

## **Strategic themes briefing paper**

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### **Purpose**

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1. The purpose of the paper is to summarise the research and analysis we have undertaken to inform the development of themes for our next strategic plan, which will cover the three-year period from April 2014 to March 2017.
2. This paper is a working paper. It is intended to provide a summary of how the external environment is changing and offer some views on the implications for the GOC. It is not intended to be a definitive report on these issues and we recognise that stakeholders may have views on these issues or issues that we have not covered. We look forward to receiving stakeholders' views during the consultation on our draft strategic plan.

### **Executive Summary**

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3. We have looked at how the external environment is changing and we have drawn on our existing knowledge and analysis.
4. The section on understanding the external environment covers the following areas:
  - 4.1 how society is changing;
  - 4.2 learning from the Francis report;
  - 4.3 public awareness of the GOC;
  - 4.4 what we know about the profession and how it is changing;
  - 4.5 how technology and treatments are changing;
  - 4.6 the optical sector and public health;
  - 4.7 changes in service delivery that will affect the profession and regulation;
  - 4.8 how consumer behaviour and the marketplace is changing;
  - 4.9 implications of the Law Commissions' review of health care regulation;
  - 4.10 Professional Standards Authority (PSA) review of the GOC and learning from other regulators; and
  - 4.11 the European and global agenda.
5. The section that draws on our existing knowledge and analysis covers the following areas:
  - 5.1 learning from our stakeholder survey;
  - 5.2 issues and themes identified in our policy issues log; and
  - 5.3 key performance data.
6. Following each sub-section, we summarise the implications for strategic planning.

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### Background

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7. The GOC has a statutory duty “to protect, promote and maintain the health and safety” of members of the public. In our last strategic plan we defined our mission as, “assuring the health and protection of those who use the services of optometrists and dispensing opticians”. The strategic plan also set out the GOC’s vision of, “leading the way in regulation” by fulfilling our mission in a manner that is innovative and exemplary.
8. The GOC’s values are to be responsible, forward thinking and principled.

### Analysis

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9. In thinking about our next strategic plan we have taken into account developments in the external environment and drawn on our existing knowledge and analysis.

#### A. Understanding the external environment

##### A1. How society is changing

10. There are predictions of a rapid increase in the UK in the ageing population. Estimates for England show that in 2010 there was 8.6 million over 65s (11,000 of these over 100) and in 2030 this will increase to 13 million over 65s (59,000 of these over 100)<sup>1</sup>. It is projected that by 2035, over 65s will make up 26% of the population in Wales, 25% of the population in Scotland and 23% of the population in England and Northern Ireland<sup>2</sup>. This is likely to lead to an increase in demand for optical services, particularly the need for more care in the community or in domiciliary settings, and an increase in the prevalence of age related macular degeneration (AMD). Research commissioned by the Royal National Institute of Blind People (RNIB) estimates that the number of people with sight loss in the UK is set to double to four million by 2050<sup>3</sup>. In line with this, the YouGov (2011) *Opticians* market report suggested that, ‘*in the longer term the ageing nature of the population will lift demand for corrective eyewear*’.
11. A 2011 report<sup>4</sup> found that ‘*changing lifestyles in the form of increased use of contact lenses and computers has led to increased dry eye syndrome (DES) in younger age groups*’.

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<sup>1</sup> <http://www.theguardian.com/society/2013/feb/24/britain-ageing-population-lords-inquiry>

<sup>2</sup> Office for National Statistics (ONS) (2012), *Population Ageing in the United Kingdom, its Constituent Countries and the European Union*, London: ONS.

<sup>3</sup> RNIB (2013), *Sight loss: A public health priority*. RNIB.

<sup>4</sup> SCRIP, Business Insights (2011), *The Ophthalmic Pharmaceutical Market Outlook to 2016*, Business Insights Ltd.

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### *Implications*

12. Our registrants will be under pressure to respond to the significant increase in the ageing population, resulting in the need to provide more care in the community and domiciliary settings, and to be able to treat a higher proportion of more vulnerable patients.

### **A2. Learning from the Francis report**

13. The Council considered the GOC paper analysing the recommendations from the Francis Inquiry report of the review of Mid Staffordshire NHS Foundation Trust (Mid Staffs) at its meeting in May 2013. The Council considered the following issues to be pertinent to the GOC:
  - 13.1 considering how the organisation handled complaints including speeding up the fitness to practise process, how we supported witnesses and the need to take a more proactive approach;
  - 13.2 openness, candour and raising concerns including considering whether GOC rules and guidance needed strengthening and whether there was a need to show more leadership in encouraging such a culture in the profession<sup>5</sup>;
  - 13.3 considering GOC standards and education including ensuring sufficient emphasis on care, compassion and working with vulnerable groups;
  - 13.4 considering how the GOC regulated businesses and students including consideration of what constituted effective supervision and the appropriate working environment for registrants;
  - 13.5 considering whether, and if so how, the GOC might raise its public profile; and
  - 13.6 considering whether the GOC needed to strengthen the connection between the Executive and lay Council members and the frontline of the profession.
14. It was agreed that priority should be given to strengthening the GOC's existing rules, guidance, education and support in respect of registrants raising concerns and that work be undertaken to ensure that the GOC's codes of conduct for registrants (including business registrants) and core competencies placed sufficient emphasis on care and compassion. It was also noted that an area for consideration in any future legislative change is whether all ophthalmic dispensing in care homes and other domiciliary settings should be carried out by or under the supervision of a registrant.
15. An update and interim action plan for the GOC has now been developed (to be presented to Council at its February meeting), which summarises some of the

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<sup>5</sup> Profession refers to both optometrists and dispensing opticians.

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more recent patient safety reports (such as the Berwick and Cavendish reviews) and outlines areas of progress against priorities identified in the May 2013 Council paper. These include:

- 15.1 collaboration with the PSA and other regulators around openness and candour;
  - 15.2 work with the Law Commissions to ensure we meet their deadlines in relation to the draft legislation;
  - 15.3 considering how our standards review project could help to strengthen support in respect of registrants raising concerns, emphasis on care and compassion, training in working with vulnerable groups and effective supervision; and
  - 15.4 progressing the business regulation and student regulation consultations.
16. In the context of developing our strategic plan, it is worth noting that the Berwick report reached some interesting conclusions around systems and the working environment often being to blame rather than individuals. It makes some recommendations that could significantly change the regulatory landscape in which we operate, including proposing a review of health care regulation by the end of 2017. It also calls for an ethic of learning, prioritising patient care above all else, patient involvement, sufficient staff and patient safety as part of initial training courses.

