that they try to have a culture of openness in relation to mistakes and try to learn from them. Others highlighted that they attempt to create a culture of openness amongst their practitioners in relation to mistakes, encouraging them to be honest when things go wrong and to learn from their mistakes to improve their practice.

We get everybody to report the errors that they make and we analyse them and look for trends centrally. We also have a team of clinical governance optometrists, so where they see mistakes happening, they actually coach people to make sure that those mistakes aren't made again.

Boots Opticians

In Scotland, within the NHS, most practices are encouraged to reflect on any issues that come up on a day to day basis and run critical event analysis. It's a good way of self-policing your activity and reducing risks to patients. If something went wrong, you could learn from it and prevent anything from happening again of that nature in the future.

Optometry Scotland

7.5.9 However, a number of stakeholders explained that they did not feel that the current culture in optometry enabled practitioners to feel comfortable admitting to mistakes when things go wrong, which meant that this would be maintained as a risk to both patients and professionals. They felt that this would change if practitioners were able to be more honest about their mistakes, enabling practitioners to begin learning from and reflecting on their mistakes. It was also suggested that practitioners could also be supported by further training in how to communicate with patients when things have gone wrong with their care, and this may become more important in the future as practitioners take on more clinical roles.

I think all professions have got a little way to go in terms of being honest when things go wrong. It's something that needs to happen and the culture needs to change so that effectively we learn from the mistakes that we make. It's not a surprise, and I think we've got some way to travel with it.

Welsh Government

Some staff are saying to us, mainly in acute health, that there are patient safety risks, where improvements are needed, but they're afraid to speak up and raise issues. They are worried that they'll be seen to be difficult, that such insight is not welcome and where everyone is working under resource pressures, the implicit message is 'just get on with it and keep your head down.' And when things go wrong there's too much evidence of a strong blaming culture. If staff feel that they're going to be pounced on when something goes wrong, then they're not readily going to share examples of unsafe care or near misses that or say that something different is needed. And it's a big problem if staff are going to be criticised for reflective practice. It's essential to share information when things go wrong, and if people are too fearful to share, then we're missing opportunities to act on that insight to improve patient safety.

Patient Safety Learning

I think the 2016 Standards have gone a long way to raising that in the consciousness of registrants, which helps. But there's still a challenge. Optical professionals, like many other healthcare professionals, are happy to be open and honest when there hasn't been any harm caused, but creating the same culture and ensuring the same duty of candour applies when there has been harm, is where the challenge lies. You have to then deal with a trickier conversation. Given the links with medicine, it is now seen as more important, but it's getting people more comfortable with how to manage those situations so that the patient is supported in the best way possible and you're not increasing the fear for them, while ensuring swift action is taken if any damage can be minimised. It's not just understanding candour, it's understanding how to communicate and interact with patients in those scenarios.

Optical Consumer Complaints Service

7.5.10 There was some discussion about the severity of risk to patients when practitioners are not honest when things go wrong. A number of participants suggested that the severity was low, stating that they perceived the risk to be to the practitioner who may face litigation or Fitness to Practise, or that it may pose a risk to the reputation of the profession, but not necessarily to the patient.

I'm not sure it's a huge risk of harm but more of lack of good will to the patient.

Optometrist, Cardiff

If we're talking about actual harm to the patient then I think the risk is actually quite low. The 'honesty' bit is about owning up, not necessarily about the care of the patient.

Primary Eyecare Services

7.5.11 Conversely, other participants suggested that not being honest when mistakes are made can pose a risk to patients, as problems may be ignored to the detriment of the patient. Furthermore, the practitioner will not learn from their mistakes and will potentially continue making mistakes in the future.

With not being open and honest when things do go wrong, the potential is that clinicians may not learn when things do go wrong. And then that could replicate across, not just one patient, but potentially multiple patients.

Head of Dental & Optical Services Commissioning, NHS England

7.5.12 Analysis of the GOC's Fitness to Practise database shows that, between 2016 and 2018, allegations received related to dishonesty occurred in 15% of cases (54 cases). This category does not include fraud, which occurred in 4% of cases (13 cases).

7.6 Poor communication with patients

7.6.1 The risk of poor communication with patients was viewed as the most likely conduct risk (3.01 out of 5), and just below average severity (3.85 out of 5). As seen for other potential risks, poor communication with patients was seen to be more likely by those who worked in a hospital setting (3.35) when compared with other settings, particularly independent opticians (2.91). No significant subgroup differences were recorded for the severity of this risk.

7.6.2 Poor communication with patients was one of the most widely discussed conduct risks in the qualitative research. However, a number of participants identified that both poor communication with patients and colleagues were also competency-based risks, as the ability to communicate was an important competency for the optical professions, linked to many other competencies and potential areas of risk.

Communication is a competency…A lot of competency risks stem from communication skills. If you're not getting the right information from your patient about history and symptoms, their lifestyle, their potential mobility problems, then you're failing to communicate. It's an overlooked competency not deemed as important as clinical skill.

ABDO Exams (awarding body)

7.6.3 Most participants agreed that poor communication with patients was likely to occur in practice. It was suggested that communication with patients improved with experience, with some participants noticing that poor communication with patients was more common amongst some newly qualified practitioners. It was therefore suggested that communication skills should be covered in greater depth with students during their education and training to overcome this issue.

Great communicating and bedside manner techniques isn't something that is taught at university. I don't think we have as much intelligence, like the other medical professionals do, about effective communication…We're a little bit behind on that, but I do think we are catching up.

Boots Opticians

By the time you get to postgraduate education it's taken as read that people understand what their communication duties are and how to effectively communicate and give written communication as necessary. But sometimes that communication can be lacking.

WOPEC

7.6.4 Some registrant participants also highlighted that the ability to communicate effectively with patients varied significantly from practitioner to practitioner, and that therefore this was a likely risk to occur in practice. Some participants held the view that the majority of concerns raised by patients were typically related to poor communication, from statistics they had seen from the GOC's FTP data and OCCS data. It was suggested that the amount of training they receive in this area via CET is lacking given the amount of time they spend communicating with patients.

We are customer facing all day long and something we don't get a lot of training in is how to talk to patients. It's not about how to break bad news to patients, it's just physically talking to patients about what's happening in their eyes, their prescription. I imagine that if we asked 25 patients why they didn't come back to our practice, some of it would be poor prescribing or dispensing, but some will be because we didn't talk to them nicely.

Optometrist, London

There may still be poor communications with some patients in some cases. The OCCS data show that, in the cases they consider, which is a very small number against the whole range of dispensing that takes place each year, they're often down to poor communication.

FODO

7.6.5 Analysis of the GOC's Fitness to Practise database goes some way to support this perception, as between 2016 and 2018, a number of allegations received related to poor communication with patients occurred in 14% of cases (50 cases). A further 2% (8 cases) related to failure to communicate risks to patients. In their latest annual report, the OCCS reported that complaints relating to customer care, the relationship between optical professional and consumer, and communication have reduced from 33% to 28% between 2016/17 and 2017/18. This equates to a 21% decrease in complaints relating to customer care and complaint handling, building on a decrease seen in 2016/17.[23]

7.6.6 It was also suggested that poor communication with patients was more likely to occur in practice due to the time constraints that many optical practitioners face. Both registrants and stakeholders highlighted that it was increasingly difficult for practitioners to communicate everything required to patients or in a way that they would be satisfied with within the time available, thereby presenting potential risks to patients if vital information is not communicated to them, or if information is not communicated clearly.

Poor communication with patients may reflect the lack of time we have with patients… and when we are stuck for time communication could be cut.

Optometrist, Edinburgh

Our communication with patients is probably minimised by the busy clinics and lack of time to really offer everything the patient could probably benefit from, so I think that could probably be improved upon.

Moorfields Eye Hospital

7.6.7 Most participants felt that poor communication with patients could be of higher severity than the survey results indicated. One of the issues identified was that poor communication with patients can lead to confusion, particularly related to referrals, which could result in follow up tests or treatment not being carried out. This was seen as particularly severe when related to eye health conditions outside the standard eye examination, where time was a factor in the potential success of a treatment.

[23] Optical Consumer Complaints Service. (2018). *Looking Ahead: The Future of Optics, Complaint Mediation and Regulation (Annual Report 2017-18)*, p.19

Poor communication with patients can be a severe risk. If you're explaining the importance of referral, or if you're advising them to see their GP.

Optometrist, Leeds

One of the risks is that sometimes people get misinformation. The risk is patients leaving the opticians confused about whether they have an eye condition or not.

Royal National Institute of Blind People (RNIB)

7.6.8 As optometrists are moving towards increased management of patients with optical disease and conditions, it was suggested that the potential risk of poor communication with patients was more severe now than ever, as poorly communicating how to manage certain conditions could have significant negative impacts on patients.

Poor communication is a big risk and carries high severity. Patients can be sent the wrong messages and may do something inappropriate as a result. If we're moving more towards management, if the communication goes awry, anything can happen. They might put the drops in the wrong eye, they may not understand what the treatment is.

WOPEC

7.6.9 It was also suggested that poor communication with patients could have the potential to scare or overwhelm patients unnecessarily, either by providing too much information, using too much technical or specialist terminology, or communicating the worst possible outcomes to patients without any form of reassurance. Some participants highlighted the problems caused by written communication available to patients, such as the leaflets provided if patients are referred for further testing, which may provide patients with too much information at an early stage in their diagnosis.

The one I see in terms of wellbeing of the patient is when something that is really not that serious has been communicated in such a poor way that it's scared the living daylights out of the patient. Technical terminology has been used but it hasn't been put into any form of context to get across that it isn't a big deal. Patients go away and Google it, and then spend the next three years avoiding having an eye test.

Optometrist, Leeds

There's a tendency to use the technical terms to show what they're talking about, when what they need to do is communicate in a way that patients can understand better. It can lead to a breakdown in understanding…It's the technical terms that might lead them to being more alarmed than they need to be.

Association of Optometrists

7.6.10 The ability of practitioners to correctly refer and signpost patients who have been diagnosed with certain eye conditions was questioned in relation to poor communication with patients. Some stakeholders from patient organisations and charities explained that they were concerned about how patients were communicated with at this stage, as this was crucial to ensure they went on to receive the appropriate support available to them.

If communication is poor at the outset, it may actually change the trajectory of somebody's journey towards getting help and support…If communication is not given clearly, and is not followed up, that person might just be sticking the paperwork into the back of a drawer somewhere and carry on as if nothing has happened, and hope for the best. The longer that goes on, the greater the risk that somebody is not going to get the help that they need…It's not only about the diagnosis because often with diagnosis there isn't a cure, it's about where people are signposted onto the next area.

Blind Veterans UK

7.6.11 Communication with patients who have disabilities and vulnerable patients was discussed by a number of participants, as this was viewed as a potentially higher risk area for optical practitioners. Participants highlighted that it is often more difficult for a patient with a disability, particularly a

learning disability, to be able to correctly communicate the required information during a sight test, and also suggested other potential barriers that practitioners may face when trying to test the sight of someone with a disability, such as the patient sitting still or having issues being touched.

For our patients the risk is much greater. If the people supporting someone can't tell how much better they can see with this pair of glasses for example, or that this person is as entitled as the next person to access cataract surgery. If I haven't got that across as an optometrist, then that person will go on to be functionally visually impaired.

SeeAbility

If I reference it back to the eyesight test for people with a learning disability, the communication skills that are needed for that type of patient would be completely different to, for want of a better word, a 'run-of-the-mill' patient…Not everybody has those skills, and not everyone will want to have those skills, to deal with vulnerable groups such as the homeless, asylum seekers, learning disability. So I think that there's a risk that we've got a gap in the market and a lack of choice for certain groups of patients.

Head of Dental & Optical Services Commissioning, NHS England

7.7 Poor communication with colleagues

7.7.1 The risk of poor communication with colleagues was viewed as above average likelihood (2.90 out of 5), but scored the lowest level of severity (3.65 out of 5). Again, this risk was seen to be more likely by those who worked in a hospital setting (3.15) when compared with those working in an independent opticians (2.80). No significant subgroup differences were recorded for the severity of this risk.

7.7.2 When discussing the potential risk to patients of poor communication with colleagues, many participants focused on the problems of communication between primary and secondary care. For example, a number of stakeholders highlighted problems with referrals between primary and secondary care, particularly around the transfer of patient records and receiving follow up information from a hospital following a referral.

There are a lot of issues with communication between primary and secondary care. Recently optometrists have managed to get NHS email addresses, which means they can directly communicate with hospitals, but that's only just happened. Records don't necessarily go complete between services.

Vision UK

In some areas the optometrist won't get information back from the hospital about the person's diagnosis. That makes it difficult to give advice about the condition or treatment. It is problematic.

RNIB

7.7.3 It was suggested that issues in communication between primary and secondary care were not necessarily the fault of practitioners, but were caused by the systems in place within the NHS that made this communication difficult. If this system of communication is improved, this would make communication between optometrists and ophthalmologists more effective, allowing for the smooth flow of advice and feedback between primary and secondary care, and also enabling optometrists to more easily take on extended roles in the community.

There is need for improvement [in communication between optometry and ophthalmology]*, and that's not a criticism of optometrists or ophthalmologists. It's the way the NHS is currently set up that makes it difficult for effective two-way communication. There are potentially better models of care that would allow optometrists and ophthalmologists to be networked effectively so optometrists can more easily get advice from ophthalmologists and ophthalmologists can feed back to optometrists better. It is a risk…but it's more about how the NHS is currently delivering its service. It would be good if optometrists were better networked with their local eye department. It's possible these days to have video linking and access to*

advice that is currently available between optometrists and ophthalmologists. One of the key issues is that the ophthalmologists need to have confidence in the work being done by their optometry colleagues. To minimise risk and enhance patient safety and efficacy of treatment, we have to have good confidence in our colleagues. It will help optometrists to have an easy way of expanding their role.

Royal College of Ophthalmology

7.7.4 Some participants also highlighted the risk to patients caused by poor communication between optical practitioners within the same workplace, which they felt could lead to serious problems, particularly if communication has been poor when handing a patient over to a colleague. A number of participants worked for national chains and suggested that communication between staff was something which they perceived to be of greater risk in this setting due to other factors such as a large number of staff, high staff turnover, record keeping systems, reliance on locum practitioners, and time constraints.

Communication is essential with both your colleagues and patients because if you are not understanding either the handover or what the patient wants, then you can't recommend the best solution for them or understand their needs.

Dispensing optician, London

7.7.5 The GOC's Fitness to Practise database does not highlight any allegations specifically related to poor communication with colleagues between 2016 and 2018, in contrast to the survey results which found that respondents perceived it as above average likelihood.

8. Contextual risks

Contextual risks relate to features of the environment in which a practitioner operates that may increase the scope of risk, or influence the severity or likelihood of risks, and are often not under the control of the individual practitioner. For example, isolated practice, time constraints with patients or poor equipment.

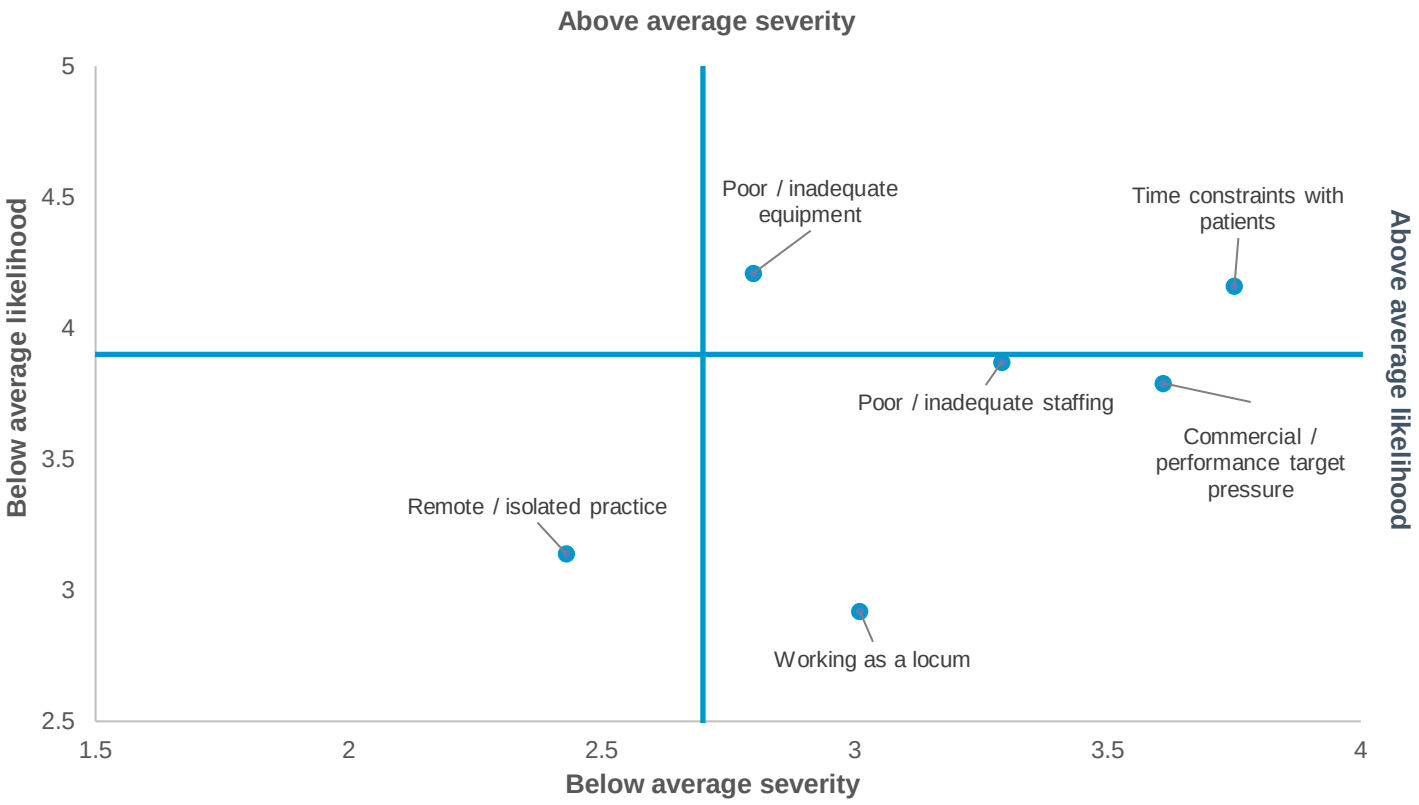
8.1 Likelihood and severity

8.1.1 Survey respondents were given a list of potential risks related to context which, if they occurred in practice, may place patients and the public at risk. The chart at ***Figure 19*** below plots the results from all respondents to the survey, combining the perceived likelihood and severity of each potential risk.

8.1.2 In comparison to competency and conduct risks, contextual risks have been plotted in a different way, with some risks perceived as above average likelihood and severity. These include *time constraints with patients* and *poor/inadequate staffing*.

8.1.3 Conversely, *remote/isolated practice* was perceived to be below average likelihood and severity.

Figure 19 – Perceived likelihood and severity of contextual risks
Base: All respondents (2,610)



8.2 Poor or inadequate equipment

8.2.1 The contextual risk of poor or inadequate equipment was perceived as just above average likelihood to occur in practice (2.80 out of 5) but as having one of the highest level of potential severity (4.21 out of five). This risk was viewed as more likely by registrant respondents (2.82) when compared with business registrants (2.43) and employers (2.41). It was also viewed as more severe by those who worked in a hospital (4.31) when compared with other workplace settings.

8.2.2 In general, qualitative research participants felt that the likelihood of this risk was low, with most registrant participants stating that they had no experience of working with poor or inadequate equipment, and that more often than not, the opposite was true, as they worked with high quality and up to date equipment and technology. Most stakeholders and employers said that they ensured that their staff had access to high quality equipment, and that modern equipment was designed to high standards, meaning that it tended to be less likely to fail.

I'm amazed that there is anybody working with poor or inadequate equipment, on the basis that the NHS check your practice before they will give you a contract.

Optometrist, Birmingham

It has been some years, probably more than ten, since I last saw poor or inadequate equipment…I find increasing amounts of very good equipment which is well designed and so less likely to fail in practice.

FODO

Poor or inadequate equipment isn't very likely now. I think the standard of equipment in most optical practices has increased significantly over the last 10 years. Adequate level of tech has become more affordable.

Association of Optometrists

8.2.3 A number of stakeholder participants suggested that it would be unlikely that optical practitioners were working with poor or inadequate equipment due to the range of standards, regulations and inspections in place to ensure that optical premises had adequate equipment, and that it was now easier for practices to have quality equipment as it was more accessible and affordable. Therefore, it was felt that this risk was very unlikely.

I don't think that in Scotland poor or inadequate equipment would be an issue because every practice that is listed to provide services must be equipped to a minimum level, and that practice gets a visit every three years to ensure that that equipment is up to scratch.

Optometry Scotland

ABDO have a list of compulsory equipment. Part of our role is to do a practice visit and make sure practices are conducive to training and there's access to everything they need.

ABDO Exams (awarding body)

8.2.4 It was, however, highlighted that not all optical premises in the UK are regulated by the GOC, and that this may mean that the risk of poor or inadequate equipment could be more likely in these practices.

Our concern at the moment is that not all premises are actually regulated by the GOC. I think there are only around 2,400 optical practices regulated by the GOC. That is the premises – not the professionals – in which the service is delivered…So there is the potential that some of the high street services, whilst NHS England will inspect them, they're not then regulated to the extent that the other 2,400 premises are regulated.

Head of Dental & Optical Services Commissioning, NHS England

8.2.5 Dispensing optician survey respondents viewed this risk as both less likely (2.62) and less severe (4.12) when compared with optometrists (2.93 and 4.25 respectively). Participants explained that, because the range of equipment that dispensing opticians used was limited in comparison to optometrists, this risk was less relevant to their role.

The one I'm surprised about is poor/inadequate equipment in terms of severity. Other than a good PD rule, what are we using? I don't know how severe that is for dispensers.

Dispensing optician, London

8.2.6 Whilst it was generally agreed that the risk of poor or inadequate equipment was less likely to occur in practice, some participants discussed the risk caused by the variation in levels of equipment and technology between practices. They explained that they had noticed significant differences in some areas, with some practices having access to very good equipment and technology, including the latest OCT machines. This placed these practices in a better position to be able to quickly and accurately detect and diagnose conditions and refer accordingly, meaning that patients who do not attend practices with this equipment are at a disadvantage, and therefore possibly at a greater level of risk by comparison.

The problem is that there's becoming a large variance in the diagnostic ability on the high street. And it's not through lack of knowledge, sometimes it's through lack of equipment. Some practices may have decided to invest in OCT, and some may not have done. And that detection level will be shown in their referral abilities. So your referrals may be quicker and easier if you have that AI technology whereas those that have not may be lagging behind and may be more of a risk to the public.

University of Hertfordshire

8.2.7 A small number of participants applied poor or inadequate equipment to the range of products available to optical practitioners, particularly focusing on frames. They explained that in some practices, the frames available to practitioners were limited and poor, particularly for children, but that there was not much practitioners could do about this. In relation to children, a stakeholder highlighted that often children's frames are scaled down versions of adult frames, which do not properly fit children, resulting in them looking above their frames. As previously highlighted, incorrect dispensing can have a much more significant negative impact on children due to their developing eyesight, and therefore this was seen to pose a more significant risk.

They might be thinking about their frame range and product. Poor product is something which our members report to us on a regular basis, relating to frames for children that are not fit for purpose, but they have to sell them because that's what's in their practice. We're trying to address that. They're doing the best they can with the products that they have. It's a risk to the patient. They don't fit, so whilst the child might be very taken with the bright colours and characters, they will invariably slide down the face… It's a huge risk.

ABDO Exams (awarding body)

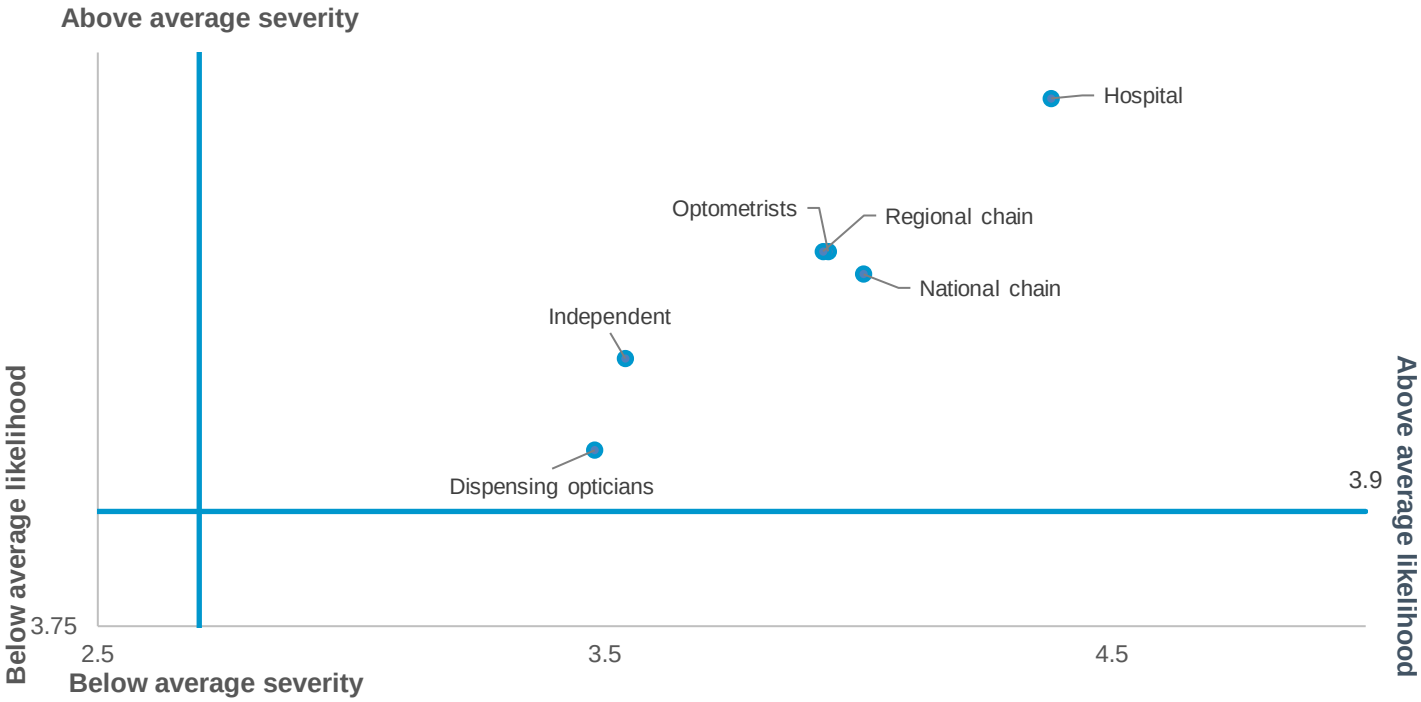
8.2.8 Analysis of the GOC's Fitness to Practise database shows that, between 2016 and 2018, allegations received which related to failures to maintain equipment or appropriate testing facilities occurred in 1% of cases (4 cases), supporting the perception held by qualitative research participants that the risk of poor or inadequate equipment is unlikely to occur.

8.3 Time constraints with patients

8.3.1 Time constraints with patients was perceived to be the most likely contextual risk (3.75 out of 5), and was also viewed as having a high level of severity (4.16 out of 5) if it occurred in practice. The chart at ***Figure 20*** overleaf presents the survey results for the perception of likelihood and severity of this risk, split by professional role (optometrist or dispensing optician) and workplace setting.

Optometrists were more likely to view time constraints with patients as both more likely (3.94) and more severe (4.24) when compared with dispensing opticians (3.48 and 3.98 respectively). Those who worked in a hospital, national or regional chain were also more likely to view this risk as more likely and more severe in comparison to those who worked in an independent opticians.

Figure 20 – Perceived likelihood and severity of time constraints with patients by workplace setting and role
Base: All respondents (2,610)



8.3.2 This risk of time constraints with patients was the most widely discussed during the qualitative research by registrants, as well as by many stakeholders. A number of participants agreed with the survey results that time constraints with patients was a risk that was very likely to occur in practice. Also reinforcing the survey results, it was often suggested that this risk was more common in multiple chain optical practices, particularly in comparison to independent practice settings, with many participants having experience of working in this type of setting. Reinforcing this view, some organisations have introduced measures to combat the issue of time constraints in order to guarantee that patients receive sufficient 'chair time'.

Most people work in multiples and any time I've spoken to them in a pastoral care kind of way they mention these issues.

Optometrist, Edinburgh

There is a sort of desire, particularly in newly qualifieds, to go and have work experience or work in an independent practice, because it's perceived that they don't have those types of pressures on them.

Optometry Wales

AIO brought out a quality mark, because there isn't one currently in optometry. One of the points we've put in our quality mark is that patients will have as much chair time as required, because it is a huge problem for both patients and practitioners. If you've got a really quick clinic, like a 20-minute clinic, the patient doesn't feel like you've spent enough time with them.