### *Implications*

17. The Francis report is of high importance for the health sector and we must be seen to consider the recommendations in detail and address the points that are relevant to us, albeit in a way that is proportionate to the risks in the optical sector. Francis has put health care regulators more in the spotlight and raised public expectations. This will lead to, for example, increased pressure to speed up complaints handling and a lower tolerance of risk that we should bear in mind as we decide how to proceed in relation to student and business regulation.

### **A3. Public awareness of the GOC**

18. The Francis Inquiry report suggested that the regulators should raise public awareness of their role. Our last research into this area in 2010 found that less than half of respondents thought that the GOC regulated opticians<sup>6</sup>.
19. Our strategy in this area has been to ensure that the public knows how to find us when they have a concern. This has been by making this information

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<sup>6</sup> ComRes (2010), *Headline findings of a survey of the public conducted on behalf of the General Optical Council*.

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available through our website and awareness raising work with intermediaries such as Citizens Advice. This approach is arguably proportionate given the low-risk nature of the profession in comparison with other health care professions such as medicine, nursing, dentistry and pharmacy.

20. We could consider whether we wish to do more to raise awareness of the GOC's role and how we would go about doing this. A barrier to doing so might be the funds that the GOC has available for any kind of advertising campaign. One way to share knowledge and discuss possible approaches might be through collaboration with other health care regulators. For example, we recently shared a stand with other health care regulators at the Citizens Advice conference. We also met Citizens Advice in September to discuss how they could improve the signposting to our website for members of the public who wish to make a complaint and ensure the advice about optical issues given by their advisers is accurate and up to date. We are also carrying out work on 'search engine' optimisation to make it easier for the public to find information on our website.

### *Implications*

21. Public awareness of the GOC may be an area that we wish to explore further. This will help us to understand what the public's expectations of the GOC are and what the gaps are between what they expect and what we currently deliver.

## **A4. What we know about the profession and how it is changing**

### **Registration figures**

22. GOC registration figures continue to rise, by 3.4% for optometrists and 3.3% for dispensing opticians between 2011 and 2012. As at 31 December 2012, there were 13,616 optometrists and 6,182 dispensing opticians on the GOC's registers, with the registrant profile as follows:
  - 22.1 optometrists:
    - 22.1.1 male: 55%, female: 45%;
    - 22.1.2 under 25: 6%, 25-39: 48%, 40-54: 31%, 55+: 15%;
  - 22.2 dispensing opticians:
    - 22.2.1 male: 59%, female: 41%; and
    - 22.2.2 under 25: 3%, 25-39: 41%, 40-54: 40%, 55+: 16%.
23. As at 3 September 2013 the GOC's specialty registers contained the following numbers of practitioners:
  - 23.1 contact lens dispensing opticians: 1,280;

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- 23.2 independent prescribing<sup>7</sup>: 195;
  - 23.3 supplemental prescribing: 8; and
  - 23.4 additional supply: 24.
24. It is notable that the number of independent prescribers on the GOC register has risen significantly in the last eight months, from 160 as at 7 January 2013 to 195 as at 3 September 2013. (See also the section on how service delivery is changing in Scotland and independent prescribing.)

### Sight tests

25. The latest *General Ophthalmic Services: Workforce Statistics for England and Wales, 31 December 2012* from the Health and Social Care Information Centre reveal that there were 11,133 ophthalmic practitioners in England and 809 ophthalmic practitioners in Wales registered to provide General Ophthalmic Services (GOS), an increase of 3% and 5.3% respectively since 2011.
26. *General Ophthalmic Services, Activity Statistics: England, 2012/13* found that GOS sight tests had risen by 0.3% during 2012/13 to 12.3 million, a lower rate of growth than in previous years; these 12.3 million including the following:
- 26.1 5.5 million sight tests were for those aged 60 or over;
  - 26.2 sight tests for children decreased slightly from 2.4 million to 2.3 million (19.2% of all NHS sight tests)<sup>8</sup>;
  - 26.3 407,000 sight tests (3.2%) were domiciliary tests; and
  - 26.4 the balance of sight tests was for the remaining categories of those entitled to NHS sight tests such as students, adults receiving income support/tax credits, adults suffering from diabetes/glaucoma and those requiring complex lenses.
27. Statistics for Northern Ireland<sup>9</sup> show that there were 620 ophthalmic practitioners in 2012, which is a 3.3% increase from 2011 and a 12.7% increase from 2005. There were 434,000 health service sight tests in 2011/12 - an increase of 2.7% on the previous year and 21.7% from 2005/06.
28. GOS in Scotland is available to everyone. In the year ending 31 March 2013, there were 1.93 million sight tests, an increase of 0.7% from the previous year's statistics. There has been a steady increase in the numbers of patients receiving eye examinations since 2007<sup>10</sup>.

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<sup>7</sup> Independent prescribing also includes supplemental prescribing and additional supply.

<sup>8</sup> An article in *Optician* entitled 'Children's eye exam rates hit 10-year low' (26 July 2013) warned that the fall in sight tests could 'spell problems for the future'.

<sup>9</sup> Business Services Organisation (2013), *Annual Health Service Ophthalmic Statistics in Northern Ireland (2011/12)*, Statistical Bulletin 30 September 2013.

<sup>10</sup> Information Services Division (2013), *Publication Summary. General Ophthalmic Services Statistics, Scotland: Information Services Division, NHS National Services Scotland.*

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29. *Eye Care Statistics for Wales, 2012-13*<sup>11</sup> includes statistics for GOS as well as other parts of the service such as Eye Health Examination Wales (EHEW). Key facts from this report include:
- 29.1 767,996 GOS sight tests (an increase of 0.1% from the previous year) – 52.1% of these were for people aged over 60); and
  - 29.2 57,993 examinations carried out under EHEW.
30. *Optics at a Glance 2011*<sup>12</sup> estimated that there had been 6.2 million private sight tests in the UK between April 2010 and March 2011. With 14.9 million NHS sight tests in the same time period, this meant that there were 21.1 million sight tests overall performed in the UK; this was an increase of approximately 300,000 from the previous year.

### *Implications*

- 31. Registrant numbers appear to have been steadily increasing over recent years.
- 32. There has been an increase in the uptake of sight tests as part of GOS. An increase in optometrists with an independent prescribing qualification means that new treatments will move into primary care more quickly. (See sections below on technology and treatment and independent prescribing in Scotland for more information.)

### **A5. How technology and treatment are changing**

33. The profession has seen many technological advances in recent years. Through our engagement with stakeholders, we understand that there has been a significant change to the equipment available to optometrists, which will enhance what they can do for patients and enable them to better track changes in eye health over time. The main changes in equipment are the availability of digital retinal photography and optical coherence tomography (OCT), a three dimensional analysis of the eye. Other technologies currently in development include use of animations to explain eye conditions in a consistent manner that can be used on electronic tablets during consultations. These types of developments could move on expectations of the profession, such that patients would expect this kind of technology in any practice that they attended. This could particularly impact smaller practices, who are less likely to be able to afford such technologies. However, it should also be noted that although there is an outlay for this equipment, these services can be fee-generating with costs varying from free to £50 per scan or £25 per photograph. The YouGov (2013)

<sup>11</sup> Welsh Government (2013), *Eye Care Statistics for Wales, 2012-13*.

<sup>12</sup> Optical Confederation (2011), *Optics at a Glance 2011*.

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*Opticians* market report found that 20% of adults opted for an enhanced sight test, with those in the 55 and over category most likely to do so.

34. The global pharmaceutical ophthalmic market was valued at \$16.2 billion in 2010<sup>13</sup>. New pharmaceutical ophthalmic drugs include development of a drug for diabetic macular oedema and drugs to treat dry macular degeneration which are expected to become available on the market in the next four to five years. Administering such drugs could put a significant strain on the hospital sector. NICE and the Scottish Medical Consortium have approved Lucentis for diabetic macular oedema and are currently reviewing evidence regarding Lucentis as a treatment for choroidal neovascularisation secondary to myopic degeneration. Eyelea is also another treatment for wet maculopathy approved for use in the NHS, with Avastin being used privately.
35. Linked to this, there have been significant developments in contact lens technology in recent years, and there are now contact lenses that can deliver drugs to the eye including delivering anaesthetic to provide pain relief following eye surgery<sup>14</sup>. Contact lens technology also includes lenses that are designed to influence refractive development<sup>15</sup>, diagnosis and monitoring of systemic conditions (such as diabetes or glaucoma) and lenses for non-medical use which can transmit images to the retina (a kind of advanced virtual reality). These developments have implications for the training that optometrists and contact lens opticians will require in order to have the skills and knowledge required to fit these devices. This is currently a highly specialised market area that few optometrists and contact lens opticians are involved in.
36. Technological advancements have also increased the scope for remote diagnosis/treatment via video links in health care, currently known as telecare, telehealth, or telemedicine. As yet, this area has not had a big impact on optometry and it is not yet clear to what extent it is likely to do so in the future. There is currently a first stage pilot study into telehealth in the delivery of glaucoma services that is being funded by the Scottish Centre for Telemedicine in Grampian<sup>16</sup>. The service means that patients can be monitored in community practices rather than in hospital clinics.
37. Technology enables a basic sight check to be delivered either online or through smart mobile phone apps. Similar technology is being utilised in a user-operated kiosk. Currently, these technologies offer limited accuracy and cannot

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<sup>13</sup> SCRIP, Business Insights (2011), *The Ophthalmic Pharmaceutical Market Outlook to 2016*, Business Insights Ltd.

<sup>14</sup> Nevin, M. (2012), 'The great leap forward', in *Contact lenses in the UK 2012*, a supplement to *Optician*.

<sup>15</sup> Text changed from 'lenses that can slow the growth of myopia' on 4 February 2014

<sup>16</sup> <http://www.abdn.ac.uk/hsru/research/delivery/organisation/telehealth/>



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perform a check on the health of the eyes, so they are not a replacement for a full eye examination.

38. Refractive laser eye surgery (performed by ophthalmologists) has also increased in popularity and uptake since its inception in 1989, with a total of 147 clinics providing the procedure in 2010, half of these being private clinics and the other half optical practices and private hospitals. A survey carried out in 2010 showed that some providers had noticed either a slight downturn in business or a slowing rate of growth, whereas others said they had been unaffected by the recession or seen significant growth in business<sup>17</sup>. Optical Express reports some downturn in recent years and has recently offered free laser eye surgery to eye care practitioners (including students) for the remainder of 2013 to promote the benefits of this to the profession.
39. There have also been advancements in intraocular lens technology (an artificial lens implanted into the eye to restore clear vision after a cataract has been removed. Some intraocular lenses can also reduce the effects of presbyopia and allow clear vision at both distance and near<sup>18</sup>) which has led to a growth in this market. This growth is thought in part to be related to the ageing population and more awareness about this kind of procedure<sup>19</sup>. The most recent YouGov *Opticians 2013* report<sup>20</sup> showed that 54% of the sample who wore glasses or contact lenses would not consider having surgery. 27% of the sample would consider having it in future although 43% of those underestimated the cost of the procedure. The most prominent reason for not wanting surgery was anxiety over having surgery on their eyes.

### *Implications*

40. Developments in technology are likely to change expectations of the profession and put more pressure on registrants (from patients, ophthalmologists and possibly the GOC through fitness to practise) to keep up with advances, which could have significant cost implications. We need to ensure that we keep up to date with developments to ensure public protection and to consider how to ensure that the profession is appropriately trained to administer new technologies and that our standards keep pace.
41. It is also possible that the growth in refractive procedures will mean a decrease in spending on spectacles and contact lenses. This could put more pressure on our registrants, particularly those owning small practices.

<sup>17</sup> Ewbank, A (2010), 'Ten years of trends in UK refractive surgery' in *Optician*, 26 November 2010.

<sup>18</sup> Text changed from "a lens implanted into the eye to correct cataracts, vision and astigmatism" on 4 February 2014

<sup>19</sup> Ayling, J (2013), 'Optical Express embarks on laser quest' in *Optician*, 30 August 2013.

<sup>20</sup> YouGov (2013), *Opticians 2013*, London: YouGov Plc.

### **A6. The optical sector and public health**

42. A significant achievement for eye health charities was the addition of an indicator to measure preventable sight loss in the Public Health Outcomes Framework for England (2012). The purpose of this framework is to improve and protect the nation's health and wellbeing, and improve the health of the poorest fastest. It aims to increase healthy life expectancy and reduce differences in life expectancy and health life expectancy between communities<sup>21</sup>. This is the first time that indicators of public eye health were included in the framework. The indicator measures rates of AMD, diabetic eye disease and glaucoma, and certification of sight loss. Please refer to the section on changes to service delivery for further information about how eye health will be prioritised. A recent survey found that only approximately 25% of eye care professionals were aware of the introduction of this indicator<sup>22</sup>. This has implications for the effective measurement of performance against the indicator as practitioners will need to collect data about clinical outcomes. The College of Optometrists released *Better data, better care: Ophthalmic public health data report 2013*. This called for the sector to 'continue to seek improvements to the CVI [Certificate of Vision Impairment] process to ensure the long term success of the public health indicator on eyes' and to improve the collection of public health data generally. They are committed to improving IT systems for optometry and encouraging optometrists and other clinicians to improve the quality of the data they collect.
43. The UK Vision Strategy was launched in 2008 by the VISION 2020 UK initiative, led by RNIB. This is a cross-sector initiative seeking to transform eye health, eye care and sight loss services. The strategy has recently been re-launched for 2013-2018 with the following intended outcomes:
- 43.1 everyone in the UK looks after their eyes and their sight;
  - 43.2 everyone with an eye condition receives timely treatment and, if permanent sight loss occurs, early and appropriate services and support are available and accessible to all; and
  - 43.3 a society in which people with sight loss can fully participate.
44. The RNIB is currently campaigning to reduce preventable sight loss and to continue promoting this area as an important public health priority. Research suggests that '1.8 million people are living with significant sight loss in the UK and 50 per cent of this sight loss is avoidable'<sup>23</sup>. Recent meetings with the RNIB suggest that they wish us to become involved in promotion of eye health

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<sup>21</sup> Department of Health (2012), *The Public Health Outcomes Framework for England, 2013-2016*.