Association of Independent Optometrists

8.3.3 It was suggested by multiple participants that this risk was becoming more likely for optometrists, because as their role expands and they take on more responsibilities such as enhanced services, they are expected to do more things with patients, but often within the same timeframe as before.

Optometry has changed over the years where you're expected to do more and more within the eye test, and then you might have enhanced services and things like that. But you don't actually get any more time to do all these extra tests that you're expected to do. I suppose it kind of means you have to streamline things and juggle things. In that rush it will be slightly riskier.

Optometrist, Leeds

8.3.4 It was also suggested that this risk is becoming increasingly more likely due to population changes, where practitioners are seeing increasing proportions of older patients who typically require more time, particularly those with physical disabilities and complex needs. Furthermore, some participants explained that, as the population was continuing to have a more active lifestyle into old age, this meant that the typical testing time for older patients was also increasing to take into account their vision and lifestyle, where multiple pairs of spectacles may be required.

You might have five people who are over 60 booked in back to back, or several patients in wheelchairs, so you're bound to be running late. Everything takes a bit longer. It needs good management to avoid it.

Optometrist, Leeds

One of the things that has changed and will continue to change is our elderly population…it's going to become a massive issue. A lot of us are now seeing very elderly patients and they need more time.

Scottish Government

8.3.5 Time constraints with patients was generally seen as a high severity risk by participants, as there was general consensus that as time pressures increase, mistakes become more likely to occur. In the less severe cases, it was suggested that time constraints and pressure could lead to poor levels of customer service, poor administration and record keeping, poor communication with patients and colleagues or incorrect prescribing and dispensing. However, at worst, participants suggested that it could lead to severe mistakes such as misdiagnosis and missed or inappropriate referrals.

Time constraints lead to errors and oversight, and oversight leads to patient harm.

Primary Eyecare Services

If you're stressed, you're more likely to miss things. You're going to not do certain things. You might make poor management decisions because you haven't had time to get all the facts and assess everything, which could lead to a different outcome for the patient.

Optometrist, Leeds

8.3.6 Although the majority of registrant participants and some stakeholders agreed that time constraints with patients was a likely and severe risk, a number of stakeholders did not agree. This was typically because, in their place of work, procedures were in place to prevent time constraints becoming a risk to patients. These measures included having no minimum length testing time or having variable testing times based on the type of patient, allowing individual stores to manage this based on the requirements of patients or the demographics of the population, including enhanced or extended services. It is interesting to note that both stakeholders who explained that they had these measures in place were from national chain opticians, in contrast to the earlier perception that the risk of time constraints is greater in multiples.

The way we have our diary set up allows flexibility, and we do understand that demographics are different in different areas…we have a regional variance where people can have longer if they need it. It's 25 minutes that we have, but it depends on the demographic. Some areas might run a half an hour diary,

some might run a 20-minute diary. That's only the eye-test time. Pre-Screening is in addition to this and usually 10-15 minutes therefore an appointment could be 35-45 minutes in total. I think the risk is managed well. If we know that someone in a wheelchair or disability is coming in and may need longer, this is planned for ahead where possible and a double appointment can be booked…it's down to the in-store manager to make sure any delays are communicated. I think it's managed well, but it relies on good communication between the optom and the clinic manager.

Vision Express

There is guidance on the minimum things that you should be doing in a consultation – investigating the patient's symptoms, history, visons and severity of condition etc. There isn't a time policy. Individual directors assign that for their practices…Practitioners have sought guidance about what they should and shouldn't do as part of EOS/MECS appointments because it's different to a standard eye exam, so there is some clinical guidance on the minimum you should be doing. But it's certainly not time constrained in any way.

Mike Horler, Ophthalmic Director, Large employer

8.4 Poor or inadequate staffing

8.4.1 The contextual risk of poor or inadequate staffing was scored with above average likelihood (3.29 out of 5) and around average severity (3.87 out of five). Subgroup analysis highlights that this risk was perceived to be more likely by registrants (3.33) when compared with business registrants (2.80) and optical employers (2.86).

8.4.2 This risk was not widely discussed by qualitative research participants in comparison to others. However, some participants said that they had experience of poor or inadequate staffing, explaining that this was more of an issue for smaller optical practices when compared with larger national chains and hospitals. However, the survey results do not support this perception, as respondents who worked in national and regional chains and hospitals were more likely to view this risk as likely (3.65, 3.67 and 3.63 respectively) when compared with those who worked in an independent optician (3.00).

We probably have inadequate staffing more than anything else because of sickness leave and holidays, plus we've got four people about to go on maternity. We have poor staffing, but they are all circumstantial.

Dispensing optician, London

8.4.3 It was suggested that poor staffing was a problem in certain areas of the country, with the south coast and north east suggested by one participant, and another identifying recruitment of staff being more difficult in rural areas of the country, meaning that the quality of available staff may be lower. The survey results reflect this, showing that respondents working in Scotland viewed the severity of this risk as greater (4.00) when compared with other UK nations.

There's a lot more demand for optoms. There's a shortage, particularly the south coast and the north east, where every single business is facing problems with recruitment, and even locum cover can be scarce.

Vision Express

Recruiting to rural parts has been more difficult, so new schools of optometry have tried to boost numbers. One could argue that this poses inherent risks because of the calibre and experience of some of the newly qualified staff working independently in some remoter parts of the UK. Are they the calibre that they used to be?

Optometrist, Cardiff

8.4.4 In terms of the impact of this risk, some participants explained that poor or inadequate staffing exacerbated time constraints with patients, particularly in smaller practices, which in turn may lead to an increased risk of mistakes being made.

Lack of staff and time constraints can put a lot of pressure on. We are a small practice and there are three of us. If one person is not there, it is hard because you have got people coming in and you want to give that level of care to patients, but at the same time you've got to look after everything else. Sometimes things can be missed.

Dispensing Optician, London

8.5 Commercial and performance target pressure

8.5.1 In the survey, the risk of commercial and performance target pressure was viewed as being above average likelihood (3.61 out of five) and just below average potential severity (3.79 out of five).

8.5.2 Many registrant participants held the perception that commercial and performance target pressure was prevalent in the optical sector, particularly within larger multiple chain practices. This perception is supported by results from the 2016 GOC registrant survey, which found that 41% of respondents had experienced pressure from an employer or business to sell a product or provide a service which was not needed by a patient, and 45% had felt under pressure from an employer or business to meet commercial targets at the expense of patient care.[24] However, during this research, it appears this perception was typically based on second-hand experience of colleagues who worked elsewhere under commercial pressure, or based on previous jobs that respondents had held in the past. Very few registrant participants had current direct experience of working under commercial and performance target pressure, and many explained that whilst they perceived this risk to be an issue within the profession, it was not a problem where they currently worked. Furthermore, just 15% of the public indicated that they had felt uncomfortable about visiting an optician due to pressure to buy spectacles or contact lenses,[25] suggesting commercial pressure may be less likely than the survey results indicate.

I know for a fact that some of my DO friends are given targets and we are not sales people.

Dispensing optician, Cardiff

I work for a multiple and we do have targets, but luckily I work in a practice that is very much patient based. If the patient needs the time, we will give them the time. Even if there is a huge queue at the desk and the phone won't stop ringing, the patient will still be our priority.

Dispensing optician, London

8.5.3 A number of participants suggested that the risk of commercial pressure was less likely to occur in independent opticians when compared with nation or regional chain practices. This perception is also found in the survey results, where the likelihood of the risk was scored more highly by those who worked for a national chain (3.84) or regional chain (3.97) when compared with those who worked for an independent optician (3.38). However, it is interesting to note that this risk was also viewed as more likely by those who worked in a hospital (4.21), perhaps reinforcing that there is a strongly held view that commercial and performance target pressure exists within the profession.

I've worked in independents and multiples and in multiples you are under so much more pressure to sell.

Dispensing optician, Birmingham

8.5.4 When discussing the severity of the risk of commercial and performance target pressure, a number of participants felt that it presented little or no risk of harm to patients and had no real impact on patient safety. They explained that, whilst the patient may be upsold products that they did not necessarily need, this would not place them at risk. Instead, they suggested that commercial and

[24] Enventure Research. (2016). *Registrant Survey 2016*, p.57-58
[25] General Optical Council. (2019). *Public Perceptions Research 2019*. p.16

performance target pressure presented more of an ethical issue for practitioners, where patients pay more for products or services that they do not necessarily need. It was also stated that, if patients decide that they are not happy with their spectacles because they see no improvement in their vision, they are entitled to a refund under the Consumer Rights Act (2015), further suggesting that the severity of this risk to patients is low.

You need an average order of over a certain amount, otherwise you're not seen as a good dispensing optician. It's things like selling unnecessary coatings and stuff. It's not putting them at risk, they'll still be able to see. But you're selling them 1.6 index lenses that they don't need because their prescription doesn't warrant it. It's not ethically or morally great, but it's not a safety risk.

Dispensing optician, Leeds

There's definitely a reputational risk. Unfortunately, we have this cross subsidy that's existed in the profession for a very long time, which ideally would disappear. The risk to patients is that they end up with something they don't desperately need and could have done without just to meet targets. If the patient returns and says their glasses aren't any better, the practice instantly refunds the money. So actually, the risk to the patient is very low.

Association of Optometrists

8.5.5 It was therefore suggested that the real risk of commercial and performance target pressure related to the reputation of the profession, rather than any real risks being posed to patients and the public, where trust in the profession may be eroded if associated with upselling and dishonest costing. It was also highlighted that, as a result of increasing distrust of the profession, this could deter the public from visiting an opticians to have their eyes tested as they see them more as retailers rather than healthcare professionals, placing them at increased risk as a result. Other research has found that the perception that a visit an optician is linked with the purchase of spectacles also appeared to negatively affect the view of optometry as a primary eye healthcare provider, which means that subsequently, people often report sub-optimal engagement with services.[26]

People can lose a lot of trust in the profession and think that we're just money makers. They don't think that we are actually healthcare professionals who are trying to do the best for them, and they're put off coming for future eye tests.

Optometrist, Birmingham

It's a danger for the profession and something which can be passed on to the patient as well. For the patient, if you're being told you need to buy a new pair of glasses every visit, which maybe they don't need. They'll lose trust in their optometrist because they'll just think they're trying to sell them new glasses.

Association of Independent Optometrists

8.5.6 Whilst many participants felt that commercial and performance target pressures had little impact on patient safety, some still highlighted potential risks. Some suggested that commercial pressure went hand in hand with time constraints with patients, because practitioners are under commercial pressure and therefore they will be encouraged to see as many patients as possible, presenting the risk of not spending adequate time with patients who may need longer appointments. Stress was also highlighted as a potential risk of commercial pressure, which if experienced by a practitioner may have an impact on the quality of the care they provide to patients. Furthermore, a stakeholder from the RNIB suggested that commercial pressure in the optical sector had created a perception amongst patients that they may be pressured into buying expensive spectacles which they may not be able to afford, and that therefore this poses a risk to economically disadvantaged members of the public who may be deterred from visiting an optician for this reason.

[26] Leamon, S. et al. (2014). Improving Access to Optometry Services for People at Risk of Preventable Sight Loss: A Qualitative Study in Five UK Locations. *Journal of Public Health*, Vol.36(4), pp.667-673.

It could lead to inappropriate prescribing. I've seen very small prescriptions being prescribed for children who don't really have any problems. I know it's a matter of opinion. You might be doing quicker eye tests to see more patients, to bring more money in, and that's where the risk comes in for the patient.

Optometrist, Leeds

From our perspective one of the risks is that there isn't equal access to primary eye care services. We know people limit and ration their use, particularly those who are experiencing poverty and are concerned about the cost of attending an opticians. We did some research a few years ago which found that many people living in poverty or on low income think they may not need to pay for an eye examination, but feel they will be pressured to buy an expensive pair of glasses when they visit an opticians.

RNIB

8.5.7 There was discussion amongst some participants that commercial and performance target pressure was a result of system issues, who mentioned the NHS contract for sight tests and how the current system of optometry in the UK allows companies to make money. They explained that this current set up meant that commercial pressure was inevitable, and that this risk would not change unless the system itself changed. Previous research conducted by the GOC has found that, as sight tests have low profitability for optical practices, this can lead to an increased focus on commercial targets and sales generation, potentially at the expense of patient care and clinical decision making.[27]

Clinicians being expected to meet increasing volume targets with fewer resources is something we're hearing more and more about. Often these pressures are being balanced by the individual clinician, and we think that's a system issue when such safety trade offs are being made. The commercial environment provides additional pressure and challenges for professionals.

Patient Safety Learning

The budget for the sight test fee is going to be squeezed again. And that's what creates the commercial pressure. If people aren't adequately recompensed for their work, as in the sight testing bit, the only way that they can make it pay is to up the commercial aspect of it.

Rachel Pilling, Consultant Ophthalmologist, secondary care stakeholder

8.5.8 However, not all participants viewed commercial and performance target pressure as a risk, but rather accepted that it was a part of the optical sector, which was commercially driven whilst still being a healthcare service. They therefore viewed commercial targets as a necessary aspect of running a business, and suggested that practitioners need to be able to manage this as part of their role in order to continue to practise safely in the interests of patients. This view was typically suggested by more stakeholder participants than registrant participants, which is reinforced in the survey results, where registrant respondents were more likely to view commercial and performance target pressure as a risk (3.64) when compared with stakeholder respondents (3.46).

Every business will have commercial targets…but we don't want to compromise safety or patients to be sold the wrong product….It's important to have the right product for the right person….We do have sales targets, and we do targets for how many appointments we want to see, because we need to be a healthy, growing business.

Boots Opticians

People have got to make a living, and it would be unrealistic to think that this wasn't a commercial business…Really that's why we pay additional fees, why the examination fee is that little bit higher, to try and offset that.

Scottish Government

[27] Europe Economics. (2013). *Optical Business Regulation*, p.7

8.6 Remote or isolated practice

8.6.1 The risk of remote or isolated practice was perceived to be the least likely of the contextual risks in the survey (2.43 out of 5). It was also one of the lowest rated contextual risks in terms of potential severity (3.14 out of 5). Subgroup analysis highlights that this risk was viewed as more severe by respondents working in Scotland (3.31) when compared with other countries.

8.6.2 In the qualitative research, a small number of participants suggested reasons why remote or isolated practice could pose a risk to patients. Some said that those working in remote or isolated practices were often only seeing a limited selection of patients, meaning that their experience would be limited as a result. Furthermore, they would be less likely to interact with other practitioners, meaning that they would lack the easy availability of support or a second opinion when required, and also will not be as exposed to the latest methods and best practice in the sector.

We do find that independents who are on their own, who have been working for twenty or thirty years, sometimes you can get issues with them because they don't understand the kind of best practice guidance or they've got into habits or ways of working and no-one's actually pointed anything out to them.

NHS England (London region)

8.6.3 However, most participants felt that remote or isolated practice posed a low risk to patients. One of the main reasons suggested for this was that the changes to the system of Continuing Education and Training (CET) had made it much more difficult for practitioners to remain isolated. Participants explained that the requirements of CET to maintain registration with the GOC meant that practitioners were required to keep up to date and continue their learning, but more importantly, that the introduction of peer review as part of CET meant that practitioners had to actively engage with others in the profession. The introduction of peer review was recommended in previous research by the GOC into risk, and therefore appears to have been successfully implemented since then.[28] In this way, peer review was seen as a positive step towards combatting isolated practice, as practitioners could no longer work in isolation and continue to work as they had done for a long time, thereby reducing the risk to patients.

I don't think it's risky because it's covered quite well by the CET system, making people take part in peer reviews. The danger comes from being a very isolated practitioner, doing the same thing they've always done for 50 years, but the CET system takes care of that quite well. Whether you want to or not, if you want to carry on practicing you have to keep up to date.

Association of Independent Optometrists

With the peer review these days it is very difficult to be isolated.

Optometrist, Edinburgh

8.6.4 Another suggested reason as to why remote or isolated practice posed less of a risk than it perhaps once did was due to improvements in communication and technology. Participants explained that improved communication channels via the internet and social media now allowed better interaction between practitioners, meaning that it was now much harder to be truly remote. Practitioners can now easily contact each other for help and support via the creation of peer support networks, with participants referencing emails, video calls, WhatsApp groups and Facebook groups, where they were able to pose questions and share ideas with their peers. It was also suggested that practitioners could now easily share test results with colleagues in other areas of the country due to improvements in technology within their practice, further mitigating the risk of remote or isolated practice.

[28] Europe Economics. (2010). *Risks in the Optical Profession: Final Report*, p.vi

You're remote in terms of your locality, but not in terms of communication. You can easily get on the internet and communicate now, and if you're a multiple, there's always somebody there you can speak to, so you're not really remote. Technology has come on a lot in that time.

Dispensing optician, Leeds

WhatsApp has also been helpful, it's a WhatsApp group for people you meet at IP for WECS training courses, and we've got little informal networks. And we keep in touch online to have the little forum discussions.

Optometrist, Cardiff

8.6.5 Finally, it was also suggested that the perceived increase in the proportion of multiple chain practices and decrease of independent opticians may have also reduced the potential severity of the risk of remote or isolated practice. Participants explained that many of the smaller independent practices which were more remote or isolated had now been brought into a larger chain, meaning that they would now be working to standardised policies and procedures, and included within a greater support network. This perception is supported in reality, as in 2010, independent opticians had approximately 40% of the UK market, but by 2013 that figure dropped to 28% and remained steady in 2015 at 29%.[29]

There were probably more isolated practices in 2010. Things have changed so much, there are so many more multiples and less independents.

Dispensing optician, Leeds

8.7 Working as a locum

8.7.1 The risk of working as a locum was perceived by survey respondents to be above average likelihood (3.01 out of 5), but was the lowest ranked contextual risk in terms of severity (2.92 out of 5). Subgroup analysis highlights that this risk was perceived as being more likely by optometrists (3.19) when compared with dispensing opticians (2.71), as well as those who worked in a hospital (3.65) when compared with those who worked for an independent opticians (2.87). It is interesting to note that the risk of working as a locum was also viewed as more likely by those who worked as locums (3.14) when compared with those who worked full time (2.73).

8.7.2 It was widely discussed during the qualitative research that the number of optometrists and dispensing opticians working as locums had significantly increased in the last ten years. This is reflected in the results of the College of Optometrists' Optical Workforce Survey, which found a substantial increase in optometrists working primarily as locums from 10.5% in 2010 to 17.5% in 2015, as well as a further 9.1% dispensing opticians working primarily as locums in 2015.[30] The is reflected in the online survey results, which show 18% of registrant respondents worked as locums. Participants suggested that this was likely caused by changing lifestyles, with practitioners seeking job flexibility and the ability to have more control over their working pattern. It was also suggested that locum working had become more popular due to the higher rates of pay available, which were attracting more to this type of employment, particularly newly qualified practitioners, a driver which was also suggested by the College of Optometrists.[31]

Traditionally locums were used for holiday cover, maternity cover or sick cover, but now over the last two to three years, locum work is on the rise. Especially in the female population, with starting families and

[29] General Optical Council. (2015). *Optical Sector Report 2014-15: A Report on Developments and Trends in the Optical Sector*, p.7
[30] College of Optometrists. (2015). *Optical Workforce Survey*, p.38
[31] College of Optometrists. (2016). *The Optical Professions: What Does the Future Hold?*, p.15

wanting more flexibility. Locums also want the higher rates so locum work can seem more attractive, however the reality can be different as employment can carry security and benefits locum work can't.

Vision Express

More people are choosing to become a locum because there's more money to be made and they've got control over their working patterns.

Mike Horler, Ophthalmic Director, Large employer

8.7.3 Some participants suggested that the increased number of practitioners working as locums may explain why this potential contextual risk was viewed as low severity, as locums who responded to the survey would not want to see their way of working as having an increased risk to patients. Locums made up 18% of the survey sample, and therefore this assertion may have some validity, as subgroup analysis highlights that locum respondents did perceive the level of severity as lower (2.59) than those working full time (3.01).

8.7.4 However, it was also suggested that working as a locum may have been recorded as a low severity risk as there is a greater awareness and understanding of this way of working than there was previously, with specific CET and guidance for those working as locums to help mitigate any potential risk.

A lot more people work as locums now. Back in 2010 the population was probably a lot smaller, so we considered them a risk because we didn't know what they were doing.

Dispensing optician, Leeds

There are probably more locums than there were then. There's also been a big push in terms of supporting locums. The AOP have created a locum log book. There is more locum CET and pointed articles.

Secondary care stakeholder

8.7.5 Despite being rated as the lowest severity contextual risk, a significant proportion of feedback from the qualitative research raised concerns about the level of risk that this way of working posed to patients. One of the main concerns raised was in relation to the continuity of care that locums were able to provide to patients when they worked in different locations at different times. This was suggested by both those working in permanent roles, as well as some locums themselves.

I do have a slight issue when I can't follow up. From that point of view all I can do is write all over the file and highlight it so that hopefully somebody sees it. If I am back within a couple of weeks then I will follow up on it. The issue is if I'm not back for a while. You're not chasing it up yourself, and you can't rely fully on somebody else to do it.

Optometrist, Northern Ireland

Locums can add risk into a system, this is the case in most health care settings, not because locums are not good, but because temporary staff are less familiar with local systems, handovers and that type of thing. Employed staff that are familiar with local protocols make it easier to mitigate risk, so if you've got large proportions of the workforce choosing to work as locums that's not as safe as the alternative, resident clinicians.

FODO

8.7.6 The difficulty of continuity of care associated with locum working focused on the follow up of patients. It was explained that locums may treat a patient, make recommendations or referrals, but then never see that patient again, and therefore never know what the outcome or results were. Some participants suggested that this led to locums not taking as much responsibility for patients as permanent staff, as well as a lack of accountability for the actions they take with their patients, thereby increasing risk to patients. It was also suggested that this style of working can mean that

locums do not have the same affinity with patients as permanent practitioners, resulting in a poorer patient experience as a result.

There are good locums, but there is a proportion that don't see anything as their responsibility and tend to cause the problems. There's less continuity of care for the patient. It can increase the risk to the patient. But the locums don't see this. They're the ones not keeping their knowledge and skills up to date, or who are unaware of local referral pathways. They tend not to have any accountability or responsibility for the area they're working in. They have no interest in completing certain things on the day such as dilations, contact lens fittings or cycloplegia, so there can be more risk.

Vision Express

They really don't care. It's quite shocking. We've had it, when our optom has gone on holiday, we have had locums. You can see their attitude. As a registrant you are supposed to look after the public. It's really shocking, through to their record cards, through to their attitudes. They are just there to get their money and go home. They'll notice something and then say book them back in for a dilation because they don't want the responsibility.

Dispensing optician, London

8.7.7 Another risk associated with locums was, because they did not necessarily see these outcomes or results, they were less likely to learn from their experiences or understand when they have made mistakes, meaning that their practice may not improve. If mistakes are made by locums, they may simply not be booked again by the employer and therefore the practitioner does not learn from the experience, in contrast to permanent employees who will be managed by their employer to rectify and learn from the mistake. In this way, locums may miss out on crucial training and development.

Anecdotally we have seen situations where a locum is not performing as they should be, and the practice explains they just won't get booked again. If individual registrants are employed within an organisation, there would be an effort to manage and support that individual and reduce their level of risk. There are situations where people move around a lot and never have those difficult conversations with people about their performance or understanding. Given employment law constraints, there may be limits to the role practices can play in 'actively managing' locums and consultants. Issues with standards of practice and attitude may therefore go unaddressed and escalate.

Optical Consumer Complaints Service

We do need to understand the issues facing the locum workforce – what tends to happen is that if an employer has an issue/concern regarding a locum, they will just not engage with them again. The locum will go on practising the way they have been, and the issue/concern may never be addressed…[Locums] *often don't get feedback from their patients, or from the Hospital Eye Service where they may have referred a patient, because of the nature of the locum work (not being in the same practice on a regular basis). This does affect professional development.*

NHS England (London region)

8.7.8 Although not highlighted by this primary research, feedback collected by the College of Optometrists found that locums are more likely to fall under the radar when it comes to appraisals and training due to their working status, which may in turn have an impact on the level of risk they pose to patients. It was therefore suggested that providers should review the content of training resources and materials to determine whether this could be developed to better support professionals who are working in locum roles.[32]

8.7.9 It was also highlighted that another risk to patients of working as a locum was that, because locums often work in different practices across multiple areas, this may mean that they are unfamiliar with local protocols and referral pathways, which could cause mistakes to be made when referring patients for further tests or treatment. Additionally, working across different and potentially

[32] College of Optometrists. (2015). *Optical Workforce Survey*, p.39

unfamiliar working environments was also suggested as a significant challenge for locums which may also pose a potential risk to patients. The College of Optometrists has recommended that systems are implemented by employers, including appropriate training, to ensure locums are familiar with local practice and protocols, allowing this risk to be better managed.[33] This issue is being addressed by the GOC in the new Standards for Optical Businesses, which come into effect in October 2019, particularly standard 3.4 which states that locums specifically should have access to information about local referral protocols.[34]

You're coming into an environment that you're unfamiliar with, and you're not familiar with how the patient records work, and you're not familiar with this piece of equipment or that piece of equipment, and you don't know the staff supporting you…So you've got to be a good practitioner to be a good locum.

Scottish Government

It's not always about competency, but about familiarity etc.

FODO

8.7.10 However, some participants were much more positive about locum working and felt that it did not pose a severe risk to patients. It was suggested that typically locums worked across a number of repeated locations, and therefore did build up familiarity and continuity with practice settings, working practices and patients. Some participants also held the perception that, because of their experience of working in new environments on a regular basis, locums were confident practitioners who were able to adapt to and cope well in a variety of situations.

A lot of locums end up working in the same places, so you could potentially see your patients throughout and finish their case.

Optometrist, Leeds

You've got to be pretty confident to be a locum. I suspect that when you are locuming you should be pretty much at the top of your game, otherwise people are not going to employ you.

ABDO (professional association)

[33] College of Optometrists. (2016). *The Optical Professions: What Does the Future Hold?* p.15
[34] General Optical Council. (2019). *Standards for Optical Businesses*, p.34

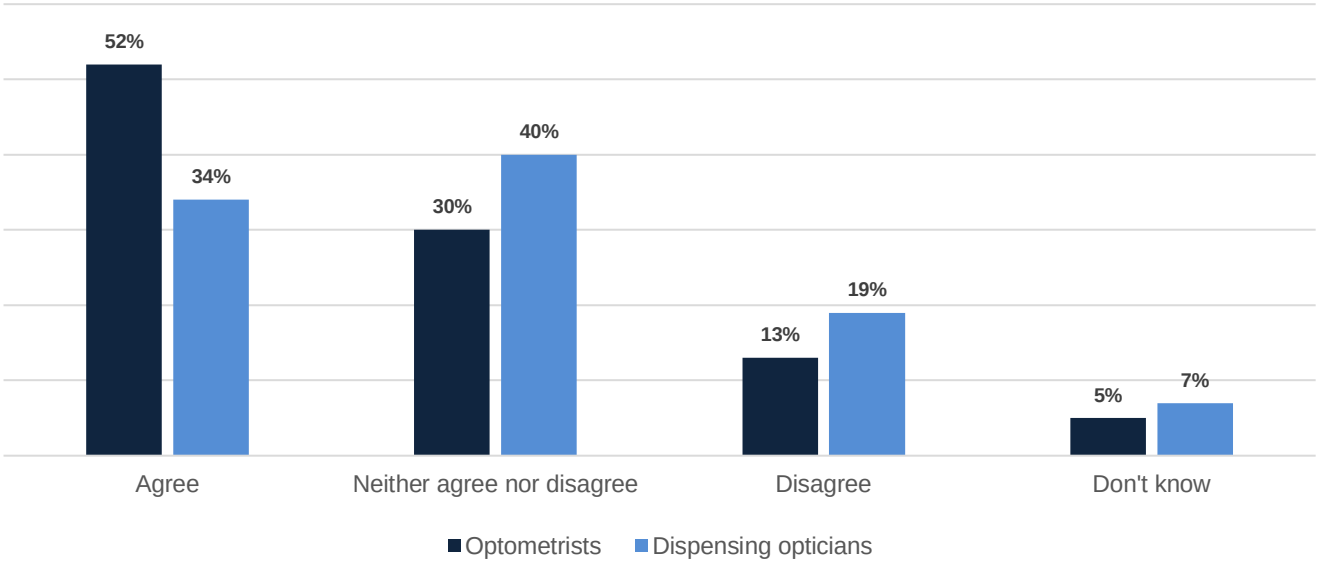
9. Changes in the optical sector and the impact on risk

9.1 The changing level of risk associated with the optical professions

9.1.1 Survey respondents were asked the extent to which they agreed or disagreed that the level of risk to patients and the public associated with optometrists and dispensing opticians is changing. The chart in ***Figure 21*** below presents the overall result to this question for both optometrists and dispensing opticians.

9.1.2 The majority of respondents (52%) agreed that the level of risk associated with optometrists is changing, but a large proportion (30%) indicated that they neither agreed nor disagreed. In contrast, a third of respondents (34%) agreed that the level of risk associated with dispensing opticians is changing, a larger proportion indicated that they neither agreed nor disagreed (40%), and one in five (19%) disagreed.

Figure 21 – Agreement that the level of risk associated with optometrists and dispensing opticians is changing
Base: All respondents (2,610)



9.1.3 For the level of risk associated with optometrists, subgroup analysis highlights that those who worked in a national chain of opticians or hospital were more likely to agree that this was changing at 56% and 57% respectively, particularly when compared with those who worked in independent practice at 47%.

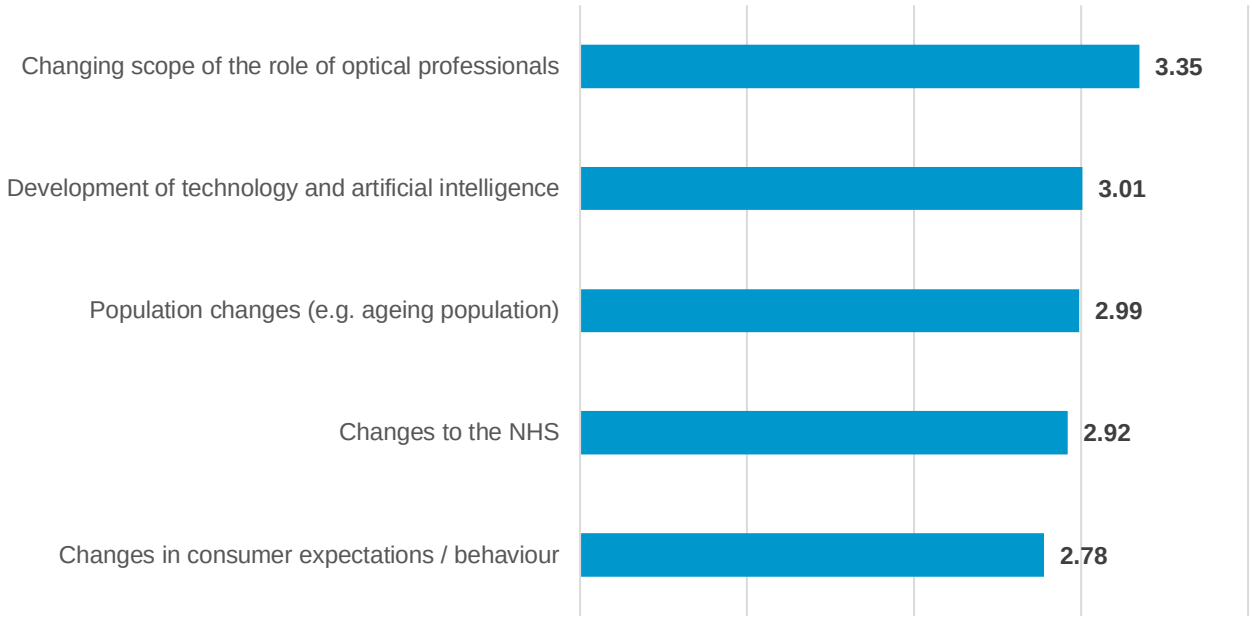
9.1.4 For the level of risk associated with dispensing opticians, subgroup analysis shows further variation in opinion. Dispensing opticians were more likely to agree that the level of risk associated with their role was changing (49%) when compared with optometrists (25%), as did those who worked for a national chain of opticians (37%) when compared with other workplace settings, particularly hospital (24%). Furthermore, those who had been registered for a shorter length of time were also more likely to agree that the level of risk associated with dispensing opticians was changing, ranging from 43% for those registered for less than two years to 29% for those registered for 21 years and over.

9.2 Factors influencing change

9.2.1 To explore what may be causing the level of risk associated with optical professional roles to change, respondents to the survey were shown a list of factors which are generally understood to be changing the way that optical services are delivered and were asked to rank these factors in order of impact. A rank of 5 indicated the highest level of impact and a score of 1 indicated the lowest level of impact.

9.2.2 As shown in the chart at ***Figure 22*** below, the *changing scope of the role of optical professionals* was perceived overall to be having the most impact on the way that optical services are delivered. Conversely, *changes in consumer expectations/behaviour* was viewed as having the least impact. However, the range between the highest and lowest ranked factors is small (just 0.58), suggesting that all factors are perceived to be having considerable impact and therefore may be linked. Each factor was discussed in greater depth in the qualitative research, covered later in this chapter.

Figure 22 – Perceived impact of factors which are changing the way optical services are delivered
Base: All respondents (2,610)



9.2.3 Survey respondents were also able to suggest any other factors that they thought were changing the way that optical services are delivered. Free text responses have been coded for analysis, and the most common suggestions are presented at ***Figure 23*** overleaf.

9.2.4 The most commonly suggested factors included *online purchasing/unregulated suppliers* and *commercial/time/retail pressures*.

Figure 23 – Other suggested factors changing the way that optical services are delivered
Base: All respondents who provided an answer (871)

Other suggested factors	Number	%
Online purchasing/unregulated suppliers	232	27%
Commercial/time/retail pressures	187	21%
Dominance of multiples/loss of independent practices	125	14%
Financial constraints/low renumeration for providing NHS services	122	14%
Lower standards for patients/less focus on patient care	98	11%
More services provided in primary care/enhanced services/MECS	96	11%
Changes to education and training standards/increase in providers	83	10%
Lack of investment in NHS/pressure on GPs	68	8%
Greater use of unqualified/underqualified staff	61	7%
Devaluation of optical services/professions	58	7%
Patient expectations/preferences/understanding of optical professions	56	6%
Deregulation/devaluation of dispensing opticians	52	6%
Lack of support from GOC and other optical bodies/failure to protect registrants	47	5%
Advances in technology/simplification of procedures/automation	46	5%
Increasing competition/advertising	27	3%
More admin/paperwork/GDPR	25	3%
Changing needs of patients/changing patient demographics	23	3%
Low/declining salaries	21	2%
Changing workforce (e.g. more part time, more locums)	20	2%
Blame culture/fear of litigation	16	2%
Differing NHS commissioning/protocols across regions	15	2%
Better health awareness/greater availability of information	14	2%

9.3 Changing scope of the role of optical professionals

9.3.1 The changing scope of the role of optical professionals was viewed as having the most impact on the way that optical services are delivered (3.35 out of 5).

9.3.2 It was widely accepted that the scope of the role of optical professionals had changed, particularly over the last 10 years. The most significant change discussed in the qualitative research was the increasingly clinical nature of optometry, with practitioners taking on more clinical roles as services were moved from secondary care into community practice in order to relieve the pressure currently facing the NHS. Various examples of the profession taking on these types of responsibilities were suggested via extended and enhanced services and shared care schemes, including the detection and management of conditions, ranging from minor conditions such as acute red eye or foreign body removal, to more serious conditions such as the detection and management of glaucoma and age-related macular degeneration (AMD). The specific nature of these responsibilities currently varies between UK regions and nations.

We're seeing an expanding role for optometrists, so they're getting involved in shared care schemes, MECS, things that fall outside the sight test aimed more at providing a clinical episode of care…That alters what they're seeing and the chance of something being wrong with the patient.

Association of Optometrists

Over the last ten plus years there has been a change from the original practice, which was to provide refraction tests, provide glasses and screen for eye disease. Now opticians are becoming more involved in the management of ophthalmological diseases. They are taking on an extended role that isn't what they were originally set up to do, but I think in the large part they are competent to do with the right training.

Royal College of Ophthalmology

Increased risk to patients as a result of changes to optical practitioner roles

9.3.3 Some participants felt that the optical professions now presented an increased risk to patients and the public because of the changes to the scope of roles in recent years. They explained that, because optical practitioners, particularly optometrists, are taking on more clinical roles and responsibilities and are dealing with things that would usually be carried out in secondary care, this automatically posed a greater level of risk, simply because they are dealing with areas of practice that were more inherently risky. The focus of this opinion was on the detection and management of ocular disease, which they considered to be riskier if managed in community practice by the optometrist, rather than being referred to secondary care.

The role, in effect, has been expanded…Our risks to the public have increased because we now have to make decisions on whether this is a referral issue or a non-referral issue.

University of Hertfordshire

With the introduction of MECS work we've got people coming in with more issues. There's more people coming through the door with a problem than there used to be before, so there's greater risk.

Dispensing optician, Leeds

If you're talking about taking on more shared care of glaucoma patients and perhaps taking on shared care of stable AMD [age-related macular degeneration] *patients, the risk there is higher because they've got a disease that could potentially blind them. There's an increased risk to the population because the undergraduate training isn't robust enough to support it. It depends on what they're delivering and how it is delivered.*

Association of Optometrists

9.3.4 It was also felt that this increasing scope of the optical professional roles could lead to increased risk for patients because it placed more expectations upon practitioners in terms of their education, training, skills and confidence, which some may not have capacity for or be ready to deliver. It was suggested that those with less confidence and experience may pose greater risk, as well as those who have been practising for longer and may therefore be less up to date with the latest ways of practising. Therefore, the changing scope of roles was viewed as increasing the level of risk to patients until there was consistent education and training available to allow all practitioners to confidently deliver these new roles and services. Research conducted in the Republic of Ireland into the expanding role of optometry recommended incorporating further education as an essential prerequisite to an enhanced scope of practice to ensure that practitioners are adequately trained to expand on the traditional role and boundaries.[35]

We [the optical sector] *are in a better place now in that we've got the systems and recognised pathways, and the College have professional certificates as well. But in my experience, having spoken to a number of practitioners, I think there are practitioners out there who still do not feel confident to take on the additional roles.*

NHS England (London region)

All graduates will qualify with new skills. The profession will follow suit, but it takes time. I think the challenge of the changing role of optical professionals won't impact on the new students, but on those colleagues in practice where CET requirements are on the fundamentals that are on the entry level of the qualification.

Optometrist, Leeds

[35] Barrett, C. and Loughman, J. (2018). Expanding the Traditional Role of Optometry: Current Practice Patterns and Attitudes to Enhanced Glaucoma Services in Ireland. *Journal of Optometry*, Vol.11(4), p.260.

9.3.5 Some participants also identified the additional risk to the practitioners undertaking these new aspects of their roles, not just to patients and the public. They held the perception that by taking on more clinical roles and responsibilities, the profession was also opening itself up to a greater risk of facing litigation from patients when things go wrong, with a particular focus given to the risk of independent prescribing to practitioners. It was suggested that the Opticians Act was now out of date, as it did not reflect the recent changes to roles, meaning that practitioners were legally at risk as a result.

If optoms start going into independent prescribing and CLOs start getting involved with MECS, then that is going to have a big impact. They will be more likely to have patients sue them over misdiagnosis.

Dispensing optician, London

The Opticians Act is no longer fit for purpose, because it says the responsibility of the optoms is to detect abnormality or injury, so we're having to work within that remit and competence. In theory, if we see anything we should refer on. We're expected to do more but legally it's not our remit. In law we are therefore not protected from litigation.

Optometrist, Cardiff

Risk to patients has not changed or is being managed effectively

9.3.6 Despite concerns about the increased risk posed to patients by the optical professions as a result of the changing scope of roles, not all participants felt that the recent changes meant that the level of risk had increased. In fact, more participants were of the opinion that the level of risk had not changed. The most common explanation for this perception was that any potential increase in risk, such as working in potentially riskier areas of clinical practice, was managed and mitigated by good levels of training, education and additional qualifications. A common example provided was independent prescribing, which in theory posed a greater risk to patients, but this risk was seen to be mitigated via the additional qualification required to be able to work as an independent prescriber. Furthermore, it was suggested that it was unlikely that the level of risk would increase due to the cautious nature of optometry, where practitioners were reluctant to work outside their scope of training, experience and qualification, and would not attempt to do so until adequately trained and qualified.

When we move services out into the community in Wales, we always have to ensure that the consultants are satisfied that risks could be mitigated. That usually involves additional training or accreditation.

Optometry Wales

As a profession we're taking on more risk and we're managing it incredibly well. The tools that the GOC have in place to help that, CET, are helpful but of course need to be modernised and brought more up to date, which we know is in the pipeline. But again, the changes to the structure of the workforce are also moving us in the right direction. From our point of view, it's an incredibly positive story and we're immensely proud of what our eye health practitioners do.

FODO

9.3.7 The specific nature of additional roles and responsibilities undertaken by the optical professions currently varies between region, with services such as Welsh Eye Care Services (WECS), where currently around 90% of optometrists are accredited to provide enhanced services[36], and General Ophthalmic Services (GOS) in Scotland, where 80% of all patients in 2013/14 were dealt with in primary care.[37] It was often suggested that the role of optical practitioners had changed more

[36] General Optical Council. (2015). *Optical Sector Report 2014-15: A Report on Developments and Trends in the Optical Sector*, p.19

[37] General Optical Council. (2015). *Optical Sector Report 2014-15: A Report on Developments and Trends in the Optical Sector*, p.12

significantly in Wales and Scotland when compared with England and Northern Ireland because of these services, which have resulted in more secondary care services being delivered in the community. The level of risk was seen to vary depending on location, as this changed the services and schemes available to patients, as well as the level of training and support available for practitioners. It was argued by some participants that the level of risk to patients created by new roles and responsibilities was therefore less severe in Wales and Scotland when compared with England and Northern Ireland. Subgroup analysis of the survey results highlights that the changing scope of the role of optical practitioners was viewed as having more of an impact by those who worked in Scotland (3.53) and Wales (3.48) when compared with England (3.32) and NI (3.10), perhaps reflecting this perception.

I would argue that it's changed more in Wales than it has in many of the other countries, with the exception of Scotland…Essentially, in Wales we took a direction more than ten years ago that we wanted to upskill our optometrists to provide a service over and above the ophthalmic service examination, because it was recognised that the capacity and demand issues in secondary care were too great a problem to solve without the workforce available in primary care.

Welsh Government

In Scotland in 2006 optometry was established as the first port of call in the community with the understanding that optometrists would manage a range of ocular conditions in the community…There has been a massive change in attitude and uptake of service in the community, and that's reflected in attendances at hospitals. If you look at the English attendance at hospital, from 2006-2017 it increased by 45%, which has meant a lot more resource has had to be put into secondary care. Whereas in Scotland, it's increased by 3.5%, because most of that acute care and other responsibilities have been retained in the community. This additional role/responsibility needs to be taken into account as the benefits of doing more and working to a general higher standard is better for patients. The risk of things going wrong should be reduced but the potential for harm is possibly increased and this needs to be recognised and accepted.

Optometry Scotland

Risk to patients is reduced as a result of changes to optical practitioner roles

9.3.8 It was often suggested that the optical professions taking on new roles and responsibilities did not pose a greater risk to patients, and in fact may reduce the level of risk, because the changes being made to move services into the community increased accessibility for patients. Several participants explained that patients were now more able to access eye care services due to the increasing integration between primary and secondary care, where a wider range of services were available in the community. This had the benefit of reducing waiting times and reducing the need for patients to be referred to hospital. The review of relevant literature supports this finding, where optometrists are seen to be more conveniently located within a community, with readily available appointments, and are likely to have weekend and evening opening hours,[38] providing a means of reducing health inequalities and increasing clinical effectiveness.[39]

It can potentially mean that they have more timely access to quality eye care services, delivered closer to home…If we can expand capacity and capability in the primary care optometry workforce then we can deliver more care which we think will be safe, accessible and accountable, but also closer to the patient's home.

Health and Social Care Board

9.3.9 It was also suggested that the changing role of optometrist meant a reduction in risk to patients and the public because often a well-trained optometrist is better qualified and equipped to manage

[38] College of Optometrists. (2013). *Better Data, Better Care: Ophthalmic Public Health Data Report*, p.5
[39] Leamon, S. et al. (2014). Improving Access to Optometry Services for People at Risk of Preventable Sight Loss: A Qualitative Study in Five UK Locations. *Journal of Public Health*, Vol.36(4), p.671

patients with eye problems than those who may have previously been the first port of call for patients, such as GPs. This is because optometrists are viewed as having much more specialist knowledge, training and equipment to be able to accurately diagnose and manage eye conditions, therefore providing a lower risk option for patients, as well as being potentially a more convenient option, particularly those with additional qualifications, such as independent prescribing.

For me, it's what would have happened to that patient had they not seen the optom with the extended role. In other words, they see an optom with independent prescribing. Had they not seen them, they would have seen a GP. For me, the optom with IP in terms of risk to the patient is less than the GP. I think most GPs would agree with that. They haven't got slit lamps and they haven't got the same level of knowledge.

Optometrist, Leeds

Quite often, if you go to an emergency eye clinic, you're not seen by a consultant ophthalmologist, you're seen by a registrar who essentially has potentially less experience than your local GP, who we know feels unconfident in looking after eye problems because they had two weeks of training in eyes. So actually the optometrist is far more qualified than that person to manage, apart from that they can't necessarily prescribe the full array of drugs that that person needs.

Primary Eyecare Services

Risks to patients posed by changes to the role of dispensing opticians

9.3.10 The majority of discussion about taking on more clinical roles and responsibilities related to optometrists, which may involve greater risk. However, there was also significant discussion about the changing scope of the role of dispensing opticians, particularly in relation to the increasing use of non-registered and potentially less qualified optical staff. Despite the role of dispensing opticians being identified by the GOC as valuable in terms of delivering additional services, such as low vision services to the increasing number of patients who need them,[40] a number of participants raised concerns about the potential downgrading of dispensing opticians, as a number of their roles were being increasingly undertaken by non-registered optical assistants, which they felt posed risks to patients. It has become common practice in the industry for the pre-screening which takes place before an eye examination to be delegated to optical assistants, who then report the test output to the optometrist for interpretation, in order to improve time efficiency.[41] However, some participants explained that dispensing opticians were trained and qualified to undertake these roles, and that therefore they should not be passed on to other non-registered members of staff who are not regulated by the GOC. It was also suggested by a number of participants that the role of dispensing optician was not clearly defined by the GOC, leading to disparity between practices about exactly what they were qualified to do, and what could be carried out by a non-registered optical assistant.

I think people should have the right to have spectacles by someone like me who did three years. I did a degree to do what I do. They will say they don't employ DOs, they are going to employ a load of optical assistants at a much cheaper price, when the public deserves to actually have the best care.

Dispensing optician, Cardiff

I think the GOC have to be clearer on what we as DOs have to do and don't have to do. It's really quite blurred in terms of what we as DOs are responsible for. It needs to be a more defined role.

Dispensing optician, Leeds

9.3.11 The risks of non-registered staff were perceived by dispensing opticians to be potentially significant to patients, which was being exacerbated by their role not being clearly defined. It was suggested that patients may not be aware that they are being cared for by an non-registered member of staff.

[40] General Optical Council. (2015). *Optical Sector Report 2014-15: A Report on Developments and Trends in the Optical Sector*, p.1
[41] Europe Economics. (2013). *Optical Business Regulation*, p.11

Some participants felt that this was being encouraged by some companies through the training they provide to their optical assistants, which overlaps with much of the dispensing optician role, but does not provide the same level of education and training as a qualified dispensing optician.

There's a greater risk to the public…if they go and see someone at a much lower level but still consider them to be a dispensing optician, there's a real disparity in that…There's a greater risk imposed upon the registrant if you have unqualified staff doing all sorts of things.

ABDO (professional association)

Some of the training that optical assistants have is brilliant, don't get me wrong. But you can't train somebody to the same level in three months that you can somebody in three years. So it's sort of surface learning as opposed to deep learning.

Educational institution stakeholder

9.3.12 Rather than allowing the role of dispensing opticians to be downgraded, or the roles of a dispensing optician to be carried out by non-registered staff, a number of participants suggested that dispensing opticians should be encouraged to step up and take on additional responsibilities to enable optometrists to do the same. The most common example suggested was that most dispensing opticians could begin to take responsibility for refraction, thereby freeing optometrists up to take on the newer aspects of their role related to eye health and disease. Participants explained that dispensing opticians were ready and interested in expanding the scope of their practice in this way, but that currently the opportunity to do so was not available. Laws would need to be changed governing the delivery of the sight test in the UK to allow refraction by a suitably upskilled dispensing optician for the purposes of issuing a prescription, which would bring the role more in line with other countries with very high standards of healthcare including the Netherlands, Switzerland and Canada.[42] However, should this change in the future, participants generally felt that this would not pose any greater risk to patients, as any additional responsibility would be accompanied by appropriate levels of training, as optometrists have when expanding their roles.

It would be great for DOs to do refraction. What a step for us to be doing that.

Dispensing optician, Birmingham

If there was an opportunity for DOs to push forward and expand their scope of practice we would certainly welcome caveats that mean we show we're demonstrating competence and capability before doing anything. So I think risk can be avoided assuming that DOs are properly trained and have been through a process where the accreditation has been achieved etc. For example, if we were allowed to do refraction, we wouldn't expect to just be allowed to go and do it. Those who want to do it would have to demonstrate capability.

ABDO (professional association)

9.4 Development of technology and artificial intelligence

9.4.1 The development of technology and artificial intelligence was ranked in second place as having an impact on the way that optical services are delivered (3.01). Subgroup analysis highlights that this factor was viewed as having a greater level of impact by respondents working in England (3.02) and Wales (3.09) when compared with those working in Scotland (2.81).

9.4.2 It is generally agreed throughout the sector that, as with many other areas of society and healthcare, technology is having a significant impact on the way that services are being delivered, with the introduction of automated refractors, deep level analytics of the OCT, iPhone

[42] Optical Confederation & College of Optometrists. (2016). *Foresight Project Report: A Discussion of the Potential Impact of Technology on the UK Optical Sector to 2030 - Full Report*, p.151

ophthalmoscopes, clear-lens extraction, free-form spectacles, online purchasing of corrective eyewear and online refraction being some of the most recent developments.[43] The development of technology was a widely discussed topic in the qualitative research. There was consensus that technology has evolved significantly in the last 10 years, and therefore has had a substantial impact on the optical sector, including the level of risk posed to patients and the public.

Reduced risk to patients as a result of developments in technology and artificial intelligence

9.4.3 Most participants felt that developments in technology had reduced the level of risk posed to patients and the public. The majority of discussion around the positive impact of technology focused on optical coherence tomography (OCT), a non-invasive diagnostic instrument used for imaging the retina. All participants were aware of OCT, and a number had direct experience of using it in practice, explaining that their place of work had invested in the technology. The key benefits of OCT discussed were the increased ability to detect and diagnose eye conditions and disease, greater accuracy and early identification. It was therefore strongly felt that the development of this technology was reducing the level of risk to patients and the public, as any potential problems could be identified sooner and more accurately, allowing the correct treatment or referral to be made.

We have an OCT scanner in our practice now, and all that is going to do is improve the early diagnosis of eye disease. I can't see any negative impact within the profession.

Dispensing optician, Cardiff

In the main I think the ability to screen, intervene, to initiate treatment and diagnosis sooner will probably lower the risk for patients.

Moorfields Eye Hospital

9.4.4 Additionally, it was explained that the introduction of OCT and other technologies, such as auto-refraction, allowed practitioners to have more time to focus on the patient, their health and the more clinical elements of their role, utilising the technology to undertake the potentially more time-consuming testing. In this way, this development in technology means a change in role for optical professionals, giving them more of a decision making and advisory role.[44]

Technology will help, because the optometrist has got lots of time to look at the clinical health part of it and spend more time on that rather than trying to deal with the refraction issues within the time constraints.

Mike Horler, Ophthalmic Director, Large employer

9.4.5 Participants suggested that developments in technology were enabling optometrists working in community practice to take on more clinical roles such as extended and enhanced services and the identification and management of conditions such as glaucoma and AMD, improving the services offered to patients in the community and helping to reduce the burden on the NHS. It was also stated that this technology was improving and refining the referral process from primary to secondary care, helping to reduce the risk of inappropriate referrals.

The equipment side [of technological advances] *clearly has had a huge impact and goes hand in hand with some of the services that we are looking to move out into primary care. For example, the OCT machines are absolutely essential in glaucoma diagnosis and follow up care, and in wet AMD, both from a diagnosis and a follow up point of view. We couldn't actually run these services without that level of equipment in primary care.*

Welsh Government

[43] Optical Confederation & College of Optometrists. (2016). *Foresight Project Report: A Discussion of the Potential Impact of Technology on the UK Optical Sector to 2030 - Full Report*, p.19
[44] College of Optometrists. (2016). *The Optical Professions: What Does the Future Hold?*, p.4

One of the biggest things has been the advent of increased use of OCT in primary care practice to refine referrals and to triage referrals going into the eye hospital.

Mike Horler, Ophthalmic Director, Large employer

9.4.6 The potential benefits of artificial intelligence (AI) were also discussed by some participants. Although still in its early stages, some participants explained that they were aware that AI had the potential to be far superior to trained optometrists when interpreting OCT results, meaning that much greater accuracy could be achieved when detecting ocular disease. Again, it was suggested that this technology would create additional time for practitioners to spend focused on the patient and their needs, rather than conducting tests and interpreting results.

AI is better at reading OCT screens already than an ophthalmologist. So if you are doing a scan for macular degeneration assessment, AI is better. It's already well documented. In the future, we will have an OCT, send off the results to AI, AI will bounce back and say treat or don't treat and our role will be to talk to the patient and advise the patient of the risk and the treatments. Our role in actually detecting will be less and we will be much more of a nursing role.

Optometrist, London

9.4.7 A related benefit of developments in technology that was also discussed was the implementation of electronic patient records. Related literature identifies that one of the most detrimental factors to ophthalmic public health data is the NHS's reliance on paper-based systems within optometry.[45] The majority of participants said that they now had or were in the process of moving to electronic patient records, which brought a number of improvements to their practice. In relation to patient risk, participants explained that the level of risk was reduced because much more accurate patient records could be kept, including photographs, measurements and results, which were far less likely to be misinterpreted or lost. Furthermore, it was stated that electronic patient records will help to reduce the risk of errors or delays in patient referrals into secondary care, as records can be efficiently shared between community practice and hospitals, but it was accepted that changes and improvements are still required within the NHS in relation to electronic communication to make this process easier and more efficient, perhaps by 2020 (with the exception of Scotland, where e-referrals are more or less up and running).[46] A recent development is NHSX, which is a new unit which aims to take forward digital transformation in the NHS, allowing patients and staff to benefit from the latest digital systems and technology.[47]

We've just had agreement from the Minister for Health here in Wales that we will have electronic referrals from optometric practices into secondary care, into ophthalmology, and a shared electronic patient record that can be utilised by both secondary and primary care. Those advancements are equally as important as the equipment and technology that we use in both of our clinical settings, because it actually allows safe communication, it allows the safe transfer of patient data, and a seamless transfer of that data.

Welsh Government

When we interface with secondary care colleagues, we should have robust IT structures that will allow electronic transfer of images, the possibility for electronic triage, and thereafter referral for advice.

Health and Social Care Board

[45] College of Optometrists. (2013). *Better Data, Better Care: Ophthalmic Public Health Data Report*, p.11
[46] Optical Confederation & College of Optometrists. (2016). *Foresight Project Report: A Discussion of the Potential Impact of Technology on the UK Optical Sector to 2030 - Full Report*, p.88
[47] Department of Health and Social Care. (2019, February). *NHSX: new joint organisation for digital, data and technology*. Retrieved from GOV.UK: https://www.gov.uk/government/news/nhsx-new-joint-organisation-for-digital-data-and-technology

Increased risk to patients as a result of developments in technology and artificial intelligence

9.4.8 Whilst the majority of discussion around the development of technology and artificial intelligence were discussed in a positive light, where the risk to patients was ultimately reduced as a result, some participants raised concerns about the potential risk that technology posed to patients and the public. One of the key issues raised was the ability of optical practitioners to interpret the results generated by technology correctly, particularly OCT results. Although AI is developing to undertake this role, OCT currently requires the clinician to interpret results and decide on appropriate action, and this is likely to remain the case for some years ahead.[48] A number of participants explained that OCT was only useful if it could be accurately interpreted, and that if a practitioner was not adequately trained to do so, eye conditions and disease could go undetected without the proper training.

It depends on who is operating it. Technology in the hands of someone talented will make things better, but in the hands of someone who doesn't know what they are doing, there is a risk. It all comes back to how qualified and how good someone is.

Dispensing Optician, Cardiff

Many optoms won't have been taught OCT at university. I qualified in 2015 and we still only had one lecture on OCT and no exams on it. It's not that long ago and OCTs were around. A lot of degrees are now outdated.

Secondary care stakeholder

9.4.9 Another commonly raised concern about the development of technology was the risk of over-referrals. Although it was suggested that technology such as OCT can help refine referrals, some participants believed that, if not interpreted correctly, this technology can increase the likelihood of false-positive referrals into secondary care. In this way, a number of participants perceived that developments in technology were potentially a 'double-edged sword', bringing the benefits of improved identification and diagnosis, but at the same time introducing the possibility of an increase in inappropriate referrals following the introduction of OCT in community practice.