<sup>22</sup> *Optician* (2013), 'Half of practices offer primary care services', 30 August 2013.

<sup>23</sup> RNIB (2013), *Sight loss: A public health priority*. RNIB.

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- e.g. through increased profile of 'ophthalmic public health' in the undergraduate and CET work for optometry.
45. There are several other eye health initiatives currently underway, often led by charities. The Eyecare Trust has organised campaigns such as an annual National Eye Health Week (a joint initiative with various charities and health care organisations to promote the importance of eye health and the need for regular sight tests for all), as well as initiatives to improve road safety and employers' awareness of eye health.
  46. The College of Optometrists and the Royal College of General Practitioners have also prioritised eye health as a public health matter, with a commitment to work across organisations to improve eye health.
  47. The College of Optometrists released its eye health strategy, *Healthy Eyes for All: An optical sector strategy to improve ophthalmic public health*, in May 2013. The focus of this was on health inequalities including the following areas:
    - 47.1 sight loss is most prevalent in the older population;
    - 47.2 the visually impaired are more likely to be in poorer physical and psychological health and less likely to participate in society;
    - 47.3 lower socio-economic groups are more likely to experience visual impairment and sight loss, but are less likely to access optical services;
    - 47.4 those who drink excessively and smoke are more likely to be diagnosed with AMD;
    - 47.5 certain ethnic groups are more likely to be at risk of particular eye conditions; and
    - 47.6 vision screening for children in schools has not been implemented consistently in all areas of the UK.
  48. Fight for Sight, the College of Optometrists, the UK Vision Strategy and the NIHR Biomedical Research Centre at Moorfields Eye Hospital have joined together to develop a Sight Loss and Vision Priority Setting Partnership. The aim of this partnership is to identify unanswered questions about the prevention, diagnosis and treatment of a number of different sight loss and eye conditions from the perspectives of patients/service users and eye health professionals, and then prioritise those which both groups agree are the most important.
  49. The National Institute for Health and Clinical Excellence (NICE) has now published guidelines on smoking cessation which outlines a role for eye care professionals in this important public health issue. Their role will be to '*advise and counsel smokers on their increased risk, the benefits of stopping and, where appropriate, refer them to local stop smoking services*'<sup>24</sup>.

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<sup>24</sup> *Optician* (2013), 'New role for ECPs in smoking cessation', 6 September 2013.

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### *Implications*

50. Attention on public eye health and health inequalities is increasing and we need to consider whether we should play a role in promoting eye health in order to fulfil our statutory function. We could consider working in partnership with some stakeholders where this aligns with our role, for example, promoting awareness of the risks that can flow from buying contact lenses online. We could also do this by directly providing more information to the public (for example, on our website) or indirectly by placing more emphasis on promoting public health in our standards. We could also contribute indirectly by building awareness of public health initiatives into our standards.

### **A7. Changes in service delivery that will affect the profession and regulation**

51. Recent changes in the NHS in England due to the Health and Social Care Act 2012 have led to the abolition of primary care trusts (PCTs) and the creation of NHS England (Area Teams) and clinical commissioning groups (CCGs). Commissioning is split between:
  - 51.1 NHS England - primary care ophthalmic services;
  - 51.2 CCGs - community-based eye care services and secondary ophthalmic services; and
  - 51.3 local authorities - responsibility for public health promotion activity and supporting and providing services for those registered as blind or partially sighted<sup>25</sup>.
52. General Ophthalmic Services (GOS) contracts are now held centrally by NHS England, which holds a central performers list, and managed through the Area Teams. Procedures for contract assurance are currently unclear but will include a self-declaration form based on a clinical governance tool Quality in Optometry<sup>26</sup> and inspections of a selection of practices will take place on a random basis.
53. NHS England Area Teams will host Eye Health Local Professional Networks to advise CCGs. A cross-sector organisation, the Clinical Council for Eye Health Commissioning, has been set up to help direct the budget (£2.2 billion) spent on eye health services in England each year. It will offer advice and guidance to commissioners, and work in partnership with NHS England. Local Optical Committees exist to represent ophthalmic contractors and performers in a defined area. The Local Optical Committee Support Unit (LOCSU) acts as a key link between the local committees and national professional optical bodies,

<sup>25</sup> Association of the British Pharmaceutical Industry (2013), *Better vision for all*.

<sup>26</sup> Quality in Optometry was jointly developed by the AOP, FODO, Association of British Dispensing Opticians (ABDO) and the College of Optometrists: [www.qualityinoptometry.co.uk](http://www.qualityinoptometry.co.uk)

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developing enhanced service pathways and working with the Department of Health and commissioning bodies to raise awareness of the expertise of local committees<sup>27</sup>.

54. Local Health and Wellbeing Boards are responsible for setting up a joint health and wellbeing strategy (JHWS) for their council area, to promote joint working and integrated services across health and social care. Joint strategic needs assessments (JSNAs) will be drawn up to describe the needs of the local population and set a strategic direction for service delivery to meet those needs. These JSNAs will be used to inform the development of the JHWS. A website has been set up by the UK Vision Strategy dedicated to eye care commissioning ([www.commissioningforeyecare.org.uk](http://www.commissioningforeyecare.org.uk)), which contains guidance on developing and influencing JSNAs related to eye health and sight loss.
55. A recent article in *Optician*<sup>28</sup> commented that '*NHS reforms encourage optometrists to migrate towards clinical care functions*', rather than just eye examinations and the sale of optical appliances. LOCSU recently commissioned a survey of practices<sup>29</sup> which found that 51% of practices are currently providing community services under NHS contracts. While many of those surveyed were positive about involvement in such schemes, there were still 23% who felt that there was no benefit in getting involved.
56. There also appears to be some divergence across the nations, for example, an increase in enhanced services delivered in the community in Scotland and Wales. Enhanced services or community services relate to care provided in the community by optometrists which include glaucoma management, diabetic retinopathy management, cataract referral and post-operative management, and low vision services. We have set out in the paragraphs below some of the key differences between the nations.
57. Sight tests in **England, Northern Ireland and Wales** for patients under 16 and over 60 years of age, those registered blind or partially blind, and those with diabetes, are funded by the NHS (through General Ophthalmic Services (GOS)) with a reimbursement fee of £20.90. (The NHS also provides optical vouchers to assist with the cost of the purchase of spectacles for certain categories of patients<sup>30</sup>.) This fee is widely considered to be less than half of the actual cost of providing a sight test. Also, the average cost of a private test is £21.67, meaning that it is necessary for all optometrists to rely upon patients purchasing spectacles, contact lenses or other eye care products to supplement their

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<sup>27</sup> <http://www.locsu.co.uk/about-us/>

<sup>28</sup> *Optician* (2012), 'ABDO's Peter Black on the right to refract', 24 February 2012.