I also work in an eye hospital. I have seen referrals from practitioners that have an OCT [and] *I don't know if they've had any training, but they've certainly not applied it when they've looked at the scans that they've sent into the eye hospital.*

Mike Horler, Ophthalmic Director, Large employer

Practices have bought an OCT and taken pictures but been unable to interpret them, and sent the patient into the hospital for someone to interpret what is essentially a normal scan in a patient without symptoms.

Secondary care stakeholder

9.4.10 The main risk of over-referrals as a result of developments in technology was seen as the impact on the NHS, with a greater proportion of patients being sent to hospital for further tests unnecessarily, potentially delaying the treatment of other patients. The impact to the wellbeing of patients was also highlighted as a potential risk, with patients being informed that they may have serious eye health conditions such as AMD due to the misinterpretation of an OCT scan result. A number of participants therefore felt strongly that high standards of training for using OCT and interpreting the results was required to mitigate this risk.

The availability of OCT in the high street…It's very definitely a doubled-edged sword. In some respects, it's beneficial because very early AMD can be detected and if there is fluid in the retina people can be referred to hospital services for injections promptly…The downsides are that we think some optometrists

[48] Optical Confederation & College of Optometrists. (2016). *Foresight Project Report: A Discussion of the Potential Impact of Technology on the UK Optical Sector to 2030 - Full Report*, p.159

are diagnosing people with AMD because they see something on the retina, which in the past they may not have mentioned, but they now do because they feel that if it's there they've got to say something. We know, for example, that there are a huge amount of false-positive referrals into secondary care, which is damaging to patients because it's clogging up the clinics and patients who do need treatment are delayed. The figure going around is something like 90% of referrals to Moorfields for wet AMD in one year were false-positives, which is a massive problem for the NHS, which rebounds on the patients.

Macular Society

Technology offers potential, but at the same time needs to be managed because patient risk isn't just about ophthalmic harm, as in loss of sight or vision, it's also harm as in unnecessary tests, investigations, referrals to a secondary care setting. A patient who is referred is still coming to harm if he or she doesn't need to go there. If they have to take a day off work, to get a carer in, that sort of thing, travel. So it depends how you measure or define risk. A risk of over-referral is very likely…With 27,000 people waiting for a first outpatient that's a significant risk for service delivery.

Health and Social Care Board

9.4.11 In contrast to discussions around the benefits of AI, some participants expressed concerns about how increased use of AI in the future could have a negative impact on patient safety by moving towards automation of the optometry process. It was explained that furthering the use of AI could reduce the need for the presence of a fully qualified optical practitioner within the process, which in turn could lead to deregulation of certain parts of eye care and potentially increase the level of risk posed if a registered practitioner was not present. The potential removal of face-to-face interaction with a professional was also seen as a potential risk when considering moves towards the increased use of AI, as this could result in problems with communication to explain results or provide advice.

The greatest risk to the professions is AI and technology automating everything. You might have unqualified people doing all the nuts and bolts with just one qualified person overseeing signing things off. This is how it's gone in orthodontics …I can see optometry as prime for this.

Optometrist, Cardiff

The risk to the patient is, the more removed you are from that consultation face-to-face – the more risk there is as any issues are not attributable to a person. If someone comes in to see me and I fail to detect their glaucoma, then I am rightly liable for that – if some AI is doing it where is the responsibility?

Optometrist, Edinburgh

9.4.12 A number of dispensing optician participants highlighted that there was a risk posed to patients of the unnecessary use of technology. They explained that in their workplace, often they felt they were encouraged to use technology to impress patients rather than to improve the level of care they provide. The most common example provided was the use of an iPad to take facial measurements, which participants said was less accurate than using the manual approach of a ruler, that many said they also used to check the measurements taken by the iPad. It was suggested that this was an example of where technology was being used unnecessarily, and whilst it did not present a high severity risk, it meant that patients received a lower standard of care as a result.

They make us use iPads, but I still trust my ruler. Every time I use an iPad the measurements are wrong, but you have to use it. I use it first as a show for the customer, then I get my ruler out and do it how I've always done it. You can lose the human touch. People prefer advice. It's not necessarily a risk, it's just poorer service.

Dispensing optician, Leeds

Technology provides a show for dispensing better lens. You get out the gizmo, I've got one, but at the end of the day, I could go back to the old ways. Because with these measuring devices, they don't necessarily take into account the posture and invariably the heights are too high. I always re-check the heights

manually because you look at someone's posture and put a mark on the lens, you get them to move your head and you see what's happening. Technology is wonderful, but experience is better.

Dispensing optician, London

9.4.13 Another potential risk posed by developments in technology and artificial intelligence was the potential for optical practitioners to over-rely on technology and de-skill as a result. It was suggested that technology may begin to be used to conduct the more simple tasks in optometry, and this may lead to practitioners being unable to carry out these things in the future, which would place patients at risk. This risk was also highlighted in the GOC's recent consultation into CET, which found that the majority of stakeholders who responded to the consultation believed that there was a risk that practitioners may be de-skilling, which was generally attributed to developments in technology and increased automation.[49]

I think there's a risk that the more they rely on automated activity within the practices for actual refraction and other tests, that there's a risk of de-skilling their manual techniques.

Head of Dental & Optical Services Commissioning, NHS England

I think that there may be, in some instances, an over-reliance in the technology, and we are forgetting the base methods of doing the dispensing. And the technology is going to work 80% of the time, but what happens in the other 20% of the time is that we don't get the correct service for the patient.

Educational institution stakeholder

9.4.14 When discussing developments in technology that related to automation of the optical sector, such as auto-refraction, feedback was generally more negative and suggestive of risk to patients and the public. Some participants explained that auto-refraction was becoming more sophisticated, able to accurately test the sight of an individual, but many others were much more sceptical and questioned how it could provide a safe and reliable test.

I've seen apps that can refract to a pretty high standard.

Dispensing optician, London

We've trialled automated refraction and we're deciding what we want to implement.

Vision Express

9.4.15 Auto-refraction was viewed as much higher risk to patients due to the lack of an optical practitioner being present to check and interpret the results and to assess the optical health of the individual, not just their sight, and some participants suggested that the technology was not yet sophisticated enough to take into account any unusual results. It was also highlighted that moves towards auto-refraction placed certain types of patient at greater risk, such as people with disabilities, for whom auto-refraction was less likely to work successfully. However, a number of sources now suggest that automation and patient-led refraction, although not suitable for all patients, will mean the number of people requiring the attention of a fully trained optometrist for traditional refraction will decrease.[50]

The big risk to the profession is deregulation of prescribing lenses. For example, patient can just go to a supermarket for an auto-refractor result and just go online and buy their glasses, but the results are variable, so that's a risk. It will work for some people but not all, so it's a risk to us and the public.

Optometrist, Cardiff

[49] Enventure Research. (2018). *Fit for the Future: Lifelong Learning Review - Continuing Education and Training Consultation*, pp.23-24

[50] Optical Confederation & College of Optometrists. (2016). *Foresight Project Report: A Discussion of the Potential Impact of Technology on the UK Optical Sector to 2030 - Full Report*, p.157

I was at a conference last September where there was a device that could measure the refraction of a patient…It was absolutely brilliant how it could do it, but it only works for certain patients. Once your prescription is outside the parameters of the device then it can't work...It literally just does a refraction, it does not look at the pathology of the eye…I think the more we have the automation, the less investigation we'll have. Sometimes it might be nothing…but we can't afford to take the risk and miss the pathology.

Educational institution stakeholder

9.5 Population changes

9.5.1 Population changes recorded a score of 2.99 out of 5 in terms of the level of impact it was having on changes to the way optical services are delivered. This factor was viewed as having more impact by optometrists (3.13) when compared with dispensing opticians (2.76), as well as those who worked in a hospital (3.24) when compared with other settings, especially those working for national chain opticians (2.97). Subgroup analysis also highlights that population changes were perceived to be having more impact by those who had been registered with the GOC for a longer period of time, from 21 years and over (3.10) compared with those who had been registered for less than 10 years (2.76).

9.5.2 Population changes were widely discussed by qualitative research participants, focusing specifically on the ageing population of the UK. In the UK, the proportion of the population aged 65 and over increased from 15% in 1985, to 17% in 2010, to 18% in 2016,[51] and it is projected that this age group will account for 22% of the population by 2030. An ageing population brings with it multiple forms of eye disease and health related concerns, while rising obesity levels will lead to more diabetes-related eye problems.[52]

9.5.3 The ageing population was seen as having a significant impact on the way that optical services are delivered, and is also linked to a number of other factors, in particular changes to the NHS. The main impact of the ageing population that was discussed was the increasing likelihood of patients presenting with more complex and therefore potentially higher risk eye conditions, such as glaucoma and AMD. For practitioners, this meant that these patients required longer appointment times to be able to diagnose and manage these conditions effectively. It was also highlighted that practitioners needed to be confident to deal with these conditions and manage any potential risk, which would increase in frequency in the future as the population continues to age.

Patients are getting older and living much longer. That brings with it more complex dispensing that requires more of the dispensing optician's time.

ABDO Exams (awarding body)

What we were seeing was an increasing number of ex-service or serving personnel who were experiencing sight loss through age-related conditions. The biggest sight loss issue that we have for our members is macular degeneration, which is the biggest cause of sight loss in the UK…We have the oldest average cohort of members that we've ever had.

Blind Veterans UK

9.5.4 From a practical stance, a number of participants explained that the ageing population meant that appointment times were increasing to take into account the increased likelihood of frailty and disability, thereby increasing the risk of time constraints with other patients. Some participants explained that the additional time with older patients was not always due to their physical or mental health, but was actually because older patients were living for longer in a better state of health.

[51] Office for National Statistics. (2018). *Living longer: how our population is changing and why it matters.* p.2
[52] Optical Confederation & College of Optometrists. (2016). *Foresight Project Report: A Discussion of the Potential Impact of Technology on the UK Optical Sector to 2030 - Full Report*, p.14

This meant that they often required more complex prescriptions and dispensing of multiple frames that would meet their lifestyle requirements if they were continuing to be active as they aged.

We get a lot of patients now that can't even make it into the practice.

Optometrist, London

Our patients are more technologically minded so we need to be able to address their lifestyle needs. It's more commonplace now that we dispense multiple pairs to patients to address their lifestyle needs, rather than just the one pair fits all. That's quite a major change and with that comes a lot more complex communication needs and more complex products. We need the skills and time to be able to dispense those effectively.

ABDO Exams (awarding body)

9.5.5 A further potential risk to patients associated with the ageing population was the increased strain this placed on the NHS, resulting in increasing waiting times for eye care or treatment for eye conditions that are more prevalent amongst older patients. Participants explained that the ageing population was an important reason why a significant proportion of eye care was moving from secondary care into community to be able to relieve the increased burden on the NHS.

With an ageing population there is always a risk that, because people are living longer, there's an over population of eye disease. The NHS has problems with having enough ophthalmologists to see everyone that requires to be seen, meaning you get patients can be left waiting for months and left in limbo, potentially coming back to the optometrist.

Vision Express

I think it's all driven by the increasing changes in the population, putting more pressure on the NHS and driving more patients to the community practices.

Optometrist, Northern Ireland

9.6 Changes to the NHS

9.6.1 The changes to the NHS were not viewed as having the highest level of impact on the way that optical services are delivered, but still recorded a relatively high score in the survey results (2.92 out of 5). Subgroup analysis shows that this factor was viewed as having a greater impact for optical business registrants (3.22) compared with registrants (2.91), and also for those who had been registered with the GOC for less time, from less than 2 years (3.09) and 3 to 10 (3.06) to 21 years and over (2.82).

9.6.2 Feedback from the qualitative research highlights that it is widely accepted that the NHS is under increasing strain in terms of capacity and resources, driven by population growth, an ageing population, and funding issues, and that this is having a significant impact on the way that optical services are delivered. Relevant literature highlights that hospital attendance has increased year on year in the UK, with over 100 million outpatient appointments made in England alone during 2013-14, of which 10% were for eye care, likely caused by the fact that common eye conditions which were previously untreatable, such as age related macular degeneration, can now be treated successfully, adding to the demand on eye clinics.[53]

9.6.3 As a result of the increasing pressure on optical services in the NHS, the most widely discussed topic was the movement of services from secondary care into community practice to attempt to

[53] MacEwen, C. (2016). *Increasing Demand on Hospital Eye Services Risks Patients Losing Vision*. Retrieved from Royal College of Ophthalmologists: https://www.rcophth.ac.uk/2016/03/increasing-demand-on-hospital-eye-services-risks-patients-losing-vision/

alleviate this pressure, with optometrists and dispensing opticians becoming more responsible for the delivery of services and management of patients typically delivered in a hospital setting. It is now believed that high street optometry practice is where most cases of eye disease are first identified, particularly in Wales and Scotland where shared care schemes are more developed, meaning that optometrists are increasingly involved in monitoring long-term conditions through locally commissioned enhanced eye care services.[54]

The interaction between hospital and community practice is a factor. There are more complex optical needs being met at a local practice level rather than in hospital.

Optical Consumer Complaints Service

The biggest change has been the increased commissioning landscape, with low risk clinical services that don't need to be in an eye hospital being commissioned out to the community, provided there is appropriate training and governance in place…AMD and glaucoma are huge workloads for all hospital eye services and they are struggling to deal with the volume…and because of our ageing population there's more and more of it.

Mike Horler, Ophthalmic Director, Large employer

9.6.4 Some participants felt that the changes to the NHS posed increased risk to patients, as often referrals into secondary care had significant waiting lists, meaning that patients had to wait for a long time to receive the treatment they needed. As previously highlighted in this research, some participants felt that by taking on more clinical roles and responsibilities as services moved into community optical practices, the level of risk to patients was increasing, as roles which dealt with optical disease and management of conditions were inherently more risky, becoming more in tune with doctors.

Given how much strain the NHS is under, I think that creates a greater level of risk. And it varies greatly depending on which area of the country you're in. I've had situations where I need to refer someone urgently, but they just say they can't do it.

Optometrist, Leeds

We are taking on way more healthcare cases and the role of DOs will begin to change… the risk is becoming the same as a doctor in hospital as we are taking on their roles.

Dispensing optician, Edinburgh

9.6.5 A number of participants felt that changes to the NHS were linked to the ageing population, as this was a key reason as to why there was an increased burden placed upon it, exacerbated by a lack of resource and capacity.

We've got an increased burden on secondary care because of the ageing population…The changes have had an impact on the potential of risk to the patient, with delayed waits.

Head of Dental & Optical Services Commissioning, NHS England

We have no more capacity, there is no more money so we all have to be careful about how we use NHS resources. I think the expansion in the older population is again going to be an issue because we are going to have to do more with less.

Rachel Pilling, Consultant ophthalmologist, secondary care stakeholder

[54] College of Optometrists. (2015). *Optical Workforce Survey*, p.14

9.7 Changes in consumer expectations and behaviour

9.7.1 Changes in consumer expectations and behaviour was ranked the lowest in terms of impact on the way that optical services are delivered, but still did not record a particularly low score (2.78). Subgroup analysis shows that optical employers considered this to have a greater impact (3.20) when compared with registrant (2.77) and business registrant respondents (2.73). It was also viewed as having more impact for dispensing optician respondents (2.86) when compared with optometrists (2.74), as well as those who worked for national (2.86) and regional chains (2.83), particularly when compared with those working in a hospital (2.51).

9.7.2 During the qualitative research, it was often suggested that consumer (or patient) expectations and behaviour had changed in recent years, and that this was having an impact on the way that optical services are delivered. A number of participants felt that patients had increasingly high standards, coupled with perceptions of what their care should look like in terms of quality and safety, which meant that they could be more demanding as a result. However, some participants explained that increasing patient expectations and standards often also came with patients wanting to receive a low-cost service, two things which were seen as at odds with each other and difficult for practitioners to balance.

I think generally an increasing awareness on compliance and safety, and from a patient point of view as well. Patients are more worldly wise about what outcomes are for different people and that they can expect high standards.

Boots Opticians

As much as their expectations have changed, they still want a cheap service. They want a lot more but they don't value you.

Optometrist, Birmingham

9.7.3 The most discussed issue in relation to changing consumer expectations and behaviour was the widely held perception that optical sector patients, as with patients and consumers in other areas of healthcare, were becoming increasingly litigious. This perception appears to be based, to some extent in reality, based on the increasing number and cost of NHS litigation claims.[55]

9.7.4 Many participants felt that there was a fear of being sued amongst the profession, explaining that patients were more aware of how to take legal action and more likely to do so. Risk of litigation, or being called in front of the GOC via Fitness to Practise proceedings, was a concern for many participants, as losing their professional registration was a threat to their livelihood and future career. However, it was accepted that this was a risk posed to optical practitioners, rather than to patients and the public.

I think that consumers' standards are really high and sometimes their expectations are unrealistic. Sometimes consumer programmes can make people more litigious and more demanding.

Dispensing optician, Cardiff

9.7.5 An aspect of changing consumer behaviour that was seen as posing a potential risk to patients and the public was the increasingly likelihood of patients moving between optical practices and not staying with one practice for an extended period of time. A number of participants suggested that patients were more likely to visit different opticians over a number of years, attracted by deals or convenience, or to have their sight tested in one location, but purchase their frames or contact lenses elsewhere. The risk posed to patients was that they were less likely to see the same optical

[55] Birks, Y., Aspinal, F. and Bloor, K. (2018). *Understanding the Drivers of Litigation in Health Services.* Partnership for Responsive Policy Analysis and Research, p.1

practitioner, reducing the opportunity for continuity of care, and that any changes in their vision or condition over time may be less likely to be noticed, as patient records may not be transferred between optical practices.

Increasing customers by attracting them with deals, means that customers are being a little less loyal to where they go, which is changing how care is delivered to them. They may not go back to the same person again and again, and they may shop around a little bit.

College of Optometrists

Previously, patients would have stayed with the same practice and purchased their spectacles where they had their sight test. Now people move around a lot more, having a sight test in one location and then purchasing products from a different location, or from the internet. They're not necessarily tying that together as well. That splitting of care and interactions means there's a greater risk of subtle changes which might not be picked up as easily as previously.

Association of Optometrists

9.7.6 A small number of participants suggested that the public was becoming more aware that they can go to an opticians if they have a problem with their eyes, such as red eye, rather than visiting other healthcare professionals such as their GP. Therefore, this change in behaviour meant that they were beginning to see an increasing number of patients with minor eye conditions. This perception is reinforced by the GOC's regular Public Perceptions Research, which since 2015 has found that the public are becoming more likely to say that they would visit an optician if they found they had a minor eye problem such as red eye, rather than visiting their GP, a pharmacist or accident and emergency, increasing from 19% in 2015 to 25% in 2019.[56] However, other recent literature has been published which suggests that eye health is still perceived to be predominantly related to sight loss and refractive error rather than preventing disease, and that there is a low level of recall of public health information concerning eye health, in contrast to the promotion of sight tests and spectacles.[57]

As dispensing opticians we're going to be more likely to come across those patients who now know that they can go to the opticians if they have a red eye rather than their doctors. That might start to bring in more risks.

Dispensing optician, Leeds

9.7.7 Another significant risk suggested by participants in relation to changing consumer behaviour was the increasing proportion of patients who purchased spectacles or contact lenses online. Previous research conducted by the GOC found that the economic downturn reduced consumers' willingness to pay for new spectacles and increased switching behaviour towards cheaper choices of optical products,[58] which may explain the increasing propensity of patients to purchase online. The Optical Confederation and College of Optometrists' Foresight Project Report predicts that it is inevitable that the direction of travel for retail in the sector is increasingly online, due to consumer trends, increasing internet connection speeds and other improvements in technology, such as online refraction.[59] Therefore, this is an area of risk which needs to be explored in greater depth.

9.7.8 Online sales of spectacles and contact lenses were generally viewed as being a great risk to patients, as it reduced the involvement of a trained and qualified optical practitioner, particularly in the fitting of the product and provision of advice and support. A number of participants recalled

[56] General Optical Council. (2019). *Public Perceptions Research 2019*, p.10
[57] Leamon, S. et al. (2014). Improving Access to Optometry Services for People at Risk of Preventable Sight Loss: A Qualitative Study in Five UK Locations. *Journal of Public Health*, Vol.36(4), p.669
[58] Europe Economics. (2013). *Optical Business Regulation*, p.6
[59] Optical Confederation & College of Optometrists. (2016). *Foresight Project Report: A Discussion of the Potential Impact of Technology on the UK Optical Sector to 2030 - Full Report*, p.78

times when patients had come into their practice experiencing problems with products that they had purchased online, which they explained was typically a result of poor fitting. The risks posed to patients and the public were seen as potentially quite severe, as if complex lenses such as varifocals or bifocals are not dispensed and fitted correctly, they could seriously distort the vision of a patient.

You get problems with frame fitting, inappropriate lens centration which can cause problems for patients concerned and compromise their vision. I've had patients come in and say they can't see with their spectacles and they've bought them online or people ask us to fit them for them.

Dispensing optician, Cardiff

I think buying glasses online is a disaster really, especially anyone with varifocals and bifocals. You could crash your car if your glasses aren't fitted correctly.

Optometrist, Northern Ireland

9.7.9 Despite concerns held by the majority of participants about online sales of spectacles and contact lenses, some participants worked for online retailers and explained that they tried to mitigate any risk to patients through the online sales process. For example, one participant explained that they employed qualified dispensing opticians to supervise and review each order placed, who would then contact customers if additional information was required, to ensure high standards were achieved. However, they also accepted that not all online retailers had the same standards or procedures in place. Previous research conducted by the GOC also highlights that online sales can still pose increased risk to patients, even if supervised by a registered optometrist or dispensing optician, as they may not have access to certain important measurements such as inter-pupillary distance, which is not required to be on prescriptions.[60]

We are the only online supplier who employ what we call a super vision statement so we employ 10 DOs who supervise and review every order. It's within their professional freedom to intervene at any stage and to contact the customer to talk about anything that they would in a high street practice. We have to contact about 25% of our customers for additional information and to have a consultation, but others don't that.

Dispensing optician, London

9.7.10 Generally, there was more concern raised by participants about the online sale of contact lenses when compared with spectacles. This was seen as posing a potentially severe risk to patients, as contact lenses were a much more invasive product by comparison, and participants often stated that patients required guidance and aftercare to correctly use contact lenses and avoid risks such as infection, which they did not receive in the same way if they purchased online. This perception is supported by previous GOC research which found that consumers purchasing contact lenses online were less likely to follow recommended contact lens behaviour, and did not have the incentive to visit an opticians for a regular check-up.[61]

Glasses are less of a risk, because you don't put them in your eye. They're not aware of the risks of poorly fitted contact lenses. Or even aftercare.

Optometrist, Birmingham

Patients really struggle to see why they should have contact lens health check-ups…a lot of people don't see the importance of it, and that can be extremely harmful…You might not be cleaning the lenses in the right way, you might not be wearing them in the right way, you might be sleeping in the lenses. By getting contact lenses online from suppliers who don't comply with the Opticians Act you're bypassing an essential eye check, and you're also bypassing all of the information you get when you see an eye professional. So there is a risk to patients, and that risk is growing as the contact lens business grows.

Boots Opticians

[60] Europe Economics. (2013). *Health Risk Assessment of Illegal Optical Practice*, p.15
[61] Europe Economics. (2013). *Health Risk Assessment of Illegal Optical Practice*, p39

9.7.11 A number of participants raised concerns about the standards and regulation of online sales due to many companies operating outside the UK, meaning that they were not subject to the same levels of regulation, thereby posing a risk to patients. The Opticians Act (1989) demands that UK vendors see proof of an authorised, up to date prescription before making a sale, but online retailers are able to bypass UK regulation by processing contact lens orders outside the UK where prescriptions or specifications do not need to be officially validated.[62]

For those offshore, there is no supervision and the Opticians Act does not apply. We would like to see everyone coming into the market having a robust level of standard.

Dispensing optician, London

There's a risk to buying contact lenses online. On the tube you see all these adverts for cheap, online only contact lenses. The materials may not be the best, but people see them as convenient. They just tick a box to say they've had a contact lens check, regardless of whether they have or not, which severely compromises patient safety. The GOC needs to contact those contact lens companies and say that the sale of those lenses in the UK is illegal.

Association of Independent Optometrists

The OCCS mediates complaints involving GOC registrants within the UK. We can mediate complaints involving online supply of contact lenses or spectacles where a GOC registrant is involved, but if the supplier is based overseas, not a GOC body corporate and without a GOC registrant involved, then it falls outside the remit of the OCCS.

Optical Consumer Complaints Service

9.7.12 Despite the concerns and warning expressed by participants about the potential risks of online purchasing, this does not necessarily appear to be borne out in reality. The Foresight Project Report found that public experience of eyewear is not nearly as poor as many dispensing opticians and educators would like to believe, citing very high Trustpilot ratings for online retailers such as GlassesDirect (9.4 out of 10) and Visiondirect.co.uk (9.5 out of 10) from nearly 9,000 reviews.[63]

[62] Optical Confederation & College of Optometrists. (2016). *Foresight Project Report: A Discussion of the Potential Impact of Technology on the UK Optical Sector to 2030 - Full Report*, p.80
[63] Optical Confederation & College of Optometrists. (2016). *Foresight Project Report: A Discussion of the Potential Impact of Technology on the UK Optical Sector to 2030 - Full Report*, p.148

10. Future risk

10.1 Suggestions of risks in the near future

10.1.1 Survey respondents were able to list what they thought the main risks to patients and the public will be in the next five years. Free text responses have been coded for analysis, and the most common suggestions are presented at ***Figure 24*** below.

10.1.2 A quarter (24%) of those who provided a response suggested that commercial pressure, targets and time constraints would be the main risks in the next five years, followed by 18% who suggested pressure on hospital services (delayed referrals/long waiting times) and 16% who suggested risks posed by the quality of education and training or lack of skills.

Figure 24 – Suggestions for the main risks to patients and the public in the next five years
Base: All respondents who provided an answer (1,558)

Future risk	Number	%
Commercial pressure/targets/time constraints	371	24%
Pressure on hospital services (delayed referrals/long waiting times)	275	18%
Quality of education and training/lack of skills/lack of training for enhanced services	255	16%
Unregulated online sales	250	16%
Lower standards for patients/less focus on patient care	199	13%
Expansion of optometrist roles/providing more services/management of conditions	184	12%
Financial constraints/lack of NHS funding	182	12%
Missed pathology/mismanagement of pathology	178	11%
Downgrading/deregulation of dispensing optician qualification	141	9%
Use of unqualified/underqualified staff	122	8%
Technological advances/automation	122	8%
Ageing population/increasing demand for services/more complex pathology	91	6%
Dominance of multiples/loss of independent practices/lack of patient choice	90	6%
Changing patient expectations/understanding of optical professions	90	6%
Lack of patient responsibility/failure to have regular eye tests/self-testing online	88	6%
Devaluation of optical services/professions	53	3%
Poor dispensing/badly fitting items/inappropriate recommendations	50	3%
Litigation/having to work defensively	44	3%
Lack of support from the GOC/other regulatory bodies	35	2%
Stressed/demotivated workforce	29	2%
Lack of appropriate aftercare/follow ups	16	1%
Data protection/cyber security	14	1%

Qualitative research participants were asked to think about what they expected the risks to patients and the public would be in the next five years, based on their experience of working in the optical sector. In the main, participants stated that they expected to see a continuation of the changes they had seen over the last five to ten years, including further developments in technology and artificial intelligence, further changes to the NHS, population changes as the population continued to age, and changes to the roles of optical professionals as a result. These are summarised throughout this chapter, with some suggestions of what the GOC could do to help support the profession to manage risk in the future.

10.2 Future risks posed by the changing roles of optical professionals, an ageing population and pressure on the NHS

The changing roles of optical professionals

10.2.1 In the survey, 12% of respondents identified the expansion of optometrist roles, including providing more services and management of conditions as a main risk to patients in the next five years. A further 9% suggested the downgrading of the dispensing optician qualification as a risk in the next five years.

10.2.2 Many qualitative research participants said that they thought the roles of optical professionals would continue to change in the future and that this would impact on levels of risk. The most common suggestion was that the role of optometrists would continue to expand as services continued to move from secondary to primary care, meaning that they will be required to take on a more clinically focused role. This is forecasted in the Foresight Project Report, which states that the NHS is likely be commissioning more community eye care services from optometrists in the 2020s, requiring them to work at the very top of their skillset and undergo regular re-accreditation.[64] This change would extend into the future as the population continued to age and community practice was increasingly required to alleviate pressure on the NHS. The future risks associated with this would be mitigated by ensuring that the profession is ready to take on these extended roles and responsibilities through updated and improved standards, education, training and development.

Our role is ever increasing in ophthalmology. We are going to be doing more small minor eye procedures to help clinical demand in the future. For instance, there are now optoms doing injections which definitely crosses the barrier between medical professional and optometrist.