<sup>29</sup> *Optician* (2013), 'Half of practices offer primary care services', 30 August 2013.

<sup>30</sup> Examples include those aged under 16, 16-18 year olds in full time education, those on income support and those eligible for a complex lens voucher.

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income<sup>31</sup>. The YouGov (2011) *Opticians* market report found that only 9% of spending on optical sales related to sight tests.

58. **England:** optometrists wishing to provide services to the NHS are required to be registered on the Performers List held by NHS England. Contracts can be for standard sight tests and also for additional services such as domiciliary testing.
59. Service level agreements for GOS in **Northern Ireland, Scotland and Wales** are held by health boards and practitioners are required to be on the ophthalmic and/or supplementary list of one of the local health boards. GOS providers in Northern Ireland and Wales are not subject to the same contract compliance requirements as providers in England. We have outlined some of the key differences in Northern Ireland, Scotland and Wales in the following paragraphs.
60. **Northern Ireland**
- 60.1 The Family Practitioner Services Ophthalmic Services are responsible for payments to optometrists for the provision of GOS and the maintenance of the Ophthalmic List<sup>32</sup>.
- 60.2 The Department of Health, Social Services and Public Safety (DHSSPS) published *Developing Eyecare Partnerships* in October 2012. This sets out the strategy for eyecare services for the next five years, which includes reorganising eye care services and examining the relationship between community optometry, hospital services and orthoptic services. This is with a view to identifying sight loss problems at an earlier stage, providing more services in the community, improving life chances for children and maximising the use of primary and secondary care resources. There is an emphasis of patients being partners in their care.
61. **Scotland**
- 61.1 Sight tests in Scotland are funded by the NHS for the entire population, with contractors receiving a reimbursement fee of between £37 and £45 depending on the age of the patient.
- 61.2 Scotland has different GOS regulations to the other UK nations and a revised GOS contract was introduced in Scotland in 2006, resulting in more care being delivered through enhanced services by optometrists in the community, reducing the burden on hospital services, and making the optometrist 'the GP for eyes'. Equipment grants were given to practices between 2006 and 2008 as part of the GOS contract. An initial evaluation of GOS services suggests substantial efficiency savings despite a growth in the number of patients using the service. It was

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<sup>31</sup> Europe Economics (2013), *Optical Business Regulation: Final report for the General Optical Council, July 2013*.

<sup>32</sup> Ibid.

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estimated that the total direct saving to secondary care was £56.16 million for the year 2010/11 – a reduction of 4.5% in referrals to secondary care since 2006 (where for the same period in England there was a 23% rise)<sup>33</sup>.

- 61.3 Children's pre-school vision screening is free in Scotland and is conducted by orthoptists and seconded optometrists as part of secondary care.
- 61.4 NHS Boards in Scotland inspect the premises of optical businesses holding a GOS service level agreement on a three-year rolling programme; practice inspections do not appear to focus on clinical governance issues<sup>34</sup>.
- 61.5 Optometrists in Scotland are being funded by NHS Education for Scotland (NES) to undertake the independent prescriber qualification. Optometrists in Scotland who have this qualification have recently been given prescribing rights and are able to make direct prescriptions, with prescribing pads being available in practices – this is considered to be '*another example of shifting and sharing the balance of eye care*'<sup>35</sup>. Only a minority of independent prescriber optometrists outside of Scotland have their own prescribing paid, the rest being reliant on GPs, hospital doctors or patients to buy their medications.
- 61.6 Each Health Board in Scotland has a process for development of Patient Group Directions (PGDs), which are written instructions for the sale, supply and/or administration of medicines in a particular clinical situation produced a group of health care professionals such as a doctor/dentist, pharmacist and optometrist<sup>36</sup>. These are used by optometrists to treat specific eye conditions. For example, Grampian Eye Network and Lanarkshire Eye Network Scheme (LENS): in Grampian, drugs are requested from the GP and dispensed in pharmacies, whereas in the Lanarkshire scheme, drugs are supplied by the local hospitals and stored in the optometrist premises for dispensing.
- 61.7 The Scottish government is currently implementing an eye care integration programme as part of a programme to deliver eOphthalmic services, which will connect optometrists to electronic systems within the NHS, facilitate electronic referral between optometrists and hospitals, and enable GOS claim forms to be completed electronically. There is strong emphasis on improving waiting times, shifting the balance of care

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<sup>33</sup> Optometry Scotland (2012), *GOS – It's Working! An Evaluation of General Ophthalmic Services (GOS) in Scotland*.

<sup>34</sup> Europe Economics (2013), *Optical Business Regulation: Final report for the General Optical Council, July 2013*.

<sup>35</sup> *Optician* (2013), 'Scotland extends OOs' NHS prescribing rights', 6 September 2013.

<sup>36</sup> NHS Education for Scotland: <http://www.nes.scot.nhs.uk/education-and-training/by-theme-initiative/prescribing-and-patient-group-direction/patient-group-directions/introduction.aspx>. Accessed 9 October 2013.

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into the community and improving patient safety (for example, by allowing quicker referral, assessment, diagnosis and treatment).

### 62. Wales

- 62.1 As of 2013 the Wales Eye Care Service (WECS) will develop a new national enhanced service, whereby optometrists will be allowed greater clinical freedom with more care being delivered in primary care rather than in hospitals<sup>37</sup>.
- 62.2 The Welsh government has recently invested in an eye care delivery plan for 2013-18<sup>38</sup>. This is essentially a public health improvement project which gives optometrists a role in public health and eye care promotion (for example, encouraging smoking cessation and health eating), involving them in early diagnosis/detection (including depression screening for patients using low vision aids), and providing access to treatment in the community setting (including providing a service to special needs groups). The aim is for all optometrists in Wales to be WECS accredited so that they can provide these services. The delivery plan also includes development of electronic patient records and referrals systems, as well as tracking outcome measures and patient experience. Training will be provided by the Wales Optometry Postgraduate Education Centre (WOPEC).

#### *Implications*

63. We should consider how to support the profession in understanding the changes in the NHS and in delivering enhanced services. This could include breaking down any barriers to training and possibly promoting the idea of including training related to enhanced services as part of the undergraduate degree. This would benefit patients by ensuring that there are sufficient health care professionals available to treat them in the community, particularly given the pressure on secondary care expected because of the ageing population. This area may also be relevant to the CET programme.
64. Across the UK we are seeing an increased role for optometrists in delivering services traditionally delivered within secondary care. This has been most marked in Scotland and Wales. In relation to Scotland in particular where optometrists are being encouraged to attain the independent prescriber qualification, this will play a large part in enabling more treatments to be carried out in the community rather than in a hospital setting. We should have a view on the implications for regulation.

<sup>37</sup> Europe Economics (2013), *Optical Business Regulation: Final report for the General Optical Council, July 2013*.

<sup>38</sup> Welsh Government (2013), *Together for Health: Eye Health Care. Delivery Plan for Wales, 2013-18*.



65. We should consider how to support the profession in their increasing role to ensure adequate protection of the public. We should also consider how extension of skill sets for some optometrists is reflected in our standards and whether we would wish to develop our relationship with education providers to enhance co-operation and collaboration in this area. In addition, we should consider how these changes will impact on fitness to practise proceedings. For example, if an optometrist makes an electronic referral to a hospital ophthalmologist and that ophthalmologist never actually sees the patient and instructs the optometrist to carry out treatment over which there is subsequently concern about, it may not be clear where responsibility would lie.

**A8. How consumer behaviour and the marketplace is changing**

66. The economic climate has led to a decrease in spend on optical goods and services. The YouGov (2013) *Opticians* market report<sup>39</sup> found that spending on optical services and products has continued to fall in the last two years (and indeed every year since 2010), with 24% of those in need of eyewear correction saying that they will be more careful in spending on optical goods in the future and 12% saying that they will delay spending on eye tests or optical goods to save money. This could have a particular impact on independent practices who are already competing for business with multiples offering free or low-fee sight tests.
67. The YouGov (2013) *Opticians* market report found that 3% of respondents bought spectacles online. This was the same percentage as in 2011.
68. The YouGov (2011) *Opticians* market report found the following (based on a nationally representative sample of the UK adult population):
- 68.1 72% had visited an optician in the last two years, with the remainder considering that they did not need an eye test and/or not being aware that they are advised to have one every two years;
  - 68.2 only a quarter of parents got their children's eyes tested as a matter of routine; and
  - 68.3 consumers were delaying eye tests due to their financial circumstances, and reducing their overall spending on eye care.
69. While these statistics demonstrate that percentages of those buying spectacles and contact lenses online appears to be relatively low, recent research by Europe Economics (2013)<sup>40</sup> surmised that '*for businesses operating at the*

<sup>39</sup> YouGov (2013), *Opticians 2013*, YouGov Plc.

<sup>40</sup> Europe Economics (2013), *Optical Business Regulation: Final report for the General Optical Council, July 2013*.

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*margin, even a small diversion of trade to other suppliers or online sellers could significantly affect their profitability, increase commercial pressures and undermine investment in high-quality patient care*'. This is particularly relevant given that the cost of eye tests is significantly greater than the standard NHS fee in England and the fees charged by optometrists, meaning that businesses are reliant on consumers purchasing spectacles or contact lenses to off-set the below cost sight test fees.

70. Use of the internet has contributed to increased consumer expectations, with consumers becoming more able to make price comparisons and likely to have higher standards. This may mean that expectations of our registrants will increase, putting more pressure on them to deliver high standards as well as keeping costs down for consumers and maintaining a good choice of products. There are drawbacks to purchasing spectacles online in that they can be supplied without all the measurements necessary to allow correct ordering of spectacles, such as the specification of the positioning of the lenses in the spectacle frame.<sup>41</sup>
71. Multiples (seen as a single entity with multiple branches) continue to have an increased share of the market. The YouGov (2013) Opticians market report found that 63% of those visiting an optician in the last two years went to one of the three largest multiple chains.
72. The last decade has seen increased competition from online suppliers of spectacles and contact lenses. A recent survey<sup>42</sup> commissioned by the Association of Contact Lens Manufacturers (ACLM) and *Optician* found that 10% of those who wear contact lenses bought their lenses online. 41% were likely to buy online in the future, the main consideration being price.
73. Online sales are expected to increase over time, with many larger companies and some smaller ones now supplying products online, although often this is to their own client base after eye examinations and contact lens checks have been performed in-store.

### *Implications*

74. Evidence suggests that the financial climate has led to consumers delaying sight tests, a decrease in spending on optical products generally, and a possible increase in buying optical products online in order to save money. This will impact on the profitability of optical businesses, where even a small decrease in sales could have a significant impact. This could in turn lead to

<sup>41</sup> Text changed from "such as the mono pupillary distance and the height of bifocal or varifocals above the horizontal centre line" on 4 February 2014.

<sup>42</sup> As reported in *Optometry Today*, May 17 2013, vol 53:10, p6.

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some patients receiving lower quality care due to lack of investment.

75. The increase in online sales could have a significant impact on optical businesses, especially those smaller businesses that may not be able to compete on price or choice. This could impact on the quality of care received by the public who may not realise the importance of ensuring that they have regular contact lens check-ups having bought their contact lenses online.

### ***A9. Implications from the Law Commissions' review of health care regulation***

76. The Law Commissions' review of health care regulation is expected to culminate in a draft Bill presented to government in spring 2014. The Government is hoping that the legislation will be enacted by the end of this Parliament, i.e. by April 2015. We are working on the basis that there will then be a two-year period during which time regulators will need to implement the new framework. This is likely to be a substantial area of work for the GOC, which will include the revision of our procedural rules governing, for example, our fitness to practise process. We need to assess the resources that will be required to carry out this work.
77. Following the outcome of the business regulation consultation and Council's final decision, a case will need to be made to the Department for Health if extension of business regulation is required. Should our current preferred option of extension of registration to all businesses be accepted, significant work will be required to implement this option and will involve further consultation around areas such as registration fees and the treatment of small businesses and sole traders. However, our assumption is that any changes would not happen until around 2017, that is, not during the life of the strategic plan that will take effect in April next year.
78. The Law Commissions' review could also have broader implications in that it will lead to health care regulators having more consistent regulatory frameworks.
79. It should be noted that there is uncertainty about who will form the next UK Government and therefore the future policy direction. There is also uncertainty about the forthcoming referendum in Scotland.

### *Implications*

80. The implementation of the new legislation is likely to be a significant area of work for us and we need to be realistic about the cost and time involved in updating our rules and ensuring consistency with the new legislation. This area also links back to the Francis Inquiry report, which has led to a significant and

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heightened political interest in health care regulators and the extent to which they are service the public interest.

81. We need to consistently demonstrate our achievements in protecting and promoting public health and safety and highlight the value of having an expert regulator in the optical sector. We should also consider the possible opportunities, for example, making the case for regulating orthoptists.