Secondary care stakeholder

To mitigate those risks we have put in appropriate standards and training for our optometrists to work to, and we will continue to push those standards and the level of training as we go along.

Welsh Government

10.2.3 In relation to the changing role of dispensing opticians, some participants expressed concerns about the future of the dispensing optician role and the continued use of non-registered optical assistants to undertake parts of the sight test and other important roles, which they felt increased the risk to patients and the public. It was suggested by both optometrists and dispensing opticians that the GOC needed to provide a clearly defined definition of the dispensing optician role to avoid any potential downgrading and prevent the illegal use of optical assistants in practice.

Tell us how we can do our job properly without being so vague. How can you protect the public if you're not clearly defining the role of DOs, so they know that they're not being sold to by any Tom Dick or Harry? It's too loose in terms of what we have to do and what can be done by a colleague. They need to make a decision and set it in stone, so then there are no blurred lines.

Dispensing optician, Leeds

10.2.4 In relation to the dispensing optician role, it was also suggested that defining the role more clearly would also help it to be more recognised and utilised as the sector changes. As previously highlighted, a number of participants felt that dispensing opticians could be doing more, with a particularly focus on refraction, and that the GOC could help to develop the extension of the role,

[64] Optical Confederation & College of Optometrists. (2016). *Foresight Project Report: A Discussion of the Potential Impact of Technology on the UK Optical Sector to 2030 - Full Report*, p.14

enabling dispensing opticians to become more skilled and qualified to support optometrists, ultimately helping to relieve pressure on the NHS.

It's obvious that community optical practices should be doing more, particularly where it's more accessible for patients and the individual's skills are being utilised. We are absolutely fully supportive of optometrists moving forward…but as they move forward there are other gaps that are going to appear. And this is why it's important that DOs are given the opportunity, and the GOC recognise what DOs can deliver.

ABDO (professional association)

The GOC need to recognise that roles are changing and encourage the change to give our patients the best service, and in turn the service they require.

ABDO Exams

10.2.5 It was also suggested that it would be of benefit to clearly define the current role of optometrists, given changes in recent years, particularly the extended roles and what training is required to be able to undertake them in practice to ensure patient safety and prevent optometrists working outside their own competency.

The GOC could help by defining what it considers the roles and extended roles of optometrists, and in the extended roles help to define what training requirements are necessary to help ensure they are fulfilling those roles competently. Similar to the way the GMC approves the curriculum for the training of doctors, the GOC could review the curriculum and training of the extended role aspect.

Royal College of Ophthalmology

A continuing ageing population and changes to the NHS

10.2.6 In the survey, 18% of respondents identified pressure on hospital services as a main risk to patients in the next five years and 12% suggested financial constraints and lack of funding for the NHS. Linked to this, 6% suggested that an ageing population was a risk, increasing demand for services and more complex pathology.

10.2.7 When discussing the potential risks in the near future, a number of participants focused on the increasingly ageing population and how this was placing pressure on the NHS. It was generally agreed that, as this pressure increased, optical services would continue to be moved from secondary care into the community. It was therefore felt that to manage this risk, the profession needed to be prepared to deal with a much wider and more varied range of patients and services, particularly more complex needs which are more common amongst older patients and those who typically would have visited secondary care for diagnosis and treatment. It was suggested that, as the profession had managed to adapt over the last ten years, it would be able to do so again over the next ten years, and that therefore future changes should be viewed in a positive light.

In the next five years the ageing population will mean the optometry and hospital link has to be a lot stronger. We all have to work in collaboration together to tackle the bigger issues together, like the ageing population, the lack of ophthalmologists in the country, and the NHS.

Vision Express

There is a huge problem with waiting lists in secondary care, so it will become inevitable with the sheer number of patients, getting older, new treatments, new technology.

WOPEC

Is the prevalence of eye diseases and conditions increasing in the population? Yes. What is the primary driver? The ageing population. We have more glaucoma, more macular degeneration, more cataracts, more pathology. That's not occurred from any change in the optical sector itself but from changes in the population…We have to step back and decide how to meet the population's needs…If opticians didn't

innovate and hadn't invested in primary care as they have over the last ten years the nation's eye health would be in a dire state now; as a sector we need to be proud of that, and push ahead so we have an even more comprehensive primary and community eye care service in the future; that is how to best mitigate risk at a population level.

FODO

10.3 Future risks posed by current education and training

10.3.1 The survey results show that 16% of respondents said that one of the main risks to patients and the public in the next five years was the quality of education and training provided to optical professionals, including lack of skills and training for enhanced services. This view was reflected in the qualitative research, where a number of participants who worked in optical education said that the current system of education and training was not necessarily preparing newly qualified practitioners adequately for practice, thereby posing a risk to patients and the public.

Undergraduate education and training

10.3.2 One of the primary concerns expressed by participants was that the current education courses are not tailored to meet the current roles and responsibilities of optical practitioners, particularly for optometrists. A number of participants said that current education and training of optometrists did not sufficiently cover the detection and management of ocular disease, something which was becoming increasingly important in current practice. It was also suggested that current undergraduate education and training did not adequately address the identification, management and mitigation of risk in practice.

I think that we need to look at the developing role of optometry. It's becoming more and more diagnostic. I believe the medics want more diagnostic abilities from the optometrists. They want better quality. And I think the universities must supply that quality to them. We need to give them better diagnostic abilities.

University of Hertfordshire

I honestly don't know if the management of risk is covered at undergraduate. I don't think necessarily it is. Things like quality improvement and serious incident reporting, those elements are not prevalent in optometry.

WOPEC

10.3.3 It was also suggested that the current education provided for optometry students was not sufficiently practical, with too much emphasis on theory and the science of optometry. Participants explained that it was the vocational and practical learning which students found most valuable and which most helped prepare them for real-life practice, and that therefore more of this should be included within education, alongside increased patient contact time and wider interaction with other professionals and multidisciplinary team learning.[65] This type of feedback was also found in the GOC's research into perceptions of UK optical education, where a survey of newly qualified optical practitioners found that a large proportion felt the amount of clinical experience they received during their academic study was too little.[66] Participants also suggested that students benefitted from being taught by lecturers with up to date experience of working in optical practice, as they were able to provide students with the accurate knowledge and understanding required for real-life practice.

[65] Optical Confederation & College of Optometrists. (2016). *Foresight Project Report: A Discussion of the Potential Impact of Technology on the UK Optical Sector to 2030 - Full Report*, p.165
[66] Enventure Research. (2018). *Perceptions of UK Optical Education*, p.27

My view is that the model should be that you receive theory and training to a particular standard at university, but the honing of those skills then happens within practice. I would be surprised if a pre-registration student on day one wasn't nervous about the range of patients that they were going to have to communicate with, because a lot of what they will have done at university will have been classroom and theory and simulation based. It's only in the pre-registration year that they're going to come into contact with enough patients to be able to start to develop those skills to communicate with every possible patient.

Education institution stakeholder

Lectures and practicals have changed, but not in keeping with the pace of change out there in community eyecare. Syllabuses have remained relatively static over the last 25 years. It's a vocational degree that also gives a lot of background science that isn't necessarily needed in practice.

WOPEC

10.3.4 It was therefore often suggested that undergraduate education needed to change to adapt to the changes in the optical sector, including the realities of current practice, thereby reducing any potential risk caused by not adequately preparing newly qualified practitioners. Participants explained that the content of education syllabuses needed to be updated to include the wider range of extended roles and skills required from optometrists, focusing on the ability to diagnose and manage ocular conditions and communicate with patients about these conditions. This view is echoed in other publications, which identified that training needs to change with an emphasis on interpreting results and making clinical decisions to prepare professionals for new roles and areas of work.[67] Most participants referenced the GOC's Education Strategic Review and stated that they hoped it would bring about the required changes to the current system of education and training.

We've got to get the skillset right for the future to build the resilience of the new generation of practitioners to be able to deal with optical conditions and whether to make referrals. They need the clinical skills to manage those conditions and the softer skills to manage clinical and emotional needs of patients, making sure they understand.

Optical Consumer Complaints Service

To ensure that the workforce is fit for the 21st century…Reform and modernisation of the undergraduate course through the education and strategic review, a fresh look at the scheme for registration.

Health and Social Care Board

10.3.5 More specific suggestions for improvements to the education of optometrists tended to focus on the increase of practical training included within undergraduate degrees, which was perceived as very beneficial when preparing students for practice, particularly in the detection and management of ocular disease. A number of participants also suggested that education and training should include additional focus on patients with more complex needs, including those with disabilities and those working in domiciliary care. In previous research conducted by the GOC into risk, the need for improved training in the area of domiciliary care was also highlighted, as typically it is only provided on the job, with no external accreditation scheme.[68] This is reflective of a key finding from the GOC's research into perceptions of UK optical education, where one of the most common suggestions for areas of skill or knowledge missing from undergraduate education and training was experience of patients with ocular health conditions.[69]

If people want optometrists to take on an extended role in the community to deliver ophthalmology disease management, that training has got to be more vocationally based, right from the undergraduate level.

Royal College of Ophthalmology

[67] College of Optometrists. (2016). *The Optical Professions: What Does the Future Hold?*, p.6
[68] Europe Economics. (2010). *Risks in the Optical Profession: Final Report*, p.vii
[69] Enventure Research. (2018). *Perceptions of UK Optical Education*, pp.39-40

When people go into domiciliary their undergraduate training hasn't necessarily prepared them at all, and a lot of people don't last long. So I think something different around the standard of training for domiciliary providers would be good. That would also cover seeing people with learning disabilities in the community and schools as well. Essentially embedding a little bit more about communication – and specifically communicating with patients with complex needs – in undergraduate training. And alongside that, something about the increased risks for this population getting a bit more into the undergraduate training.

SeeAbility

10.3.6 It was also suggested that a greater breadth of experience could be provided during pre-registration training for optometrists by ensuring a wider range of practice settings are included. Some participants felt this could significantly improve optometrists' preparedness to practise, especially in terms of increasing their confidence and ability to manage risk.

[Pre-registration students] don't rotate enough through a range of clinical settings…If they're not exposed to things and they don't have the skillset which enables them to competently manage that risk then they will over-refer or, less likely but more catastrophically, under-refer. They may have a misplaced belief in their own competencies. The only way to avoid that is to ensure that there are adequate clinical placements throughout the undergraduate and the scheme for registration year.

Health and Social Care Board

10.3.7 Despite many participants focusing on improvements to education by increasing the amount of practical-based learning, some highlighted the importance of the academic learning provided by the current education of optometrists. They explained that moves towards increased practical learning would be beneficial, but that it should not come at the expense of rigorous university education.

Future risks hinge on the outcome of the education review, and proper enforcement of the business standards. A lot of our members were quite troubled by a few points that were raised that suggested the door was being opened to an apprenticeship style qualification in optometry. We don't feel that would be a suitable way forward for the profession, particularly if more things are coming out of the hospital and moving into primary care. There needs to be that rigorous university education. The current education system needs to be tweaked and reformed before we start exploring other routes to qualification.

Association of Independent Optometrists

10.3.8 It appears that concern about education is more directed towards optometrists rather than dispensing opticians. Stakeholders representing the education of dispensing opticians felt that their current system of education was more in touch with current practice and did help to address the mitigation and management of risk. ABDO Awarding Body explained that they regularly updated their syllabus for dispensing opticians to reflect the changes in the sector, and other organisations indicated that they make their students aware of how to assess and mitigate risk, with support from the GOC who visit and talk to students about Fitness to Practise.

ABDO change the syllabus to reflect activity and patient need in the sector. We consult every five years, to keep on the front foot of what care is required for the population we serve and in turn this minimises risk.

ABDO Exams (awarding body)

Continuing Education and Training and additional qualifications

10.3.9 A large proportion of participants suggested that the current system of Continuing Education and Training (CET) was in need of change to avoid registrants posing an increased risk in the future. Whilst a number of participants indicated that CET had improved in recent years, with a wider variety of courses available and the inclusion of interactive CET, it was still felt that further

development was required in order to meet the changing nature of the sector and evolving professional roles and mitigate the associated risks.

I think it is good that they have brought in the interactive CET…When I go it's really interesting hearing what people have to say and how other people do things.

Optometrist, Birmingham

Are the current CET requirements equipping practitioners for the changing face of the profession? We are certainly hoping that the upcoming review will address this.

British Contact Lens Association (BCLA)

10.3.10 It was often suggested that the current system of CET had become a 'box ticking exercise' where practitioners carried out the bare minimum education and training required to maintain their registration, a finding that was reflected in the GOC's recent CET consultation.[70] Some participants also felt that CET could be low quality or insufficiently challenging, a finding highlighted in the 2016 GOC registrant survey, where almost half of survey respondents indicated that they thought it was not challenging to meet the GOC's requirements during the 2013-15 CET cycle.[71] This goes against what has been identified as best practice for an effective continuing professional development scheme, which should include professional improvement, effective learning interventions and accountable, transparent, amenable to regulation.[72] This was seen as posing a risk to patients, as it allowed the potential for practitioners to get by with basic CET and not develop professionally. These participants suggested that CET should be made more difficult for practitioners to complete each cycle, requiring a wider range of points from different areas of practice, increasing the difficulty of courses, and encouraging practitioners to push themselves beyond the core competencies.

With the current CET scheme, some practitioners do see it as 'I have to get my six points for the year', 'I have to go to one peer review'…But there's not that professional development, and I think that's probably one thing that's lacking.

NHS England (London region)

The continuing education system is one of box ticking to some extent. There are certain competencies and you've got to tick them off, which I'm not sure is particularly good as a professional development tool.

Education institution stakeholder

10.3.11 Some participants suggested that to make CET more effective at mitigating risks posed to patients and the public by the optical professions, it should include courses and content specifically related to the assessment, management and mitigation of risk as compulsory for all registrants. In support of this view, the GOC's recent consultation into CET found that a large proportion of stakeholders felt that the current CET scheme does not adequately address risks in the profession or do enough to support registrants.[73]

A review of the CET. Make it compulsory that risk assessment is part of the current programme.

Educational institution stakeholder

Perhaps they could start having more engaging conversations with the profession about risk – what the risks are and how to mitigate those risks.

Boots Opticians

[70] Enventure Research. (2018). *Fit for the Future: Lifelong Learning Review - Continuing Education and Training Consultation*, p.29
[71] Enventure Research. (2016). *Registrant Survey 2016*, p.34
[72] Felipe, H. et al. (2014). Continuing Professional Development: Best Practices. *Middle East African Journal of Ophthalmology*, Vol.21(2), pp.134-141.
[73] Enventure Research. (2018). *Fit for the Future: Lifelong Learning Review - Continuing Education and Training Consultation*, pp.21-22

10.3.12 To combat the issue of CET allowing practitioners to maintain a basic baseline of skills and competencies and avoid real development, a common suggestion was to move towards a system of Continuing Professional Development (CPD) as a replacement for CET. As found in the GOC's recent Continuing Education and Training Consultation,[74] a number of participants explained that a system of CPD would be more appropriate and beneficial for the optical profession, as it would encourage registrants to improve and explore areas beyond their current abilities, something which it was felt was required due to the evolving role of optical practitioners and moves into more clinical areas. This perception is supported by relevant literature, which states that in comparison to CET, CPD shifts the emphasis to demonstrating change in behaviour in clinical practice.[75] It was felt that this would also bring optometry in line with other healthcare professions in terms of ongoing development, education and training, such as dentistry, where it is viewed as working effectively.[76] A recent study into CPD in dentistry found that CPD which uses a combination of methods, including outreach visits and reminders, and those aligned with learning needs of specific relevance to a professional's scope of practice, can benefit the impact of this learning.[77]

It keeps you at a base level, but you never ever improve with CET. You improve with CPD. And I think the GOC need to realise that…A shift from the culture of CET baseline to CPD improvement, where people not only reflect on their performance, but actually audit their performance and subject that to peer to peer, either anonymised or otherwise. It's the only way you can bring up standards.

Health and Social Care Board

[CET] *is all about maintaining the baseline, and it should not be that at all. The mindset should be Continuing Professional Development, like every other medical profession…If you improve the professional development of optometrists then they become more skilled and the risks reduce…Getting better, improving, being aware of yourself, where you're not so good, educating yourself to get better in those areas.*

Scottish Government

10.3.13 To further reinforce this finding, research conducted into whether current CET can help combat a high referral rate from primary care optometrists, contributing to capacity issues in the hospital eye services, found that CET alone is unlikely to be an adequate approach to improving decision-making, and that CPD with mentoring support and referral case-discussion for newly qualified optometrists has the potential to reduce the number of false-positive referrals.[78]

10.3.14 Some stakeholder participants also suggested that more could be done to encourage optical practitioners to undertake additional qualifications and higher level education. Again, in order to meet the demands of the changing optical sector, some participants said that the GOC should do more to recognise the need for increased specialisation to allow the profession to undertake extended roles, thereby meeting the demands being placed upon community optical practice.

We're now seeing genuine working beyond the core competencies and thus the need for higher qualifications or additional training.

Primary Eyecare Services

[74] Enventure Research. (2018). *Fit for the Future: Lifelong Learning Review - Continuing Education and Training Consultation*, p.30
[75] Felipe, H. et al. (2014). Continuing Professional Development: Best Practices. *Middle East African Journal of Ophthalmology*, Vol.21(2),pp.134-141.
[76] Picker Institute Europe. (2012). *Evaluation of Supporting Evidence Types of Revalidation Stage 1*, p.23
[77] Association for Dental Education in Europe. (2019). *A Review of the Literature on Continuing Professional Development*, p.36
[78] Parkins, D. (2018). *An Investigation into the Decision-Making of Primary Care Optometrists and Whether Contemporary Continuing Education and Training (CET) Improves Referral Practice*, p.149

I think the GOC needs to recognise the need for specialist optometrists who have much higher levels of training, skills, qualifications and experience to safely undertake extended roles. Emphasise the importance of training and recognise higher qualifications, such as the College of Optometrists qualifications.

Secondary care stakeholder

10.4 Future risks posed by technology and artificial intelligence

10.4.1 Just 8% of survey respondents suggested that technological advances may pose a risk to patients in the next five years. However, the continued development of technology was widely discussed by qualitative research participants when discussing risks in the near future. Some participants again highlighted the potential risks posed by increased automation of refraction, allowing people to test their own eyesight using their smartphone or in other locations outside an optical practice. They explained that whilst some technology may be able to produce an accurate prescription, removing an optical practitioner from the process placed patients at increased risk as this would remove the ability to conduct a thorough eye health check, meaning that issues could go undetected and important advice could not be provided.

I think looking to the future there will be more areas of risk – especially around people undertaking their own eyes tests online and on their smartphone.

Optometrist, Edinburgh

If technology enables that people can have a refraction from their homes, I can almost see that the health check part of the eye test will go out of the window…If you have an eye test from your desk then you're bypassing that health check, which means that something could go undiagnosed.

Boots Opticians

10.4.2 Discussions about the future risk posed by technology often focused on artificial intelligence, something which many participants indicated was still in its early stages of being utilised in the profession. Some participants were very positive about the future use of AI in optometry, allowing for more accurate and faster diagnosis of disease than optometrists alone were capable of.

AI is better at reading OCT screens already than an ophthalmologist. So if you are doing a scan for macular degeneration assessment, AI is better. It's already well documented. Our role in the future, we will have an OCT, send off the results to AI, AI will bounce back and say treat or don't treat and our role will be to talk to the patient and advise the patient of the risk and the treatments. Our role in actually detecting will be less and we will be much more of a nursing role.

Optometrist, London

10.4.3 However, a concern held by a number of participants was that if the use of AI was to increase in the future, even though it may be increasingly sophisticated, it may still miss something when analysing the results of tests, and therefore place a patient at risk. Some participants explained that they were concerned that AI would not be able to pick up conditions which were more difficult to spot if they were outside the ordinary, and that therefore the interpretation of results by a qualified optometrist would still be vital.

If the public use online retinal scanning or diagnostics, then there is a big risk of missing something else, and optometrists can pick up any other issues whereas a computer programme might not. You might have software looking at the optic disc but might miss something else.

Optometrist, Cardiff

10.4.4 Some participants highlighted a potential risk of lack of responsibility that could be caused by increasing use of technology and artificial intelligence. An example was provided where it may

become difficult to assign responsibility if AI missed a diagnosis or incorrectly diagnosed a condition, as this may not necessarily be the fault of an optical practitioner.

The risk to the patient is, the more removed you are from that consultation face-to-face – the more risk there is as any issues are not attributable to a person. If someone comes in to see me and I fail to detect their glaucoma, then I am rightly liable for that – if some AI is doing it where is the responsibility?

Optometrist, Edinburgh

10.4.5 Another concern about increased use of technology and AI was that the level of interaction between practitioners and patients may be significantly reduced, if not completely removed, as a result. It was suggested that patients still appreciated human interaction, which was at risk of being lost through increased automation. As a result, this may lead to a reduction in the number of optical practitioners, potentially making them more difficult to access in the future.

Everyone's buzz word at the moment is artificial intelligence, but it really depends on how it's used. We've been doing some work on this, and it's got huge potential as it can sit there as a diagnostic support for patients, like having an expert in the corner who can help with your decision making. That could massively reduce risk. The danger is if it's not used in a supportive way and replaces what optometrists do. The danger to patients is that they could lose a lot of that contact and it could become depersonalised…The risk to patient is that it could remove the need for optometrists, meaning that they're only available in sparse locations where there's the ability to still make a retail model work.

Association of Optometrists

10.4.6 As previously highlighted, one of the main concerns in relation to technology was the risk it posed to current optical professional roles. Some participants felt that, as technology and AI continue to develop, the risk to their roles becomes greater. It was suggested that there may be increased use of non-registered, potentially less qualified technical roles if optometrists and dispensing opticians are no longer required, potentially leading to deregulation of some aspects of optometry. It was also stated that, in order to stay relevant in their role, optometrists may push themselves into areas that they are not adequately trained to deliver. To mitigate this risk, some participants said that the profession needed to continue to develop into more clinical roles, supported with sufficient levels of education and training, thereby allowing technology to take on the more technical aspects of the profession.

I think it's a risk to the profession, if they don't develop the professionalism that they need. So they are primarily a clinician and yet actually what they are becoming is a technician. They need to continue to develop the clinical skills side, because actually the technical skills side, the technician side, can be done by anybody.

Rachel Pilling, Consultant Ophthalmologist, secondary care stakeholder

The risk for optometry is that machines will start to replace what their core business was. There is a need for them to redefine their role and place in the health provision sector. Done well, I think it's not a risk, but will provide people with opportunity and a sustainable and interesting career. If it's done badly, and without proper training and communication, there is a risk that, in the search to find something else to do, optometrists will find themselves undertaking things that they're not really competent to do.

Royal College of Ophthalmology

10.5 Future risks posed by patient behaviour

10.5.1 Patient (or consumer) behaviour was discussed in the qualitative research as something to take into consideration when contemplating future risk. The primary focus of this was on online sales of spectacles and contact lenses, an area of the sector which many participants felt would continue to grow in the coming years. Previously expressed concerns about patient safety were raised when

optical products are purchased remotely, particularly in the absence of an optical professional to provide advice and support. In relation to future risk, participants concerns related to the perceived lack of regulation in this area which allowed online companies to expand their services in a way that potentially increased risk to patients and the public. Some participants recalled occasions where they had found an online retailer to be practising outside the current regulations, which caused them to be concerned.

I know there are companies online now that can accept NHS vouchers remotely. If the GOC are saying that you have to follow all the rules of a DO, that can't be happening, but they're still allowing it. That poses a risk to patients, because we have to do those things in practice, so how is it allowed online?

Dispensing optician, Leeds

The contact lens prescription needs to be supplied to patients upon completion of fitting and lens supply. This is not always happening, and those businesses supplying lenses via the internet channel are required to have the prescription checked and verified prior to supply, along with advice and guidance on aftercare. These procedures (or lack of) need to be monitored.

BCLA

10.5.2 It was therefore a common suggestion that the GOC should do more to regulate online sales of optical products and services, with emphasis on the online sale of contact lenses, which were often viewed as posing a greater risk to patients when compared with spectacles. In particular, it was often suggested that something should be done to regulate companies operating outside the UK but selling to people living in the UK, which are currently outside the remit of the GOC.

In terms of risks to the public, the GOC aren't clear in terms of what they do with unregulated contact lens sellers.

Optometrist, Leeds

The GOC needs to make sure that practitioners know they should be giving a valid contact lens prescription, as this does not always occur. We need to make sure that it is being policed properly, so if somebody is buying contact lenses on the internet, both the patient and supplier are following what the legislation requires. A key issue is the GOC only have UK jurisdiction. Many internet suppliers are outside of the UK, so that makes it very difficult for the GOC.

BCLA

10.5.3 It was accepted that this may be a difficult thing for the GOC to regulate, and some participants therefore suggested that instead the GOC could do more to communicate with the public about the risks involved with purchasing products online and the benefits of visiting an optical professional in person, especially the benefits of fitting contact lenses and ensuring high quality aftercare.

The contact lens issue is something we'd like to see more dialogue on. Illegal contact lens sales is quite a significant risk to patients.

Association of Independent Optometrists

11. Secondary data sources

11.1 Fitness to Practise data

Background to the analysis

11.1.1 Analysis of the GOC's Fitness to Practise (FTP) data was conducted to highlight any patterns or trends in the types of cases opened in relation to complaints received in recent years. Two years of FTP case data was analysed, including all closed cases raised in relation to complaints received between 1 April 2016 and 30 April 2018, following the introduction of the GOC's new Standards of Practice for optometrists and dispensing opticians.

11.1.2 It is important to note that this analysis is based on cases opened as a result of complaints received, and not on the outcomes of FTP proceedings, in order to highlight concerns raised by patients and the public and provide further insight into potential areas of risk. This included a total of 376 FTP cases.

11.1.3 To conduct insightful analysis, additional categorisation of the FTP data was carried out by Enventure Research by analysing the relevant redacted case examiner reports. Further details of this categorisation can be found in the methodology of this report in chapter 2.

11.1.4 This chapter of the report contains a summary of the analysis of these FTP cases opened in response to complaints, which has also been referenced where relevant throughout this report to support the research findings.

Volume of investigations

11.1.5 The GOC's Annual Report highlights that, in the year 2017/18, 262 FTP investigations were opened, representing a small decrease from the number opened in 2016/17. The number of investigations opened from the last three years are shown at ***Figure 25*** below, generally indicating consistency.

Figure 25 – Number of FTP investigations[79]

Year	Number
2017/18	262
2016/17	293
2015/16	223

[79] General Optical Council. (2018). Annual Report 2018. p.29

Allegations

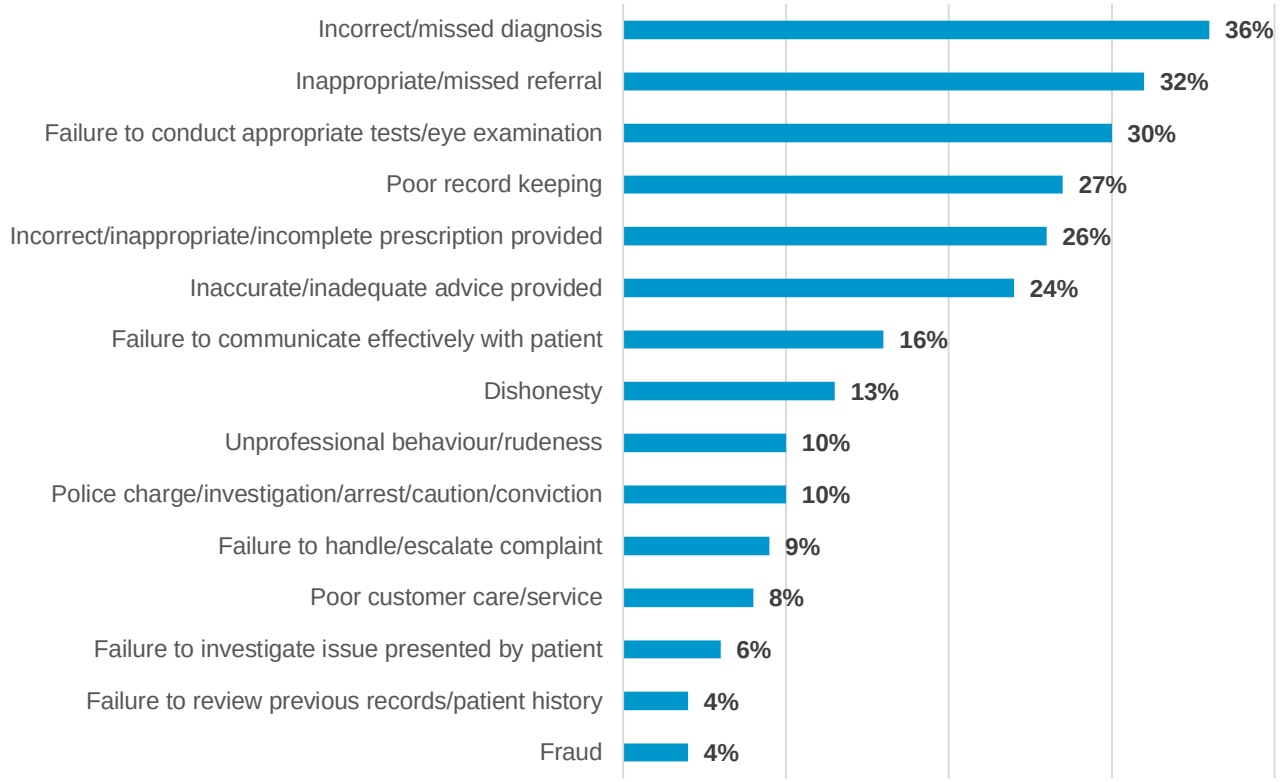
11.1.6 The most common allegations raised related to incorrect or missed diagnosis (27%), closely followed by inappropriate or missed referral (24%), two risk factors which were viewed as having high severity in the online survey. Other common allegations raised included failure to conduct appropriate tests or examinations (23%), the provision of incorrect, inappropriate or incomplete prescriptions (21%), the provision of inaccurate or inadequate advice (20%) and poor record keeping (20%). The table in ***Figure 26*** below presents the complete categorisation of allegations.

Figure 26 – Categorised allegations
Base: 369 cases

Allegation category	Number	%
Incorrect/missed diagnosis	98	27%
Inappropriate/missed referral	87	24%
Failure to conduct appropriate tests/eye examination	84	23%
Incorrect/inappropriate/incomplete prescription provided	79	21%
Inaccurate/inadequate advice provided	74	20%
Poor record keeping	74	20%
Dishonesty	54	15%
Police charge/investigation/arrest/caution/conviction	52	14%
Failed to communicate effectively with patient	50	14%
Failure to handle/escalate complaint	44	12%
Unprofessional behaviour/rudeness	41	11%
Poor customer care/service	33	9%
Failure to investigate issue presented by patient	21	6%
Failure to declare relevant information to GOC	14	4%
Practising whilst not registered or without appropriate qualification	14	4%
Data breach/failure to protect data/confidentiality	13	4%
Failure to provide prescription	13	4%
Fraud	13	4%
Failure to review previous records/patient history	11	3%
Adverse physical/mental health	9	2%
Failure to communicate risks to patient	8	2%
Failure to ensure procedures in place/staff compliance	8	2%
Failure to obtain consent from patient	7	2%
Practising without a supervisor/failure to supervise appropriately	7	2%
Failure to fit/check contact lenses	5	1%
Discrimination	4	1%
Failure to maintain equipment/provide appropriate testing facilities	4	1%
Inappropriate touching of patient	4	1%
Failure to investigate/act on employee concerns	3	1%
Inappropriate/sexual comments to patient	3	1%
Plagiarism	3	1%
Assault of colleague	1	0%
Inappropriate behaviour towards/sexual harassment of colleague	1	0%
Suspension of director	1	0%
Theft from employer	1	0%

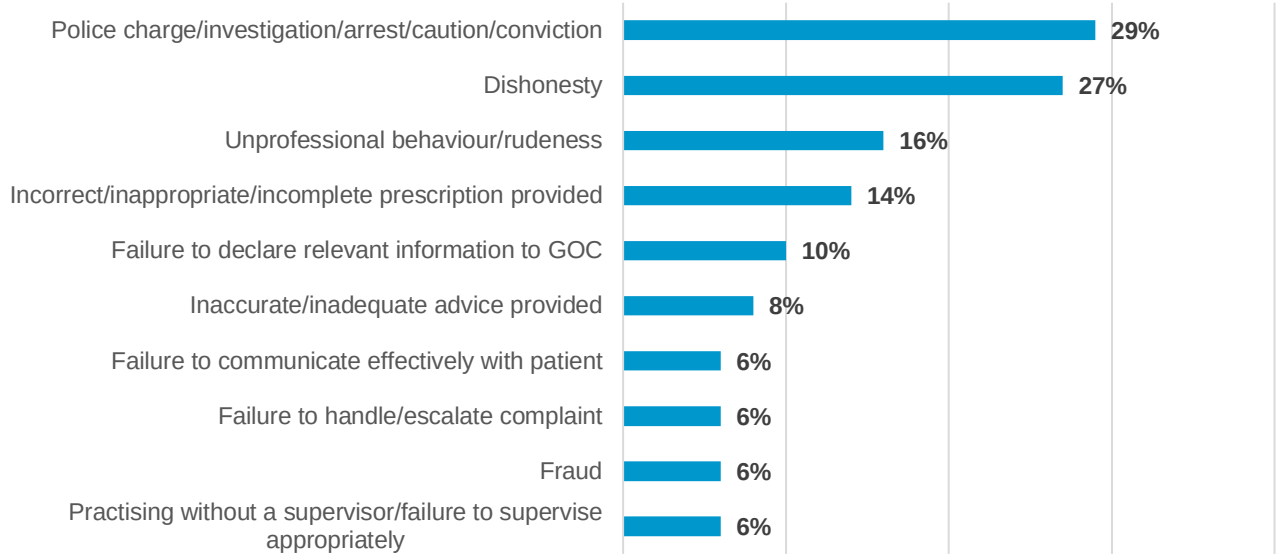
11.1.7 The most common allegations opened against optometrists are displayed in the chart at ***Figure 27*** below, closely matching the overall data due to the large number of optometrists in the data sample.

Figure 27 – Most common allegations opened against optometrists
Base: Optometrists (259)



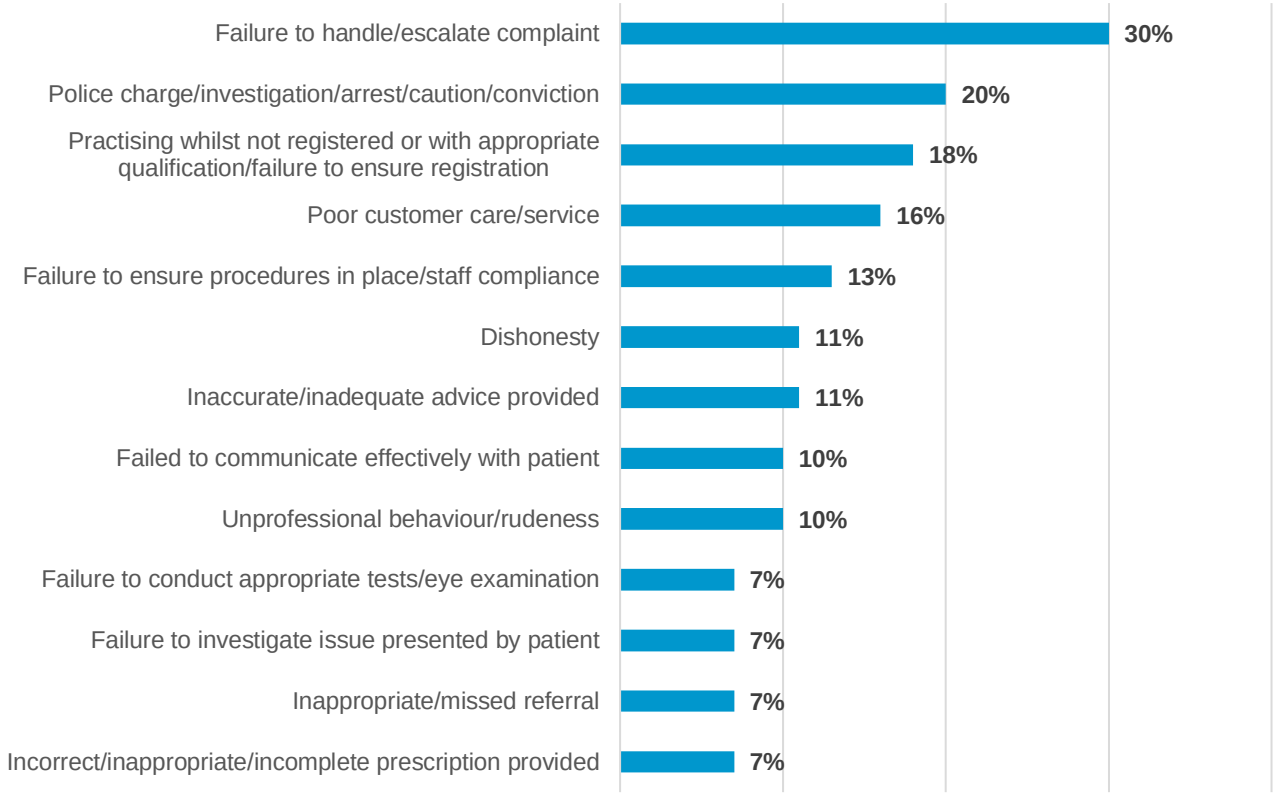
11.1.8 The most common allegations opened against dispensing opticians, displayed in the chart at ***Figure 28*** below, were related to police charge/ investigation/caution/conviction (29%) and dishonesty (27%).

Figure 28 – Most common allegations made opened dispensing opticians
Base: Dispensing opticians (49)



11.1.9 The most common allegations opened against business registrants displayed in the chart in ***Figure 29*** below, were failure to handle/escalate complaints (30%), police charge/investigation/arrest/caution/conviction (20%) and practising whilst not registered or with appropriate qualification/failure to ensure registration (18%).

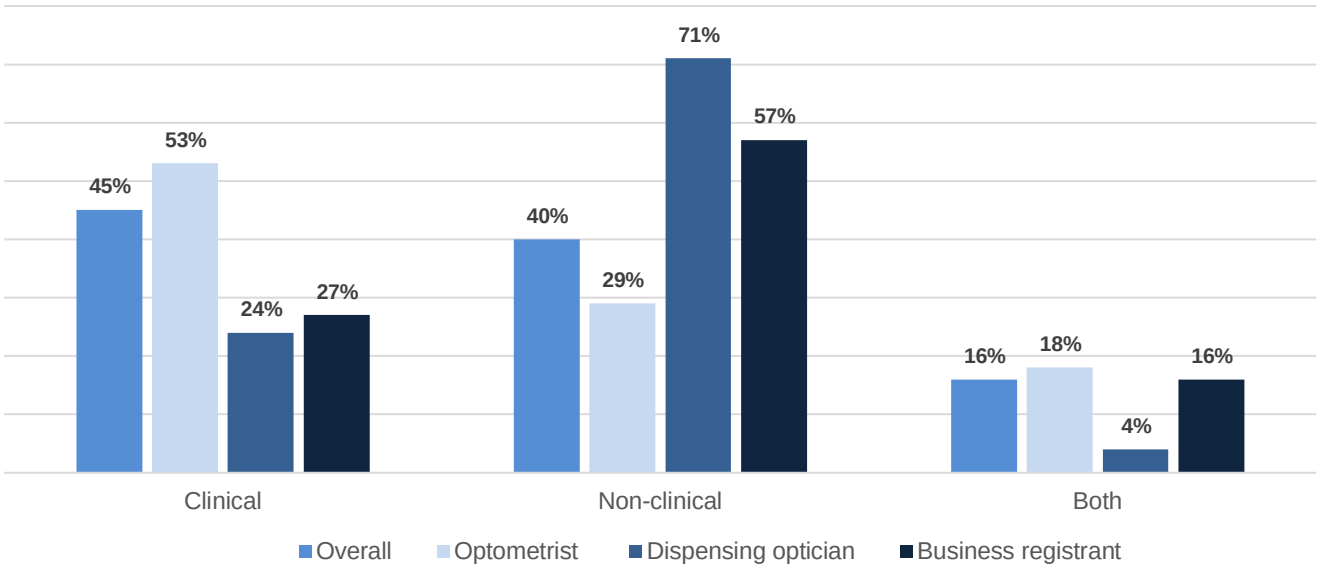
Figure 29 – Most common allegations opened against business registrants
Base: Business registrants (61)



11.1.10 It is interesting to note that a larger proportion of clinical allegations were related to optometrists (53%) when compared with dispensing opticians (24%) and business registrants (27%). In contrast, dispensing opticians (71%) and business registrants (57%) were more likely to be involved in non-clinical allegations when compared with optometrists (29%).

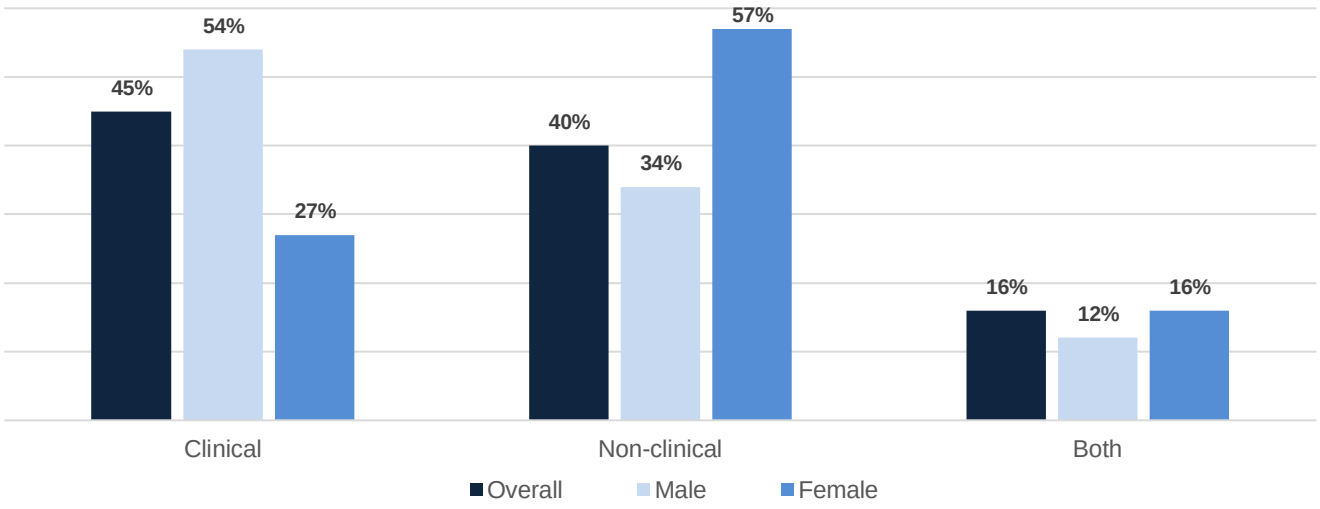
11.1.11 ***Figure 30*** overleaf shows the split of cases between clinical and non-clinical for optometrists, dispensing opticians and business registrants. Of all the allegations, 45% have been categorised as clinical, 40% as non-clinical, and 16% as including both clinical and non-clinical allegations. It is interesting to note that a larger proportion of clinical allegations were related to optometrists (53%) when compared with dispensing opticians (24%) and business registrants (27%). In contrast, dispensing opticians (71%) and business registrants (57%) were more likely to be involved in non-clinical allegations when compared with optometrists (29%).

Figure 30 – Categorisation of allegations as clinical, non-clinical or both by registration type
Base: All cases (372), Optometrists (260), Dispensing Opticians (49), Business registrants (63)



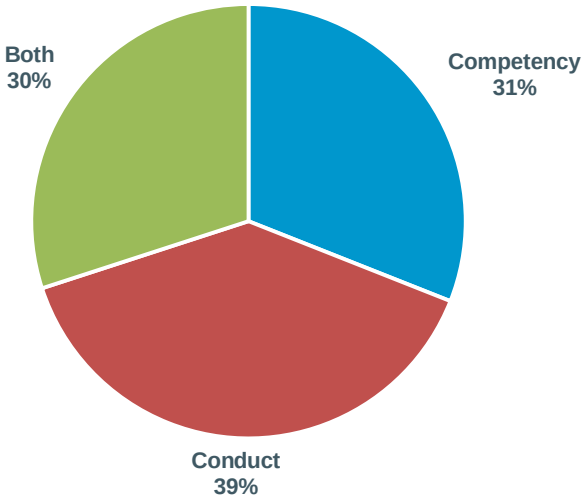
11.1.12 As shown below in ***Figure 31***, the data also highlights that that male registrants are more likely to have clinical allegations opened against them (54%) when compared with female registrants (27%), whereas female respondents are more likely to have non-clinical allegations opened against them (57%) when compared with male registrants (34%).

Figure 31 – Categorisation of allegations as clinical, non-clinical or both by gender
Base: All cases (372), male registrants (125), female registrants (63)



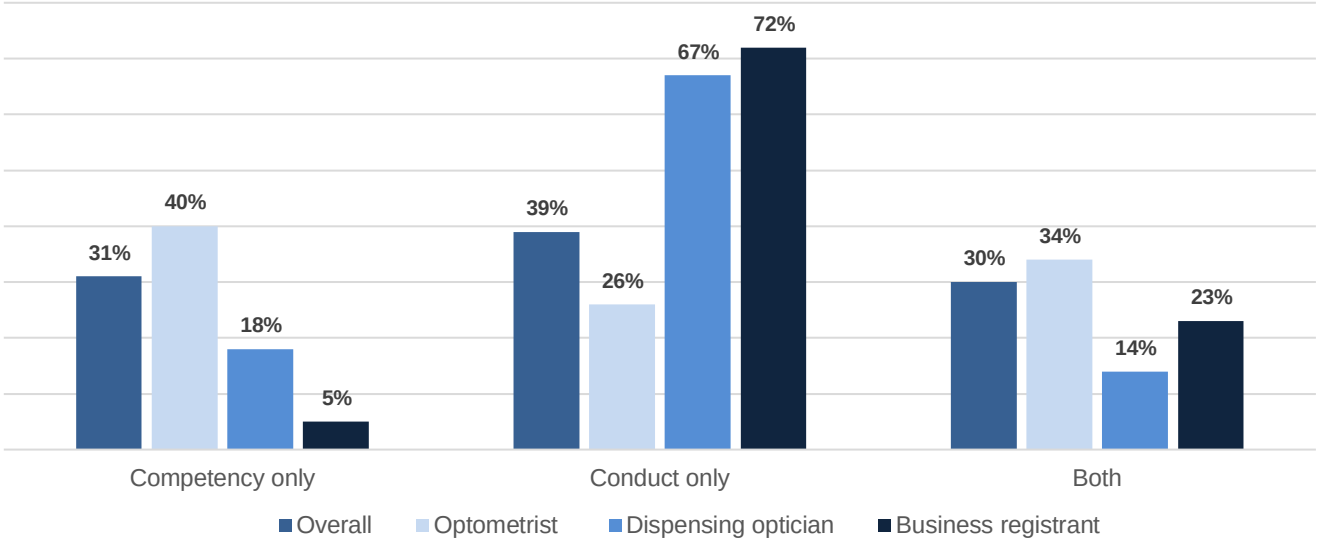
11.1.13 Each allegation has been categorised as either a competency or a conduct risk, in line with those presented to respondents in the online survey. As shown in the chart at ***Figure 32*** overleaf, a larger proportion of allegations (39%) were categorised as conduct risks only, with a further 31% categorised as competency risks only. However, 31% of cases included both competency and conduct risks, highlighting a significant level of overlap.

Figure 32 – Risk associated with allegation
Base: 369



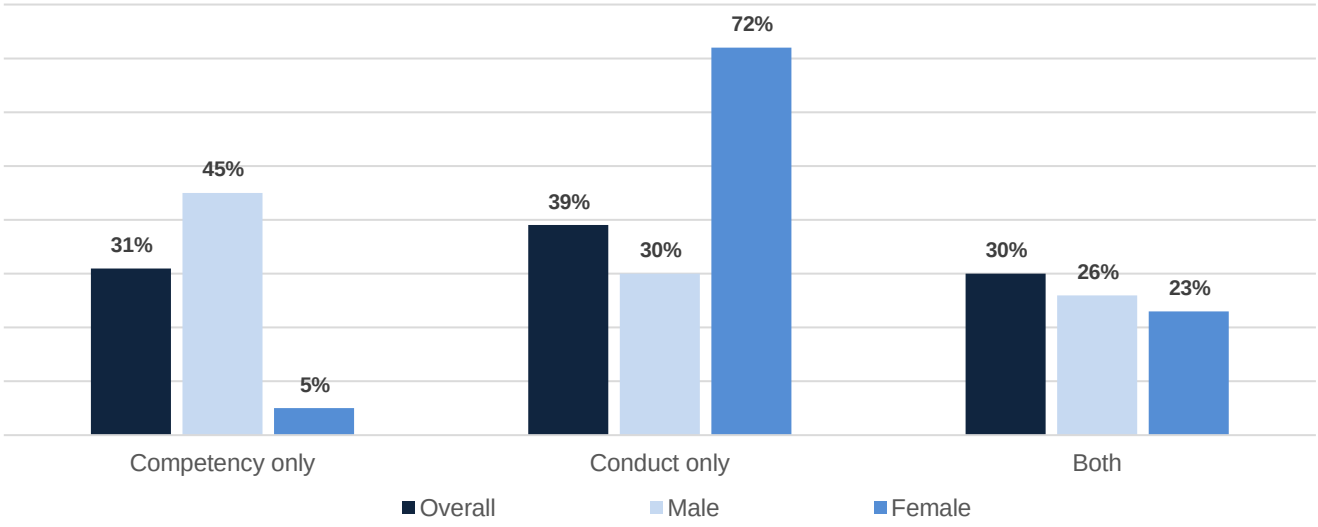
11.1.14 The chart at ***Figure 33*** below shows the split between competency and conduct cases for optometrists, dispensing opticians and business registrants. Analysis of this result shows that optometrists were more likely to have allegations opened against them related to competency risks only (40%) and to both competency and conduct risks (34%) when compared with dispensing opticians (18% and 14% respectively) and business registrants (5% and 23% respectively). In contrast, allegations related to conduct risks only were more likely amongst dispensing opticians (67%) and business registrants (72%) when compared with optometrists (39%).

Figure 33 – Categorisation of allegations by risk type by registration type
Base: All cases (369), Optometrists (259), Dispensing Opticians (49), Business registrants (61)



11.1.15 Additionally, the data shows that male registrants are more likely to have competency related allegations opened against them (45%) when compared with female registrants (5%), whereas female respondents are more likely to have conduct related allegations opened against them (72%) when compared with male registrants (30%).This finding is presented in ***Figure 34*** below.

Figure 34 – Categorisation of allegations by risk type by gender
Base: All cases (369), male registrants (125), female registrants (61)



Standards or Codes breached

11.1.16 The FTP database includes details of which of the GOC's Standards of Practice for optometrists and dispensing opticians, April 2016 the allegations would imply have been breached for each case. Although the database extends back to April 2016 when the new Standards were introduced, some cases in the database refer to the previous Code of Conduct for individual registrants (2010 to 2016), as this was based on the time of the incident the allegation referred to. Additionally, some allegations referred to the GOC's Code of Conduct for optical businesses (2010 onwards). FTP could be associated with multiple standards or codes depending on the number and nature of the allegations.

11.1.17 The table at ***Figure 35*** below and overleaf presents breached Standards of Practice for the two years of FTP data. The most commonly breached standard was Standard 5 (Keep your knowledge and skills up to date) which occurred in 43% of cases (82 cases), closely followed by Standard 7 (Conduct appropriate assessments, examinations, treatments and referrals) occurring in 40% of cases (75 cases) and Standard 17 (Do not damage the reputation of your profession through your conduct) occurring in 39% of cases (73 cases).

Figure 35 – Breached Standards of Practice
Base: 189 cases

Standard	Number	%
1. Listen to patients and ensure that they are at the heart of the decisions made about their care	68	36%
2. Communicate effectively with your patients	61	32%
3. Obtain valid consent	5	3%
4. Show care and compassion for your patients	20	11%
5. Keep your knowledge and skills up to date	82	43%

Standard	Number	%
6. Recognise, and work within, your limits of competence	52	28%
7. Conduct appropriate assessments, examinations, treatments and referrals	75	40%
8. Maintain adequate patient records	44	23%
9. Ensure that supervision is undertaken appropriately and complies with the law	6	3%
10. Work collaboratively with colleagues in the interests of patients	10	5%
11. Protect and safeguard patients, colleagues and others from harm	15	8%
12. Ensure a safe environment for your patients	5	3%
13. Show respect and fairness to others and do not discriminate	12	6%
14. Maintain confidentiality and respect your patients' privacy	8	4%
15. Maintain appropriate boundaries with others	15	8%
16. Be honest and trustworthy	45	24%
17. Do not damage the reputation of your profession through your conduct	73	39%
18. Respond to complaints effectively	16	8%
19. Be candid when things have gone wrong	20	11%

11.1.18 The table below at ***Figure 36*** shows that, in terms of allegations which related to the previous Code of Conduct for individual registrants, over half (53%) related to Code 1 (Make the care of the patient your first and continuing concern). A further 46% related to Code 8 (Keep professional knowledge and skills up to date).

Figure 36 – Breached Code of Conduct
Base: 116 cases

Code	Number	%
1. Make the care of the patient your first and continuing concern	62	53%
2. Treat every patient politely and considerately	18	16%
3. Respect patients' dignity and privacy	9	8%
4. Listen to patients and respect their views	30	26%
5. Give patients information in a way they can understand and make them aware of the options available; on the issue of patient consent, be aware of and comply with the guidance published by the professional bodies	30	26%
6. Maintain adequate patients' records	39	34%
7. Respect the rights of patients to be fully involved in decisions about their care	22	19%
8. Keep professional knowledge and skills up to date	53	46%
9. Recognise, and act within, the limits of your professional competence	47	41%
10. Be honest and trustworthy	19	16%
11. Ensure that financial and commercial practices do not compromise patient safety	11	9%
12. Respect and protect confidential information	2	2%
13. Make sure that personal beliefs do not prejudice patient care	-	-
14. Act quickly to protect patients from risk where there is good reason to believe that you, or a colleague, may not be fit to practise, fit to undertake training, or in the case of a business registrant fit to carry on business as an optometrist, dispensing optician or both	15	13%
15. Never abuse your professional position	15	13%
16. Work with colleagues in the ways that best serve patients' interests	12	10%
17. Register with and maintain registration with the GOC	5	4%
18. Be covered by adequate and appropriate insurance for practice in the United Kingdom throughout the period of your registration	2	2%

Code	Number	%
19. Ensure your conduct, whether or not connected to your professional practice, does not damage public confidence in you or your profession	43	37%

11.1.19 Allegations opened against business registrants referenced the GOC's Code of Conduct for business registrants (which is in place until 1 October 2019 when they will be replaced by the new Standards for Optical Businesses). The most common Code breached (74%) was Code 1 (Ensure that each person who undertakes activities regulated by the Opticians Act does so in accordance with the Act). This is shown in the table at ***Figure 37*** below.

Figure 37 – Breached Business Code of Conduct
Base: 39 cases

Business Code	Number	%
1. Ensure that each person who undertakes activities regulated by the Opticians Act does so in accordance with the Act	29	74%
2. Require as a condition of employment or engagement that those individual registrants currently employed or otherwise engaged to provide optical services comply with the GOC's Standards of Practice for Optometrists and Dispensing Opticians or the Standards for Optical Students	15	38%
3. Not knowingly act in a way which might contribute to or cause a breach of the Standards of Practice for Optometrists and Dispensing Opticians or the Standards for Optical Students by any individual registrant employed or otherwise engaged by it to provide optical services	21	54%
4. Ensure that individual registrants are always able freely to exercise their professional judgement in the best interests of patients	9	23%
5. Provide a system for the proper maintenance of patient records	2	5%
6. Respect and protect confidential information for both patients and employees in accordance with current legislation	1	3%
7. Ensure that advertising or publicity complies with appropriate advertising codes of practice	-	-
8. Provide mechanisms to enable those that work for or are otherwise engaged by the business registrant to raise concerns about risks to patients	6	15%
9. Protect patients if it has reason to believe that an individual registrant or other health professional, may not be fit to practise, fit to undertake training, or if a business registrant, may not be fit to carry on business as an optometrist, dispensing optician or both	11	28%
10. Ensure that the criteria enshrined in this code are applied as may be appropriate to registered medical practitioners in relation to the GMC and any other relevant codes and guidance	1	3%
11. Ensure that financial and commercial practices do not compromise patient safety	12	31%

Outcome of case examiner decisions

11.1.20 When considering whether an allegation ought to be referred to the Fitness to Practise Committee (FTPC), case examiners first establish whether there is a realistic prospect of establishing that the registrant's fitness to practise is impaired to a degree that justifies action being taken against their registration. This is known as 'the realistic prospect test'. It is not the role of the case examiners to decide whether or not a registrant's fitness to practise is impaired – that is a decision for the FTPC to make (if the case is referred onto that stage).