### **A10. PSA review of the GOC and learning from other regulators**

82. The PSA *Performance Review 2012-13* judged that the GOC was an effective regulator and had met all 24 standards of good regulation. The CET scheme was highlighted as good practice, and it was noted that improvements had been made in the two areas that in the previous performance review had not been met or met inconsistently.
83. The PSA will be reviewing progress with our projects on standards (and subsequent evaluation of the effectiveness of the revised standards), illegal practice, business regulation and student regulation by the end of the current financial year. They will also follow up on:
- 83.1 the outcomes of effectiveness of the CET scheme;
  - 83.2 challenges of sharing data with other organisations involved in visits to education providers;
  - 83.3 outcomes from the review of the effectiveness of dedicated visit panels;
  - 83.4 implementation of independent quality assurance monitoring process for registration;
  - 83.5 implementation of the customer relationship management (CRM) database;
  - 83.6 outcome of a pilot study into sharing indemnity insurance data;
  - 83.7 review of timescales relating to fitness to practice processes including our plans to make further hearing days available;
  - 83.8 outcomes of work around supporting witnesses; and
  - 83.9 implementation of our information governance strategy.
84. Activities of other regulators over recent years that the GOC may be interested in include the following:
- 84.1 the General Medical Council's (GMC) learning materials to help doctors understand guidance on standards and their explanatory guidance to provide more detail on the numerous topics referred to in *Good Medical Practice* (2013);
  - 84.2 the General Pharmaceutical Council's emphasis on a risk-based approach to regulation through inspection of pharmacies, reducing the

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- frequency of inspections and concentrating on those pharmacies that have not met the standards;
- 84.3 the legal regulators are currently undertaking a Legal Education and Training Review, a joint initiative to review education and training requirements for the legal professions;
  - 84.4 the GMC's review of its approach to quality assuring medical education and training;
  - 84.5 the General Dental Council's (GDC) annual patient survey to, amongst other things, capture public and patient awareness and perceptions of the GDC;
  - 84.6 the Health and Care Professions Council's (HCPC) research into public expectations about the HCPC and to inform public information campaigns;
  - 84.7 the Solicitors Regulation Authority operates a risk-based approach to monitoring firms that are registered – it uses a mixture of desk-based supervision (discussion and requests for information) and visit-based supervision (visits to address one-off events and risks identified); and
  - 84.8 the GMC's launch of a confidential telephone helpline for doctors who have concerns about patient safety.

### *Implications*

- 85. We need to ensure that we have the capacity to continue to meet all of the standards of good regulation, so that we continue to be an effective and efficient regulator.
- 86. Several of the activities of other regulators referred to in this section touch upon areas that are mentioned elsewhere in this paper, for example, research into public perceptions. The GOC may wish to consider its current approach in this area in comparison to other regulators.

### ***A11. The European and global agenda***

- 87. The GOC is a member of the Alliance of UK Health Regulators on Europe (AURE), which brings together nine health and social care regulators in the United Kingdom to work collaboratively on issues in Europe affecting health and social care regulation. Recent work has included a joint briefing for the Civil Liberties, Justice and Home Affairs Committee on amendments proposed to data protection legislation.
- 88. The GOC is also a member of the Joint Optical Committee for the European Union (JOCEU) alongside the optical professional bodies. A recent area of interest has been the amendment of the European Directive on the Recognition

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of Professional Qualifications (including language requirements, voluntary European Professional Card scheme, mandatory CPD, common framework and testing systems for trainees) – this is an opportunity to harmonise professional qualifications and promote recognition of trainees across Europe. Fluorets has also been a significant issue in Europe. This has meant understanding the European Union regulatory framework for optical medicines and medical devices. We will need to track developments in this area carefully, including the Commission decision scheduled for the spring.

89. JOCEU works in partnership with the European Council of Optometry and Optics (ECOO), of which we are also a member. In July 2013 ECOO published professional guidelines for optometric and optical services in Europe to establish consistent guidance on the quality of service provision.
90. We also seek to keep in touch with global developments through our membership of the World Council of Optometry. It is their mission to facilitate the enhancement and development of eye and vision care through education (*'debating education issues, practice modes and teaching methods'*), policy development (*'dedicated to promoting optometry as a health care profession'*) and humanitarian outreach (working in partnership with the World Optometry Foundation *'to upgrade optometric education, augment primary care and prevent visual impairment'*)<sup>43</sup>. It has over 150 member organisations and represents over 300,000 optometrists. It serves as a forum to respond to public health needs and opportunities around the world.

### *Implications*

91. We should consider whether we are engaged in the right forums (including whether membership of any existing forums is inappropriate given that our interests and those of the professional bodies are not always aligned) so that we take developments at European and global level into account and seek to influence them where appropriate.

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<sup>43</sup> World Council of Optometry (undated), *World Council of Optometry*.

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### B. Drawing on our existing knowledge and analysis

92. This section of the paper will address the following areas in order to assist in understanding the external environment:

- 92.1 learning from our stakeholder survey;
- 92.2 issues and themes identified in our policy issues log; and
- 92.3 key performance data.

#### ***B1. Learning from our stakeholder survey***

93. Stakeholders were asked about the GOC's values and whether they saw the GOC as responsible, principled and forward-thinking. While many of our stakeholders and registrants thought of us as responsible and principled, only 9% of registrants and 14% of stakeholders thought of us as 'forward thinking'. We need to consider further how we can be, and be seen as, forward thinking.

94. Priorities facing the optical sector / professional practice identified by registrants included:

- 94.1 increasing NHS payments;
- 94.2 managing changes in the NHS structures and changes to commissioning arrangements;
- 94.3 continuous improvements in public health;
- 94.4 ensuring standards of service; and
- 94.5 better regulation of internet providers, control of internet supply, competing with internet supply and increased competition (with regard to this point, it should be noted that there may be a misunderstanding amongst some registrants about the powers of the GOC and our remit in this area).

95. Many of our stakeholders (organisations) wanted us to communicate more and be more transparent with them. There were a few comments around being more flexible over education policies and reforming fitness to practise processes.

96. The feedback shows that there is a particular concern from both our registrants and stakeholders that we are not dealing with illegal practice appropriately, particularly in relation to online/internet contact lens providers. This area will be important in relation to the perception of the GOC and its ability to fulfil its mission.

97. Many organisational strategic plans refer to having the 'right people' in place and the 'right culture'<sup>44</sup>. The perceptions survey suggested that staff felt there could be improvements to rewards, benefits and performance, some aspects of

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<sup>44</sup> See, for example, General Pharmaceutical Council (2013), *Strategic Plan 2013 – 2016*.

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the working culture (for example, the physical environment), some aspects of management and motivation and communication. It is important that all staff are supported to achieve the GOC's mission and vision.

### *Implications*

98. We need to consider our stakeholders' concerns and how to assist the profession in understanding and embracing the changes in the NHS and public health to help ensure high standards of public health and protection. There may be capacity to do this through education and standards, and there are also implications for our approach to communicating with our registrants. We need to explain our role and remit so that stakeholders are clear about what they can expect from us.
99. We also need to think about developing our capacity to gather and analyse intelligence so that we can anticipate and respond to change.
100. We also need to move forward in developing our strategy for dealing with illegal practice.

### ***B2. Issues and themes identified in our policy issues log***

101. The Policy team has set up a log to identify matters of policy that might affect the public in the optical sector. The policy log has identified the following issues that are relevant to the strategic plan:
  - 101.1 the trend towards more domiciliary care – this has implications for our standards, for example, ensuring that registrants are equipped to care for vulnerable patients and that there is appropriate supervision;
  - 101.2 security of supply of medicines and devices – in the light of the recent withdrawal of Fluorets we need to know whether there are other products, the withdrawal of which would be detrimental for patients;
  - 101.3 internet supply – this raises questions about current rules, such as whether prescriptions should contain all the information arguably needed to dispense spectacles properly, for example, interpupillary distance, as well as potentially affecting the viability of some traditional businesses as discussed above; and
  - 101.4 concerns about dispensing – these continue to be expressed (principally by ABDO) about dispensing by non-registrants, particularly in relation to children and vulnerable adults. At the same time, it has been suggested that in some circumstances dispensing opticians should be able to extend their scope of practice and carry out refraction.



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### *Implications*

102. The issues we have captured in the policy log are largely discussed elsewhere in this paper. However, the issues raised by ABDO highlight the fact that in examining how the profession is changing in the light of, for example, changes in commissioning, we should consider the role of dispensing opticians as well as optometrists.

### **B3. Key performance data**

#### **Fitness to practise**

103. We made progress in fitness to practise cases in the year 2012/13 by cutting the time it takes to make an Interim Order decision from 37.5 to 12 weeks, setting up extra hearing dates and revising our Fitness to Practise Rules to speed up the process for handling complaints. This will lead to the appointment of case examiners to make faster decisions on whether to refer to a Fitness to Practise committee and to fast-track complaints involving serious criminal convictions.
104. Our annual report for 2012/13 and draft fitness to practise annual report for 2012/13 highlight the following statistics:
- 104.1 we received 171 complaints (an increase of 15% from 2011/12);
  - 104.2 the complaints involved 239 registrants – 0.93% of our registrant base in comparison with 184 registrants (0.78% of our registrant base) in 2010/11;
  - 104.3 there has been an increase in complaints against optometrists and business registrants:
    - 104.3.1 complaints against optometrists have risen from 122 in 2010/11 to 160 in 2012/13;
    - 104.3.2 complaints against businesses have risen from 16 in 2010/11 to 33 in 2012/13 (and from 21 in 2011/12 to 33 in 2012/13 meaning a 57% increase);
  - 104.4 there has been an increase in the number of complaints from the public and from primary care trusts as well as cases opened under our statutory powers; and
  - 104.5 the top-ranking categories of complaints were personal conduct, spectacle prescription, business complaint handling, clinical complaints against a multiple and other clinical complaints.
105. The Investigation Committee considered these complaints and directed the following:
- 105.1 122 (40%) closed with no further action;
  - 105.2 46 (15%) referred to Fitness to Practise committee;

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- 105.3 31 (10%) closed as no further action with advice;
  - 105.4 27 (9%) referred for further investigation;
  - 105.5 23 (7%) minded to warn;
  - 105.6 19 (6%) issued with a warning;
  - 105.7 11 (4%) other;
  - 105.8 9 (3%) performance assessment;
  - 105.9 7 (2%) direction to close as withdrawn;
  - 105.10 7 (2%) health assessment; and
  - 105.11 5 (2%) terminate referral to fitness to practise and no further action.
106. During 2012/13 the Fitness to Practise committee concluded cases involving 26 registrants (13 optometrists, 8 dispensing opticians, one student optometrist and four student dispensing opticians) and one business registrant. The committee reached the following outcomes:
- 106.1 7 (23%) erasure from the register;
  - 106.2 6 (19%) issued a warning;
  - 106.3 5 (16%) suspension;
  - 106.4 5 (16%) no further action;
  - 106.5 4 (13%) conditions;
  - 106.6 2 (7%) conditions to continue following review hearing; and
  - 106.7 2 (6%) suspension to continue following review hearing.
107. As well as the 25 concluded cases, the Fitness to Practise committees upheld a further nine applications for interim orders.
108. Key performance indicators relating to fitness to practise show the following continuous improvements for 2012/13:
- 108.1 progressing 87% of cases to first consideration by the Investigation Committee within nine months of receipt of the investigation form (against a target of 80);
  - 108.2 serving the Notice and other documents on the Hearings Manager in 87% of cases within seven months of the referral of the case by the Investigation Committee (against a target of 80%); and
  - 108.3 the median time between referral by the Investigation Committee and service on the hearings manager is 28 weeks.
109. This performance is against a backdrop of a significant rise in overall caseload and case complexity (the latter has meant that hearing lengths have doubled on average). We are committed to continuous improvement and so have decided to take the following additional steps:
- 109.1 further increase the number of hearing days from 1 April 2013: 10 to 15 hearing days each month - this will mean a total of 175 hearing days over the year;

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- 109.2 introduction of a more flexible approach to scheduling hearings to deal with peaks and troughs in the number of cases; and
- 109.3 recruitment of a full time assistant to work with the Hearings Manager to ensure that hearings are scheduled as efficiently as possible.

### **Continuing education and training (CET)**

110. In January 2013, the GOC implemented an enhanced CET scheme for registrants, with more emphasis on interactive learning methods and registrants reflecting on their own and others' practice. The new CET cycle involves registrants obtaining 36 CET points per three year cycle, with a minimum of six points per year. There is now an emphasis on competency areas, interactive learning and peer review. Registrants can track their CET progress through use of the MyCET section of the MyGOC area of the website. The latest figures for CET (quarter one of 2013/14) show the following:

- 110.1 22% of registrants have completed their peer review requirement (against a target of 20%);
- 110.2 17% of registrants are doing only distance learning CET (against a target of 20%);
- 110.3 53% of points awarded have been for interactive CET (against a target of 50%); and
- 110.4 67% of registrants are on target to meet their annual six point minimum (against a target of 80%).

#### *Implications*

111. Complaints continue to rise and although we have made progress in speeding up the fitness to practise process, there is still work to do in this area. CET is progressing well although not all targets in this area have been met. We will continue to monitor registrants' progress and publicise the new arrangements for enhanced CET.