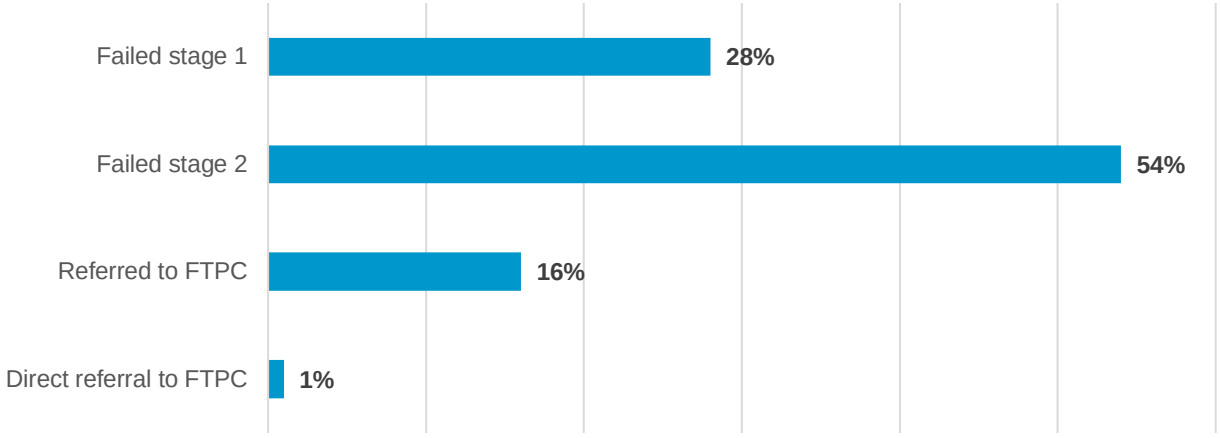
11.1.21 This is a two-stage process. Case Examiners first consider whether there is a realistic prospect of proving the facts of the allegation if it was referred to the FTPC (stage 1) and then consider whether,

if the alleged facts are proved, they are so significant as to indicate that the registrant's fitness to practise is or may be currently impaired to a degree that justifies action being taken against their registration (stage 2).

11.1.22 Almost three in ten (28%) cases failed the realistic prospect test at stage one. However, the majority of cases (54%) were categorised as failing stage two of the test, meaning that at least one allegation within the case had passed stage one.

11.1.23 As presented in the chart at ***Figure 38*** below, one in six cases (16%) passed both stage one and stage two, and were therefore referred to FTPC. A further 1% (4 cases) were directly referred to FTPC, as the case was so serious (conviction resulting in a custodial sentence) that the realistic prospect test was not required. This suggests a potential decrease when compared with previous years, where during the three years from 2010-2011 to 2012-2013, about one-fifth of all complaints resulted in an FTP hearing.[80]

Figure 38 – Realistic prospect test outcome
Base: 376 cases

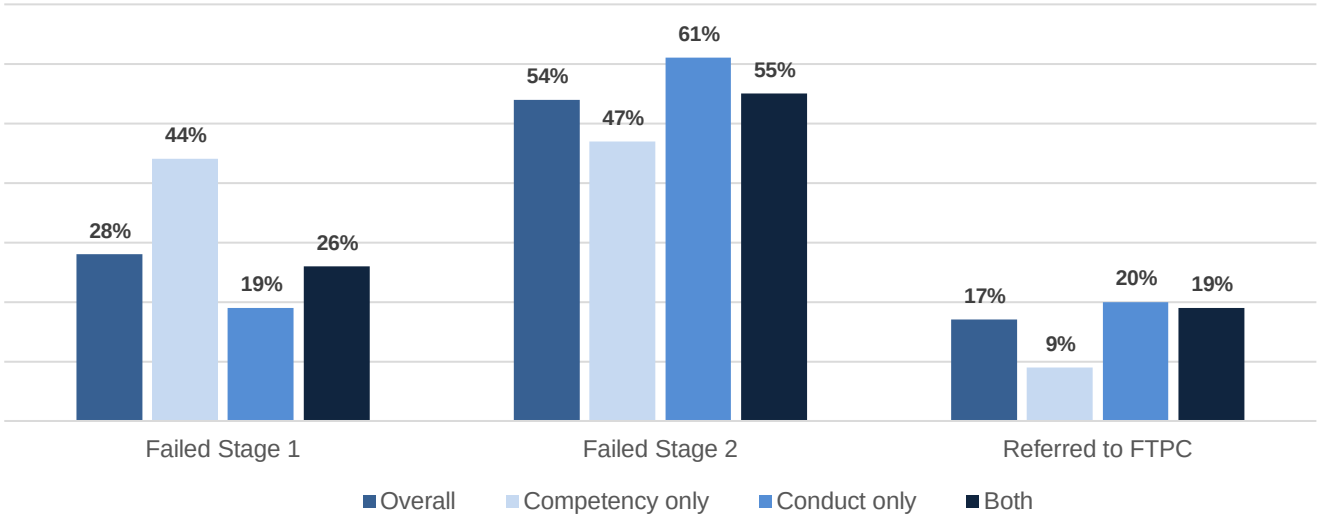


11.1.24 Analysis of the data highlights that clinical cases were more likely to fail the test at stage 1 (37%) when compared with non-clinical cases (20%). In contrast, non-clinical cases were more likely to pass both stages of the test and be referred to FTPC (23%) when compared with clinical cases (8%).

11.1.25 ***Figure 39*** overleaf shows that cases which failed at stage one were more likely to be allegations related to competency risks only (44%). Those that failed at stage two were more likely to be related to conduct risks only (61%). Those which were referred to FTPC were more likely to be related to conduct risks only (20%) or included allegations related to both competency and conduct risks (19%).

[80] D'Ath, P. et al. (2015). Fitness to Practise Amongst UK Optometrists. *Optometry in Practice*, Vol.16(1), p.6

Figure 39 – Realistic prospect test outcome by risk type
Base: All cases (369), competency only (116), conduct only (114), both (109)



Warnings and remediation

11.1.26 In the majority of cases (82%) no warning was issued. The most common warning issued was to ensure compliance with the GOC's standards (11%). The full range of warnings issued is shown in the table at ***Figure 40*** below.

Figure 40 – Warning issued
Base: 376 cases

Warning	Number	%
Not issued	288	82%
Comply with GOC Standards	38	11%
Do not repeat behaviour	14	4%
Ensure behaviour does not damage public confidence in/reputation of profession	13	4%
Improve record keeping/maintain adequate records	9	3%
Conduct appropriate assessments, examinations and referrals	7	2%
Maintain GOC core competencies	7	2%
Manage patients in line with latest clinical guidelines	7	2%
Be honest and trustworthy	4	1%
Improve communication with patients	4	1%
Maintain appropriate boundaries with others	4	1%
Maintain confidentiality/respect patient privacy/protect patient data	4	1%
Work within limits of competence and training/refer to colleagues where necessary	4	1%
Be candid when things go wrong	3	1%
Accurately complete annual retention form and seek advice if necessary	2	1%
Complete prescriptions accurately	2	1%
Comply with CET requirements	1	0%
Put measures in place to improve speed of providing appointments/prescriptions	1	0%
Respond to complaints effectively	1	0%
Show respect and fairness to others and do not discriminate	1	0%
Use social media responsibly	1	0%

11.1.27 A warning was more likely to be issued when:

- Allegations were non-clinical in nature (23%) when compared with those that were clinical (14%)
- Allegations related to conduct risks only (23%) when compared with those that related to competency only (14%)
- A case failed stage 2 (29%) when compared with those that failed at stage 1 (3%)

11.1.28 In the majority of cases (82%) no remediation or learning was advised. Where remediation or learning was suggested by case advisers, the most common suggestion was reflection (12%). The full range of remediation advised is shown in the table at ***Figure 41*** below.

Figure 41 – Remediation/learning advised
Base: 343 cases

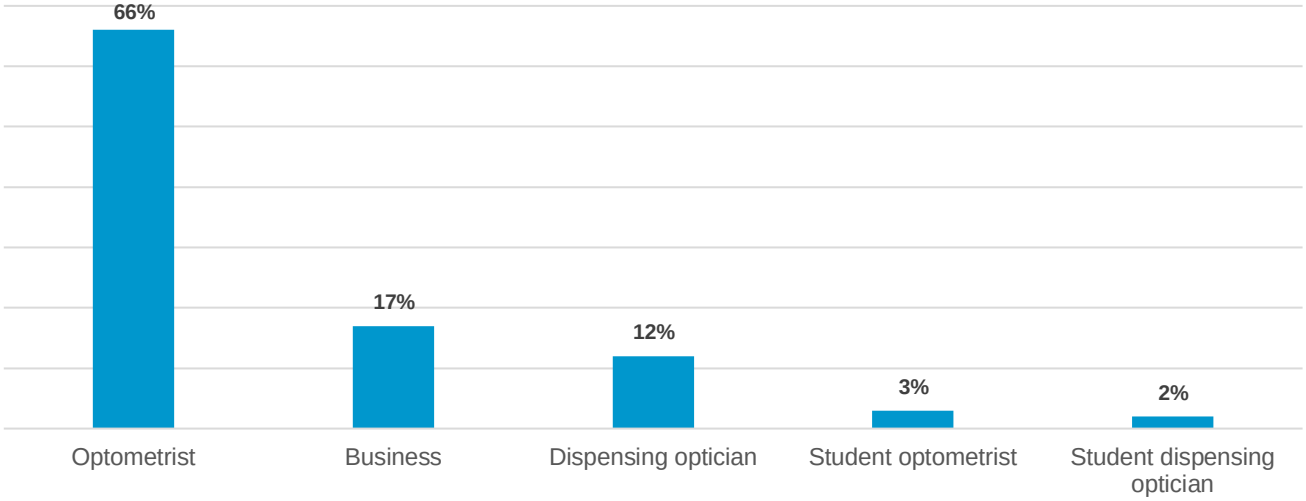
Remediation/learning	Number	%
Nothing advised	281	82%
Reflection	40	12%
Improve record keeping/maintain adequate records	18	5%
Improve communication/communicate effectively with patients	17	5%
Review Standards/Code of Conduct	12	3%
Respond effectively to complaints	7	2%
Report any criminal charges/proceedings promptly to the GOC	4	1%
Be candid when things go wrong	3	1%
Take reasonable care/maintain concentration	3	1%
Review staff/policies	2	1%
Take steps to check staff registration	2	1%
Comply with current guidance from College of Optometrists	1	0%
Comply with regulatory requirements and maintain registration	1	0%
Ensure that supervision is undertaken appropriately and complies with the law	1	0%
Keep knowledge and skills up to date	1	0%
Manage personal data in accordance with current legislation	1	0%
Monitor mental health and seek assistance if required	1	0%
Notify GOC/employer about changes to health	1	0%
Work collaboratively with colleagues in the interest of patients	1	0%

11.1.29 It was more likely that nothing would be advised in terms of learning or remediation when a case failed stage 1 (89%) when compared with those that failed at stage 2 (74%).

Profile of cases

11.1.30 The chart at ***Figure 42*** below presents the distribution of FTP cases according to registration status. Between April 2016 and April 2018, 66% of cases related to optometrists, 17% to businesses, and 12% to dispensing opticians. A total of 5% related to student registrants.

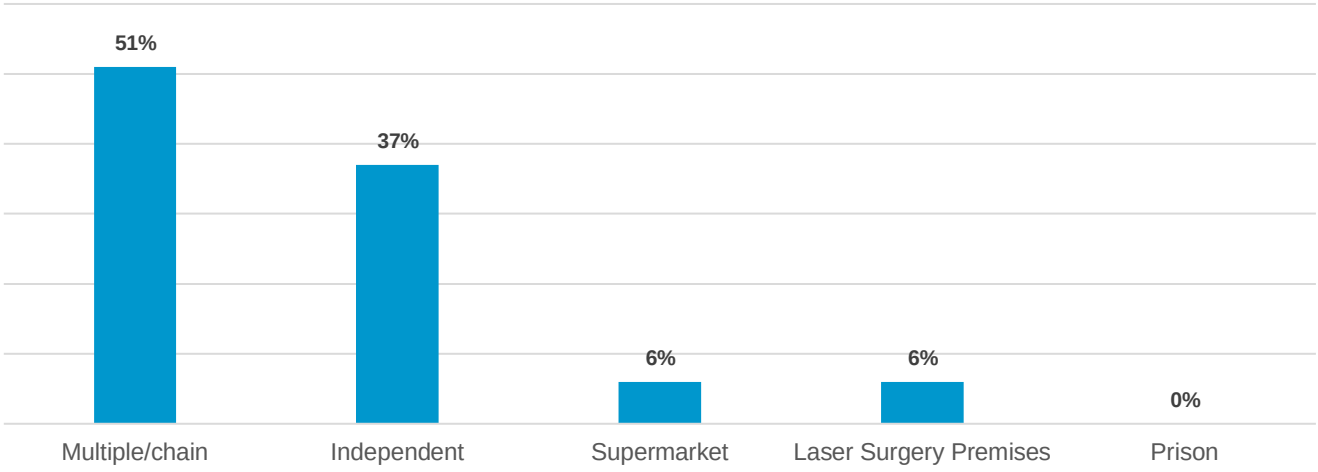
Figure 42 – Registration status
Base: All cases (376)



11.1.31 If looking at cases opened against optometrists, dispensing opticians and students only (excluding businesses), this shows that 79% of cases were against optometrists, 15% against dispensing opticians, and 6% against students. When compared to the overall GOC registrant population, this shows that optometrists are over-represented in FTP cases (57% of the registrant population), whereas dispensing opticians and students are under-represented (25% and 18% respectively).[81]

11.1.32 As illustrated by the chart at ***Figure 43*** below, half of cases (51%) related to multiple/chain practices, followed by 37% which related to independent optical practices, and 6% to supermarkets or laser surgery premises. Just 1 case was opened in relation to a prison setting. No cases related to a hospital setting.

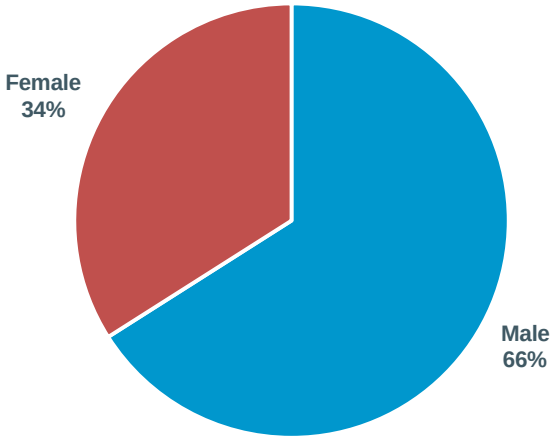
Figure 43 – Setting of FTP case
Base: 300 cases



[81] General Optical Council. (2019). *Equality and Diversity Monitoring Report.* p.16-17

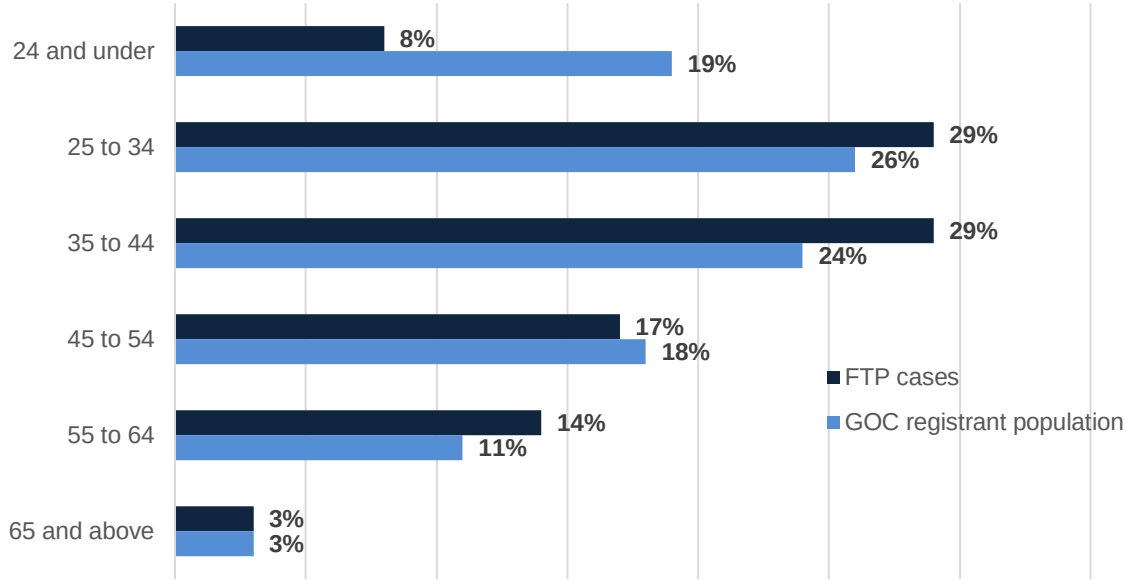
11.1.33 The sample of cases includes allegations opened against more male registrants (66%) than female registrants (34%), as shown at ***Figure 44*** below.

Figure 44 – FTP cases by gender
Base: 188 cases



11.1.34 The chart at ***Figure 45*** below presents the age breakdown, showing that the majority of cases involved registrants aged between 25 to 34 (29%) and 35 to 44 (29%). The chart below shows the age breakdown of FTP cases against the GOC registrant population, highlighting that cases are over-represented from the older age groups and under-represented from the youngest age group of 24 and under (8% of cases compared to 19% of the registrant population.

Figure 45 – Age of registrants in FTP database
Base: 304 cases



Improved communication of Fitness to Practise data

11.1.35 During the qualitative research, a popular suggestion from participants to help the profession manage future risk, including both registrants and stakeholders, was for the GOC to utilise the outcomes of Fitness to Practise proceedings more, which was seen as potentially beneficial to the profession.

11.1.36 It was highlighted that, whilst currently it is possible to read the outcomes of FTP proceedings, this requires a lot of reading through information on the GOC's website and interpretation to understand what the outcomes mean for the profession and potential risks. As this information was potentially very valuable for the optical profession in terms of increasing awareness of risks in practice and how these can be avoided, a number of participants suggested that the GOC should publish this information in a different way that was much easier for the profession to access, and which distilled the useful aspects of the FTP proceedings for the reader to easily learn from. It was suggested that this information could be provided on a regular basis to all optical professionals, something which some participants were aware of in other healthcare professions.

When you go through some of the claims on the GOC website, some of the nuggets of information you get out of it are so useful. But the reports are quite clunky and you have to go through these lengthy documents to bring out those nuggets. They do summarise it in their end of year booklet, but for me they've got access to all that information about why people raise serious complaints, and they should have it more available to the profession in bitesize chunks. Not just a big document at the end of the year or long documents on their website. Publish a summary once a quarter in The Optician or something like that to let people know what the things to look out for are. That would be a really useful learning experience.

Optometrist, Leeds

They do that in the NHS don't they? Nurses get medical updates and learning outcomes.

Optometrist, Leeds

11.1.37 Some participants said that having access to this information would be very beneficial for CET providers, who would be able to tailor their training courses according to the types of cases and issues raised at CET, thereby helping the profession to manage and mitigate future risk. It was suggested that optical businesses would also find this useful, as it would enable them to make improvements to their internal training and education for practitioners.

They could take that information and build it into CET.

Optometrist, Leeds

For businesses, having information from the GOC about general trends…the business is always keen on knowing general trends and outcomes so we can make improvements for the better.

Vision Express

11.1.38 Participants explained that having better access to the outcomes of FTP cases was potentially very valuable for the profession, as they perceived optometry to be less successful at sharing data than other healthcare professions. Some explained that often useful data can become trapped within organisations, even though it would be hugely beneficial if shared. The charity Patient Safety Learning indicated that they would be keen to help share any insights from FTP data via their forthcoming online community platform called 'The Hub', designed to share local, national and international skills, learning and experiences in relation to patient safety with both patients and professionals.[82]

[82] Patient Safety Learning. (2019). The Patient-Safe Future: A Blueprint for Action, p.37

There's very little industry data available in optics. If you look at other professions like pharmacy, they share things a lot more. We know what we're doing in Asda, and we have an idea of what other companies are doing. The GOC could give more guidance in terms of these are the things we're seeing, the types of cases, the hearings, the ways in which people are falling foul of the standards we are setting. For example, they could say in 2020, these are the three things that are impacting on patient safety the most, and we want you to learn more about that. It would help direct the traffic.

Asda Opticians

There's definitely value in improving our data and insight for patient safety. We need to better understand when things go right and how we share knowledge of good practice and when things go wrong, learning where the safety risks are. Knowledge is often trapped inside organisations and the knowledge that the GOC have through its regulatory activity would be tremendously rich insight. At Patient Safety Learning, we are developing the hub, a knowledge platform for patient safety and communities. This would enable every optometrist to freely access information on patient safety, share their good practice and flag up safety risk and how to best address them.

Patient Safety Learning

11.1.39 It was also felt that promoting this information may also help to dispel misconceptions held by optical practitioners about the FTP process, as it was suggested that a large proportion of the profession are very fearful of their regulator and the FTP process, perhaps unnecessarily. If the outcomes of FTP were communicated to registrants, this may help them better understand how the process works, how they can avoid risks in the future, and perhaps reduce any disproportionate levels of fear.

We have delivered a couple of CET sessions with the agreement of the GOC all about de-terrorising the view of the GOC within the profession. The aim is to help optical professionals to understand the risks and situations that would be considered an impairment to your fitness to practise, and trigger an FTP investigation, and those issues which are complaints or at worst, for both the patient and the individual optical professional, a civil claim. A civil claim will not prevent you practicing, although it should prompt reflection, further training and an opportunity to learn from what happened to prevent it recurring in the future. The communication type issues that we see at the OCCS need to be handled a bit better and consumers expect clear and empathetic explanation and communication. All regulated professionals should be very aware of their regulator and understand what it means to be a professional. When an individual falls below those professional standards, they should have a clear understanding of what happens. But, there's a disproportionate fear as to when the GOC will be interested and the risks that a regulator will and should investigate in order to protect the public and maintain confidence in the professions they regulate.

Optical Consumer Complaints Service

11.1.40 The benefit of improved use and communication of FTP data was also highlighted in the literature review. In a number of articles and reports, the Professional Standards Authority (PSA) state that all healthcare regulators need to identify trends and correlations in this type of data to contribute to reducing harms[83], and that a*ny improvements made to the consistency and quality of FTP data quality may not just help professional regulators, but also system regulators, providers and other actors beyond the regulatory world.*[84] The PSA also state that there needs to be improved consistency of categorisation of this type of data across the healthcare professions in order to utilise it for preventative regulation in the healthcare system.[85]

[83] Professional Standards Authority. (2016). *Regulation Rethought: Proposals for Reform*, p.9
[84] Professional Standards Authority. (2017). *Categorisation of Fitness to Practise Data: A Description of UK Health and Care Professional Regulators' Categorisation of Fitness to Practise Allegations*, p.17
[85] Professional Standards Authority. (2017). *Categorisation of Fitness to Practise Data: A Description of UK Health and Care Professional Regulators' Categorisation of Fitness to Practise Allegations*, p.18

11.2 Optical Consumer Complaints Service data

Background to the analysis

11.2.1 Analysis of the Optical Consumer Complaints Service (OCCS) data was conducted to assess any patterns or trends in the types of complaints that patients raise. To provide consistency with the FTP data analysis, this analysis includes all complaints received between 1 April 2016 and 30 April 2018. Further details of this analysis can be found in the methodology chapter of this report.

11.2.2 This chapter of the report contains a summary of the OCCS data analysis, which has also been referenced where relevant throughout this report to support the research findings. The results are also supported by feedback from an in-depth interview conducted with the OCCS.

Volume of enquiries

11.2.3 Between April 2016 and April 2018 there were 2,911 enquiries to the OCCS, compared with 376 cases that were considered for Fitness to Practise.

11.2.4 In 2017/18 the OCCS received 1,410 enquiries. In recent years there has been an increase in the volume of enquiries received, with an increase of 226% between 2014/15 and 2017/18. However, the volume has levelled off in the previous year, with just a 1% increase between 2016/17 and 2018/19.[86]

11.2.5 The OCCS attribute this increase in the volume of enquiries to an increase in awareness of the service, rather than any changes in the nature of optical practice or the behaviour of patients. It is, however, interesting to note that many qualitative research participants felt that patients' standards and expectations were changing and that they were becoming increasingly more likely to complain or take legal action when they are dissatisfied or when things go wrong.

We've seen an increase in the number of complaints at the OCCS, but I attribute that to awareness rather than an increase in complaints. It's more that the service is being used, rather than a change in the nature of practices and individual patients…GOC registrants now have an obligation to provide information about us at an appropriate time, so I think that, along with the effectiveness of mediation and OCCS insight sharing, helps to explain the increase in enquiries and mediations.

Optical Consumer Complaints Service

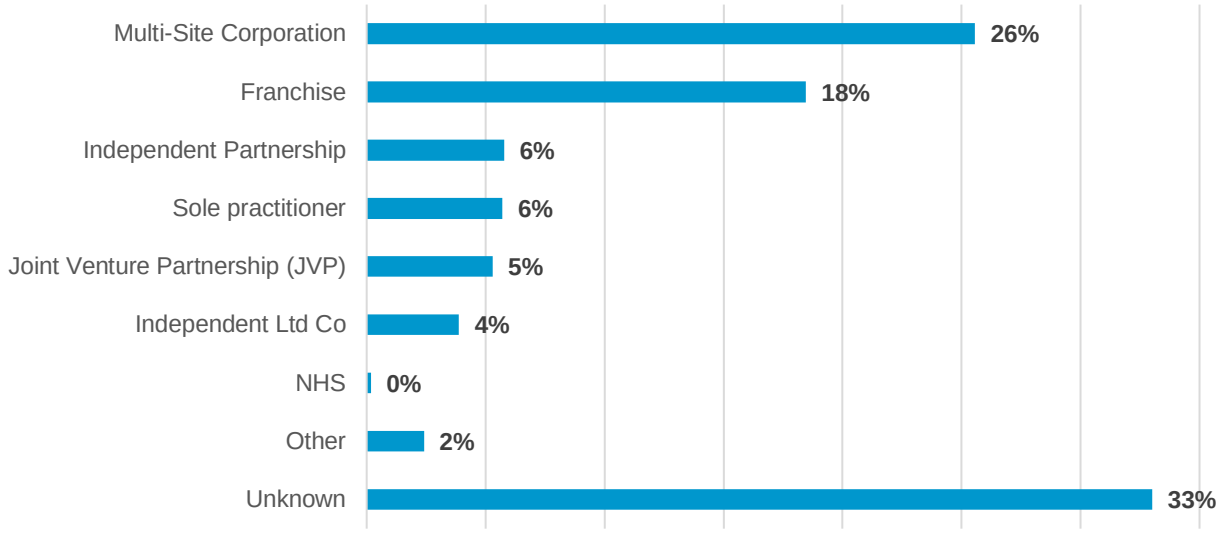
Source of complaints

11.2.6 Half (50%) of OCCS complaints between April 2016 and April 2018 came via the OCCS website, highlighting the large proportion of patients who are online.

11.2.7 As shown in ***Figure 46*** overleaf, in terms of practice type, a quarter of complaints (25%) were related to multi-site corporations, followed by 18% from franchises.

[86] Optical Consumer Complaints Service. (2018). *Looking Ahead: The Future of Optics, Complaint Mediation and Regulation (Annual Report 2017-18)*, p.8

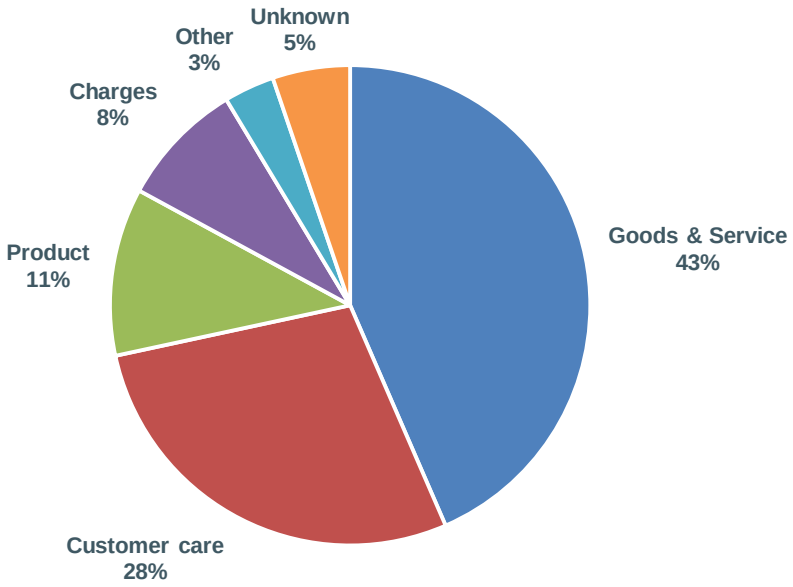
Figure 46 – Practice type of OCCS complaints April 2016 to April 2018
Base: 2,911 complaints



Nature of complaints

11.2.8 The chart below at ***Figure 47*** shows the overall categorisation of complaints received by the OCCS between April 2016 and April 2018.

Figure 47 – Nature of OCCS complaints April 2016 to April 2018
Base: 2,911 complaints



11.2.9 The largest proportion of complaints were categorised as goods and service (43%). Of these complaints, 25% were related to errors in prescription, followed by 15% which related to dispensing, 13% which related to the outcome of laser eye surgery, and 9% which related to a prescription prescribed in one practice and dispensed in another.

11.2.10 Over a quarter (28%) related to customer care. Of these complaints, 15% were related to complaint handling, 14% to attitude, 13% to delays in supply, and 6% to failure to deal with concerns/complaints.

11.2.11 In their latest annual report, the OCCS reported that complaints relating to customer care, the relationship between optical professional and consumer, and communication have reduced from 33% to 28% between 2016/17 and 2017/18. This equates to a 21% decrease in complaints relating to customer care and complaint handling, building on a decrease seen in 2016/17. The OCCS state that this trend has been influenced by the impact of complaint handling and communication explicitly referenced in the GOC *Standards of Practice for Optometrists and Dispensing Opticians*, since April 2016, and the profile of the OCCS and consistent messages on the importance of customer care and communication. This includes profession wide insight sharing via industry publications and journals, focused CET and grassroots insight sharing, engagement with multiples to share insight at professional conferences, and CET covering professional duty of candour.[87]

11.2.12 A further 11% related to product, which included frames (43%), lenses (20%), lens coatings (16%) and contact lenses (7%). Eight per cent related to charges, including charges for replacements or repairs, aftercare entitlement, price changes, consumer rights when cancelling an order, and clarity or misunderstandings.

11.2.13 There are small variations in the type of complaints raised by the practice type. For example, there was a slightly larger proportion of complaints related to goods and service for multi-site corporations (48%), independent limited companies (46%) and independent partnerships (45%), whereas customer care complaints were more likely amongst joint venture partnerships (JVPs) (38%). Additionally, product complaints came from a larger proportion of sole practitioners (16%), JVPs (16%) and independent limited companies (18%).

11.2.14 Although not directly highlighted in the data, the OCCS stated that they had noticed an increase in complaints about misdiagnosis in recent years, and that this may have been caused by the profession taking on more clinical roles that involve diagnosis and management of ocular disease, where they are more likely to come into contact with patients with more complex needs.

In recent years we've seen an increase in the misdiagnosis aspect, certainly in terms of patient perception. Patients have felt that issues have been missed, which a lot of the time is about communication and understanding. For example, when AMD might have gone from dry to wet…I can see that risk both clinically, but also in terms of managing the patient's expectation and checking understanding, will become more likely than it has been in the past, because of an ageing population and more patients with more complex needs. Therefore, the risk of there being something to spot, diagnose and treat is going to be higher.

Optical Consumer Complaints Service

11.2.15 During the qualitative research, the OCCS also highlighted that the types of complaints they receive tend to be consistent every year, with the majority relating to problems with prescriptions, either caused by a difference in opinion due to the subjective nature of eye examinations, or because a prescription has been dispensed elsewhere.

It's fairly consistent in terms of what we see. Consumers complaining that their prescription is inaccurate. It's quite a subjective test, and the reason why they feel their spectacles are not effective can vary and be due to a number of factors. For the OCCS, it is about finding a resolution and not judging the 'why'. It's the most frequent issue that comes through to us. Prescriptions being taken from one practice and dispensed elsewhere…it will always run the risk of confusion or conflict as to whether the problem is with the prescription or the dispense. The complaints referred to the OCCS are not unique or necessarily optically complex. The complaint will frequently escalate because the consumer feels their concerns or complaints

[87] Optical Consumer Complaints Service. (2018). *Looking Ahead: The Future of Optics, Complaint Mediation and Regulation (Annual Report 2017-18)*, p.19

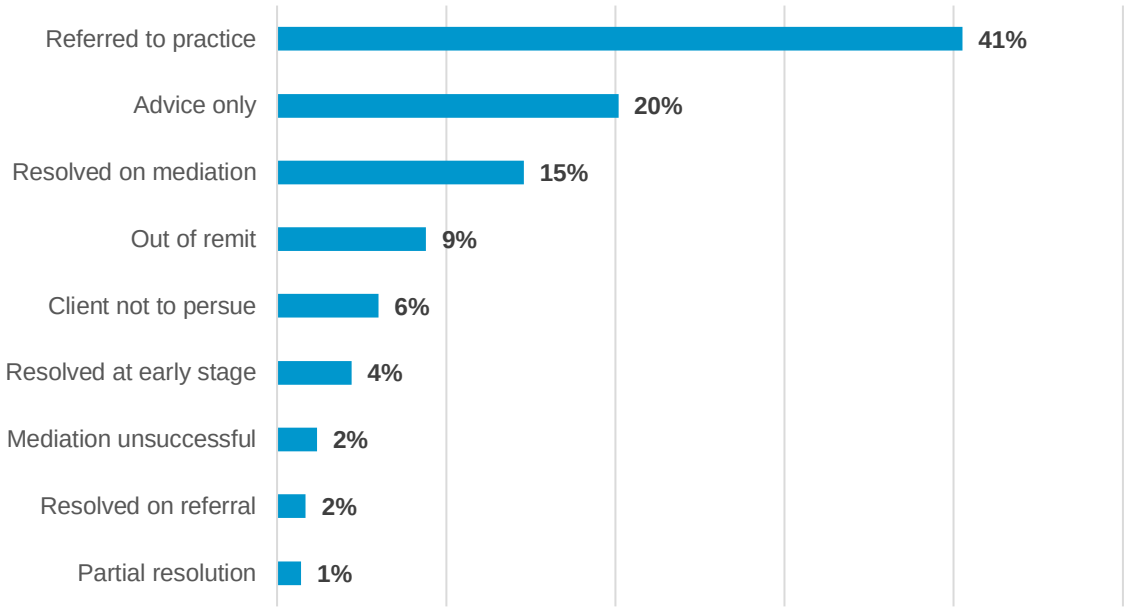
have not been met with the response and attitude they expect. For most consumers, their priority is for the practice to respond in a timely and constructive manner.

Optical Consumer Complaints Service

Outcome of complaints

11.2.16 Between April 2016 and April 2018, 41% of complaints were referred back to practice. One in five cases (20%) were where only advice was provided, whereas 15% were resolved on mediation. The full range of outcomes are shown in the chart below at ***Figure 48***. Those categorised as out of remit (9%) included those that were referred to the GOC for Fitness to Practise.

Figure 48 – Outcome of OCCS complaints April 2016 to April 2018
Base: 2,911 complaints



11.2.17 Complaints were more likely to be referred back to practice when in relation to product (44%), particularly when compared with charges (39%). They were also more likely to be referred to practice when in relation to independent partnership practice (51%) when compared with multi-site corporations (36%).

12. Conclusions

In this chapter we have drawn conclusions from the research based on analysis of the quantitative and qualitative research, and analysis of secondary data sources. The conclusions aim to highlight the key themes and recommendations that have emerged from this research, in line with the original research questions.

12.1 Optometrists and dispensing opticians continue to be viewed as a low risk

Increased risks are managed through education, training and a culture of risk aversion

12.1.1 As found in the previous research into risk in the optical sector conducted in 2010, it is perceived that optometry and dispensing optics generally remain low risk professions. Whilst there are risks which the professions acknowledge to be of potentially high severity to patients if they were to occur in practice, particularly more clinical areas of practice that are newer to optical roles, this research shows that most registrants and stakeholders perceive these risks to be well managed and mitigated, meaning that the profession continues to be low risk.

12.1.2 Typically, risks in the professions are mitigated through education, training and qualifications, where practitioners are required to complete additional training or gain additional qualifications before they can work in potentially riskier areas of practice. For example, whilst independent prescribing was viewed as a higher risk area of practice for optometrists, as it was not routine and required increased professional judgement, it is an area of practice which requires significant additional training and qualifications to deliver, therefore reducing any potential risk.

12.1.3 This is coupled with the strong assertion that optical professionals are often risk averse by nature and do not tend to work outside their scope of competence, being much more likely to refer to more qualified colleagues or secondary care when required if they are unsure. In recent years, risk aversion appears to have intensified following the R v Rose 2017 case, which has led many professionals to practise defensively and refer to other healthcare professionals, rather than attempt to diagnose and manage themselves.

Differences in levels of risk due to professional role and workplace setting

12.1.4 Although the professions are viewed as generally low risk, particularly in comparison with other healthcare professions, differences are still perceived between different roles and settings. It is accepted that the role of optometrist involves a higher degree of risk to patients when compared with the role of dispensing optician, as it includes responsibilities which are inherently risker such as the detection and management of disease, coupled with the fact that the optometrist is ultimately responsible for the patient when the two roles are working together, and the fact that dispensing opticians can defer to optometrists when needed.

12.1.5 However, it is interesting to note that dispensing opticians view most areas of their practice as higher risk when compared with the overall survey results, suggesting that they see more risk in their role than the rest of the profession.

12.1.6 Those working in secondary care also appear to have a greater level of risk because they are more likely to see complex cases and needs when compared with those working in community setting.

This perception is supported throughout this research, where survey respondents working in a hospital setting almost always viewed potential risk factors as more likely and more severe.

The optical professions are viewed as low risk in comparison to other healthcare professions

12.1.7 In comparison with other healthcare professions such as dentistry, pharmacy and nursing, it is accepted that the optical professions pose less risk as they are rarely involved in carrying out invasive procedures or prescribing high risk medication. Furthermore, if mistakes are made, the potential impact to patients is generally much less severe, again coupled with the fact that the profession tends to be risk averse and ready to refer. However, it is important to note that the profession is aware that the level of risk posed by optometrists to patients is changing due to taking on more clinical roles from secondary care, becoming more comparable with other healthcare professions.

12.2 Potential risks have changed since 2010, but the sector has adapted to manage them

12.2.1 It is widely agreed that the optical sector has changed significantly in the last 10 years. However, it does not appear that there is an agreed single cause behind these changes, but changes have been driven by a combination of factors including an ageing population, changes to the NHS, changes in patient expectations and behaviour, and developments in technology. All these factors have resulted in changes to the scope of the role of optical professionals.

12.2.2 Each factor appears to be interlinked, with each one influencing another. For example, the ageing population has meant that pressure has increased on the capacity of the NHS, due to the increasing number of patients presenting with ocular conditions, meaning that changes have been required. More services are being moved from secondary to primary care as a result, meaning that the role of optical professionals is changing and expanding to take on different roles and responsibilities. Additionally, technology is developing to enable professionals to undertake a wider range of roles in a community setting, which is impacting patient behaviour as a result.

12.2.3 The main impact of these changes appears to be that optical professionals, particularly optometrists, are taking on a wider range of roles and responsibilities, and opening themselves up to increased levels of risk, particularly when undertaking more clinical roles such as disease detection and management.

12.2.4 However, it appears that during this time as the sector has changed, the optical profession has adapted in order to work effectively within these changes and manage new areas of risk, typically through education and training. Schemes such as MECS and WECS highlight how professionals are required to undertake additional training to ensure they are fully qualified and confident to deliver new roles, thereby mitigating any increased levels of risk.

12.3 The sector will continue to change in the same ways in the near future, and can continue to adapt if appropriate action is taken

12.3.1 When assessing risk in the near future, this research has found that there is a strong perception amongst optical professionals that the sector will continue to change, but that this will be a continuation of the changes seen in the last 10 years.

12.3.2 For example, the population will continue to age, which will continue to mean that there is a greater number of patients requiring treatment for eye conditions and disease, resulting in increased pressure on the NHS. In turn, this will require community optical services to be called upon even more to take on clinical roles and responsibilities to help manage ocular conditions and disease to alleviate this pressure.

12.3.3 In relation to technology in the near future, risks were identified in terms of the development and increased use of artificial intelligence. Whilst it was explained that AI meant significant benefits in optometry, particularly around the identification of disease, interpretation of results, screening and referrals, this could pose a risk to the roles of optical practitioners, who could soon find many of their responsibilities carried out by machines, meaning they take on more of an advisory role. Furthermore, developments in technology related to automation, such as auto-refraction, could result in patients having much easier access to eye examinations, but without the presence of a qualified optical practitioner. In both these scenarios, the level of risk to patients could increase due to the absence of a trained and qualified optical practitioner, if they are no longer required to be present to interpret results, diagnose disease or conduct eye examinations.

12.3.4 Another risk identified in the near future is the increasing moves towards online sales of spectacles and contact lenses. The key risks here were seen to be patients missing out on the eye health check as part of an eye examination, meaning that conditions could go undiagnosed, and the lack of regulation from companies operating outside the UK, and therefore outside the jurisdiction of the GOC.

12.3.5 It therefore seems likely that the level of risk posed by the optical professions to patients and the public may increase in the near future. However, as this has happened over the last 10 years due to considerable change in the sector, and any increases in risk have been managed and mitigated via education, training and a propensity towards risk aversion, this would suggest that there is no reason why this will not continue into the near future.

Recommendation – Continue to support registrants to adapt to changes in the optical profession, as in the past ten years, allowing the sector to mitigate any increased levels of risk that may present themselves.

12.4 Competency risks related to ocular disease are viewed as potentially more severe

The riskiest areas of common practice are perceived to be those related to ocular disease

12.4.1 When assessing the risk in relation to common areas of practice for optometrists and dispensing opticians, those which relate to ocular disease are perceived to entail the highest level of risk. For optometrists, this included independent prescribing, and detecting and managing ocular disease, and for dispensing opticians, this included detecting ocular disease and referral decisions. These areas of practice are viewed as inherently riskier because, by working in these areas, practitioners are increasing the likelihood of encountering more complex patient needs, conditions and issues. It is interesting to note that the areas of practice which were viewed as entailing higher levels of risk are those which are still relatively new to or developing within the role of optometrists and dispensing opticians, suggesting that lack of experience may translate into a perception of risk.

12.4.2 This perception is reflected in the FTP data, where the most common allegations related to incorrect or missed diagnosis and inappropriate or missed referrals, highlighting the severity of these risk factors.

12.4.3 Although dispensing opticians felt that these areas of practice were inherently riskier, in contrast to optometrists, it was generally viewed that they were not particularly common areas of practice for dispensing opticians, but typically the responsibility of the optometrist. However, this meant that their experience in these areas may be lacking, therefore increasing the level of risk.

12.4.4 Less risk was seen in areas of practice which were perceived to be more routine and which were also more longstanding roles for optometrists and dispensing opticians, such as the eye examination/sight test, dispensing, understanding the visual needs of patients, and fitting spectacles. However, it is important to note that risk was still recorded for these areas of practice (as opposed to no risk), perhaps explained by the example that the eye examination and understanding the visual needs of the patient encompass other risks, such as the detection of disease.

Competency risk factors related to ocular disease are viewed as having potentially high levels of severity, but less likely to occur in practice

12.4.5 The research shows that risk factors of misdiagnosis of or failure to detect disease, failure to refer and inappropriate referral were viewed by both optometrists and dispensing opticians as having the highest levels of potential severity to patients if they occurred in practice, both of which were related to the identification and management of ocular disease.

12.4.6 However, at the same time both these risk factors were perceived to be below average likelihood in terms of occurring in practice. This appears to be related to the likelihood of encountering ocular disease for the majority of practitioners, the additional training provided when working in areas of practice related to ocular disease, and again the propensity to err on the side of caution amongst the optical professions, referring patients if they are unsure about something.

Mitigating the risk of missed referrals through cautious practice is increasing inappropriate referrals, which is impacting on other risks

12.4.7 In relation to the risk of missed referrals, which is viewed as a potentially severe risk, in trying to mitigate this risk, many practitioners may be increasing the number of inappropriate referrals by being overly cautious in order to avoid making a mistake. Therefore, this does not necessarily mitigate the risk of missed referrals, but shifts the risk to other areas such as increased strain on secondary care, increased waiting times, and unnecessary stress for patients. This has the potential to become more commonplace, as practitioners worry about the risk to their livelihoods should they miss ocular conditions or disease, heightened by the increasingly litigious environment in which they work.

Competency risks related to more routine areas of practice are viewed as less severe

12.4.8 In contrast to competency risks which relate to ocular disease, those which relate to more routine areas of practice, such as poor dispensing, prescribing errors and poor administration and record keeping, are viewed as more likely to occur in practice, but at the same time having less potential severity to patients. However, it was also frequently highlighted that prescribing and dispensing errors could pose a greater risk to certain types of patients, particularly those with disabilities or children.

Recommendation – Ensure that registrants are supported in newer areas of practice which may increase competency risks, particularly in more clinical areas related to the detection and management of ocular disease.

12.5 The conduct risks of poor communication with patients and not being honest when things go wrong could be better managed

The risk of poor communication with patients may become more severe in the future

12.5.1 Whilst it was not seen as the most likely or severe risk, poor communication with patients was widely discussed, as communication skills were generally seen to be very variable from practitioner to practitioner. This risk is potentially exacerbated by time constraints with patients, making it difficult to communicate everything needed to a high standard within a standard appointment, particularly if there are more complex patient needs.

12.5.2 The GOC's FTP data highlights that poor communication with patients is the result of a large proportion of allegations opened against registrants, something which much of the profession have some awareness of.

12.5.3 It was suggested that poor communication could become a more severe risk in the future, because as optical professionals take on more clinical roles and responsibilities, effective communication with patients becomes increasingly important. As participants felt that they did not receive sufficient training in this area, given their patient-facing role, it was often stated that more education and training could be provided in this area to ensure the risk of poor communication was managed in the future.

Whilst awareness of duty of candour has increased, professionals are still fearful of admitting mistakes

12.5.4 There appears to be significant awareness of the duty of candour guidelines amongst the profession, who understand the need to be open and honest with patients when things go wrong. However, some professionals do not believe that all practitioners abide by this in practice, as there is significant fear attached to being honest when a mistake has been made, particularly based on current patient attitudes and behaviours which are seen as increasingly litigious. Again, this risk was perceived to be to the professional rather than to the patient. It was suggested that more could be done in the sector to prevent optical professionals feeling deterred from admitting their mistakes, in order to encourage openness in the sector, as well as increased learning and development amongst practitioners.

Recommendation – Review education and training to ensure it equips registrants to effectively communicate with patients, providing them with practical experience to do so, with a focus on the communication of clinical information to patients.

Recommendation – Help to develop increased openness in the sector to allow registrants to feel more comfortable about being honest when things go wrong, thereby allowing learning from mistakes, improvements in practice and mitigation of future risks.

12.6 Contextual risks are perceived to be more likely to occur in practice and can impact on other risks

Contextual risks are perceived as more likely to occur in practice compared to competency and conduct risks

12.6.1 The research has found that contextual risks factors tend to be perceived to be more likely to occur in practice when compared to most competency and conduct risks. In particular, the risk factors of time constraints with patients, commercial and performance target pressure, poor or inadequate staffing and working as a locum were recorded as the most likely to occur in practice by both optometrists and dispensing opticians.

Time constraints with patients can exacerbate other risks

12.6.2 Whilst most contextual risks were viewed with lower levels of potential severity to patients if they occurred in practice, it is important to note that this was not the case for all contextual risks. In comparison, it was generally competency and conduct risks which were perceived by optometrists to be of higher potential severity if they occurred in practice, including misdiagnosis, failure to detect disease, failure to refer, inappropriate referral, inappropriate behaviour towards patients or colleagues and not maintaining confidentiality.

12.6.3 Time constraints was perceived to be both above average likelihood and severity, was recorded at the top of the combined ranking of all risk factors, and was one of the most widely discussed topics amongst qualitative research participants. These results may be explained by the perception that time constraints can exacerbate a number of other risks, such as misdiagnosis and failure to detect disease, failure to refer, poor communication with patients and colleagues, and prescribing or dispensing errors. Optical professionals have less time to deliver a thorough and high quality level of service when time is limited, making mistakes more likely to occur.

12.6.4 Similarly, commercial or performance target pressure was also perceived to exacerbate other risks, as although the level of risk this directly poses to patients was perceived to be low in terms of upselling products or services that are not needed, practitioners may need to rush their appointments with patients to hit targets and practices may only concentrate on patients where more money can be made, thereby increasing risk to patients who may have more complex needs.

Perceptions of locum working are changing, but it is still seen to be higher risk than permanent employment

12.6.5 Working as a locum was perceived to be a risk with above average likelihood, something which is possibly explained by the significant increase in the number of professionals working as locums in the past 10 years.

12.6.6 However, despite the survey results suggesting that the risk of working as a locum was perceive as below average severity, it appears that many people working in the profession still have reservations about locum working, identifying potential issues with continuity of care, taking responsibility, follow up with patients, referrals and local pathways, and learning and development.

12.6.7 Some participants were aware that more tailored CET was available for those working as locums, but it appears that more work needs to be done to ensure that working as a locum poses no greater risk to patients than those working full time in a single practice.

The risk of remote or isolated practice has been significantly mitigated through changes to CET

12.6.8 Remote or isolated practice was perceived to be both low likelihood of occurring and low severity in terms of the risk it posed to patients. Some risks related to remote or isolated practice were identified during this research, such as lack of support and not being exposed to the latest methods or best practice.

12.6.9 However, it was generally agreed that, in comparison to 10 years ago, it was now much harder to be isolated due to improvements to the CET scheme, which require registrants to keep up to date and also to interact with other professionals via peer review. This was further helped by improvements in communication technology, and the increasing number of multiple chain opticians. Therefore, this risk appears to have been significantly mitigated.

Recommendation – Further investigate the pressures faced by registrants caused by time constraints and what impact this may be having on patient care to ensure this risk factor does not continue to exacerbate other areas of risk.

Recommendation – Further investigate concerns raised in relation to locum working to help ensure that this growing area of the sector does not pose any increased risk to patients.

12.7 Systems risks also have an impact on the level of risk posed to patients

12.7.1 A number of risks that have been identified during this research could be categorised as system risks. The main systems risks highlighted include risks posed to patients caused by the differing referral pathways and shared care schemes that exist across different areas of the UK, and the difficulties of communication between primary and secondary care. These areas therefore require further investigation by the GOC to establish what could be done to help mitigate these risks in partnership with other appropriate organisations.

Recommendation – Further investigation into systems risks is required to understand how any inequalities and inconsistencies in patient care across the UK can be reduced, thereby mitigating the impact that they can have.

12.8 Levels of risk can vary for certain patient groups

12.8.1 Throughout this research, a common theme highlighted is that the levels of risk posed by optical professionals can vary depending on the type of patient being treated. The most common groups discussed were children, people with disabilities and the elderly.

12.8.2 The level of likelihood and severity of a number of risks can increase when these groups are being treated, particularly in what have been seen as lower risk areas such as prescribing errors and poor dispensing. Often the reason for this was related to issues with communication, as optometry is heavily reliant on the ability of the patient to communicate how well they can see.

12.8.3 Paediatric optometry appears to be an area of significant risk, as mistakes made when eyesight is still developing can have serious consequences in later life related to vision, development and learning. Therefore, what may be low risk for other patients may be considerably higher for children, such as errors when prescribing or dispensing spectacles.

Recommendation – Enable further education and training for registrants to understand how to effectively care for certain patient groups such as children and people with disabilities.

12.9 Education and training needs to evolve to help manage risk in the future

Undergraduate education and training needs to evolve to prepare newly qualified practitioners for a changed optical sector

12.9.1 In the main, this research highlights that the sector feels that the current system of education and training needs to change in order to adequately prepare newly qualified practitioners for practice. Due to the changes to the optical sector in recent years, it was suggested that education courses have not changed in tandem, meaning that newly qualified practitioners require more support when they first begin to practise.

12.9.2 It was often suggested that current education is too theory focused, and does not include sufficient practical experience based on the realities of current practice, and does not include enough content related to the changing roles of practitioners, particularly optometrists and the detection and management of ocular disease and the ability to communicate clinical issues with patients.

12.9.3 It is, however, anticipated that education and training will change soon due to the GOC's Education Strategic Review, which may result in improved education and training, thereby mitigating increased risk posed by newly qualified practitioners.

The current system of CET needs to develop, possibly into CPD, to foster development within the sector

12.9.4 The competency risk of lack of up to date skills and knowledge was not highlighted as a particularly likely or severe risk in this research. Whilst some participants suggested it could be difficult to keep up with the quickly changing optical sector, it was also accepted that it was now easier to access education and training via an improved system of CET.

12.9.5 However, this research has shown that there is a significant desire from the profession to introduce changes to the current system of CET in order to shape it to match recent changes to the roles of optical professionals, for example, including more relevant training related to the extended roles and responsibilities being taken on by optometrists.

12.9.6 The main suggestion in terms of improvements to CET was that it should be developed into a system of Continuing Professional Development (CPD), as this would foster increased professional development within the sector and prevent some practitioners from getting by with maintaining their minimum core competencies. It was felt that CPD would also be more appropriate, given the changing roles of optical professionals, bringing the sector in line with other healthcare disciplines.

Recommendation – Continue the review of undergraduate education to ensure it is up to date and adequately equips registrants for the realities of current practice, including a greater focus on practical experience, helping to reduce any additional risk posed by newly qualified practitioners.

Recommendation – Review and update the current programme of CET to bring it more in line with a programme of CPD, ensuring that registrants continue to develop throughout their careers.

12.10 Developing clearer definitions for optical professional roles

12.10.1 A suggestion from this research is to develop clearly defined definitions for both the role of optometrists and dispensing opticians. For optometrists, it was suggested that an updated definition of the role was required, taking into account changes to the role in recent years, including extended services and clinical roles. For optometrists it was also suggested that the training and qualification requirements to deliver extended or enhanced services also needed to be clearly defined to ensure the safety of patients and reduce potential risks.

12.10.2 For dispensing opticians, a defined profile of the role was suggested to clearly outline what the roles and responsibilities of dispensing opticians are, including what they can and cannot do. The main benefit of this would be to distinguish dispensing optician roles from those than can be carried out by non-registered optical assistants, something which was perceived to be a significant potential risk due to the blurring of the lines between the two roles. It was also suggested that the role of the dispensing optician could be reviewed to explore the potential for taking on more responsibility, particularly in refraction, to develop the role and allow optometrists to develop further into new areas.

12.10.3 In relation to definitions for optical professional roles, it is recommended that the GOC aims to improve its understanding of the optical workforce, including the number of registrants working in specific roles, workplace settings, working patterns and positions, in order to assist with the assessment of risk in the future.

Recommendation – In consultation with both optometrists and dispensing opticians, develop clearer definitions for both roles, taking into account recent changes to their roles and developments in the sector.

Recommendation – Develop a better understanding of the optical workforce by updating the registrant database with additional profiling information.

12.11 Management of future risk posed by online sales

12.11.1 As a key concern of many within the sector for the near future is the increasing move towards online sales, particularly of contact lenses, the GOC may wish to explore what more it could do to manage this area in order to mitigate risk to patients. It was suggested that the GOC could attempt to communicate with the public about online purchasing of spectacles and contact lenses, highlighting the potential risks that it involves.

12.11.2 It was also suggested that the GOC could change the way that it regulates online sales, with a particular focus on those selling from outside the UK, in order to ensure that all relevant standards are being met, thereby mitigating risk to patients.

Recommendation – Raise public awareness of the potential risks posed by purchasing spectacles and contact lenses online.

Recommendation – Investigate how the online sale of contact lenses could be more effectively regulated.

12.12 Improvements to the recording and communication of FTP data and future sharing of optical insurance data

12.12.1 To enable the analysis of FTP data for this research, a number of new ways of categorising the data from information recorded in case examiner reports have been developed. This includes more detail of the allegations made, warnings issued, remediation or learning advised and standards breached. The GOC could consider adopting these categories for the recording of future FTP cases, which will allow future tracking of FTP data and potentially greater levels of insight to be derived.

12.12.2 This research also strongly highlights that the sector would benefit from receiving analysis and insight of FTP data on a regular basis in order to be made aware of what the main risks are in current optical practice and how these can be avoided. It was often suggested that the GOC could better communicate FTP outcomes and analysis to the sector, perhaps via email on an annual basis or more frequently, including supporting information and commentary about the common types of cases seen and how registrants can prevent finding themselves in similar situations.

12.12.3 This communication could allow professionals to better manage risk as they would be more aware of what the risks were, and would also enable CET providers to shape their training accordingly. It may also result in professionals worrying less about losing their registration when they see the realities of the FTP process (for example, how the majority of cases fail the realistic prospect test, with just 17% being referred to FTPC), which may mean that they practise less defensively, potentially leading to a reduction in inappropriate referrals.

12.12.4 Although it was not possible to obtain sufficient optical insurance data for this research to enable meaningful analysis alongside the FTP and OCCS data, it is important to note that the sharing of this information in the near future could be very beneficial to the sector. The GOC could work with key stakeholders in the sector, including those who provide optical insurance to optometrists and dispensing opticians, to enable the sharing of data (where possible, taking into consideration confidentiality and commercial sensitivity) to help provide insight into patient concerns and complaints in order to improve patient care.

Recommendation – Update the way that FTP data is recorded to allow more insightful analysis to be conducted on a regular basis.

Recommendation – Communicate analysis of FTP data and outcomes to the sector on a regular basis to allow registrants and stakeholders to learn from these cases and become more aware of the realities of the FTP process.

Recommendation – Engage with optical insurers to investigate the future sharing of data, which may provide additional insight into risks to patients and the public.

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