A survey of the availability of state-funded primary eye care in the UK for the very young and very old

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Abstract

Background: The National Health Service (NHS) provides General Ophthalmic Services (GOS) to eligible patients in the UK. Nearly all community optical practices have a contract with the NHS via local primary care organisations (primary care trusts in England) allowing the practices to provide NHS sight tests to eligible patients.

Objective: To determine the accessibility of GOS sight tests for certain groups of patient in the UK.

Method: A telephone survey was carried out to investigate the availability of GOS sight tests for two categories of eligible patient. A total of 200 primary eye care practices were randomly selected, of which 100 were telephoned to establish the availability of a sight test for a child aged 1 year whose mother is concerned due to the presence of a family history (parental) of strabismus. The other 100 practices were telephoned to investigate the availability of a sight test for a person aged 90 years who was described as having dementia.

Results: A total of 199 of the 200 practices provided GOS sight tests. The mean age at which practices declared that they start examining children was 3.1 years. Most (76\%) practices recommended an eye examination for the 1-year-old child, but only 46\% said that they would carry this out themselves. Of the other 100 practices telephoned across the country, 93\% said that they could arrange an eye examination for the patient with dementia.

Discussion: Of the UK optical practices that participated in this study, 99.5\% provide GOS sight tests. About half of these would not offer a GOS sight test to a 1-year-old child. It has been suggested that the GOS Terms of Service do not permit practitioners to exclude categories of patients from GOS services, although we argue that this interpretation is equivocal. Indeed, it is suggested that clinical and ethical reasons may sometimes require practitioners to decline to examine certain categories of patient. It is worrying that one quarter of practices did not recommend an eye examination for a young child with a family history of strabismus. It is hoped that a continuing education and training project will increase interest in paediatric optometry.

Keywords: eye examination, General Ophthalmic Services, National Health Service, optometry, primary eye care, sight test

Introduction

Most optometrists in the UK work in primary care community optical practices and these are the major providers of primary eye care services. Nearly all of these primary care optometrists have a contract with the National Health Service (NHS) via local primary care organisations (PCOs) to provide sight tests to eligible persons. In England, the PCOs are known as Primary
Care Trusts (PCT). Through these PCOs, the NHS provides General Ophthalmic Services (GOS) to children, people aged over 60, and various other exempt groups (Table 1). In 2003–2004, 11.4 million of the 17.2 million primary eye care examinations were paid for by the NHS (Department of Health, 2004). A recent survey of 75 optical practices found that all 75 practices provided NHS-funded eye examinations to eligible patients (Jessa et al., 2007). The goal of the present study was to determine the availability of GOS sight tests for two categories of eligible patients: an infant and an older person with special needs.

The Association of Optometrists, who represent most optometrists in the UK, have advocated using the term sight test to refer to the GOS sight test, in order to differentiate this from a full optometric eye examination which may include additional procedures (Association of Optometrists, 2003): this terminology will be followed in this paper.

In order to be able to provide GOS under the NHS, optometrists, ophthalmic medical practitioners (OMPs) and corporate opticians need to be on the appropriate PCO list and state the availability of GOS services (Hirji et al., 2001). For inclusion in the list, practitioners agree to adhere to the GOS Terms of Service. These terms are contained in the National Health Service Regulations (General Ophthalmic Services) (2006).

Several authors have noted that the fee for GOS sight tests is uneconomic, so that GOS work is only viable if subsidised by income from spectacle dispensing (Atkinson, 1994; Evans, 1998; Anon; 2001). GOS contractors may limit the amount of time they devote to the GOS. For example, they may restrict the number of appointments or number of hours available per day or numbers of days or sessions during which GOS services are available (Hirji et al., 2001). The local PCO should be advised of the times (Hirji et al., 2001). Optometrists can refuse to see anyone for a GOS sight test on a case-by-case basis. However, it is not explicitly stated in the regulations whether optometrists can decline to provide GOS sight tests to certain categories of eligible patients (e.g. young children), although the Department of Health (DoH) has advised that they doubt whether GOS practitioners can exclude whole categories of patients (Hirji et al., 2001).

A PubMed search was carried out for keywords: (primary eye care OR sight test OR eye examination) AND (GOS OR General Ophthalmic Service OR NHS OR state funded). This search revealed no published studies that have investigated the availability of GOS sight tests in the UK. In the present study, we therefore telephoned randomly selected primary eye care practices to enquire about the availability of a GOS sight test for a patient meeting one of two scenarios.

We did not seek to carry out a detailed investigation of regional variations in the availability of GOS sight tests. As a preliminary indicator of whether this issue is worthy of further study, the results obtained from practices in the London area (practices whose telephone number had a 020 prefix) were compared with those in the rest of the country.

Methods

Sample selection

To practise in the UK, optometrists must be registered with the General Optical Council. Registrants are listed in the Opticians Register (General Optical Council, 2005), along with the addresses at which they practise. To randomly sample practices, we used the 2005 edition of the Opticians Register, which contains details of about 60 practitioners per page. A ‘random number between’ function was used in Microsoft Excel to generate random numbers between 1 and 60. The list of random numbers generated was used to select practitioners from each page, i.e. the numbers 7, 52 and 33 meant the 7th, 52nd and 33rd practitioners were selected from that page. Five practitioners were selected from each double page (three from one page and two from the next). This method of selection was followed throughout the register, which gave 500 randomly selected practitioners. This sampling method was designed to select more practitioners than were required for the study, to allow replacements for practitioners for whom telephone numbers were unavailable.

For these 500 randomly selected practitioners, we recorded the GOC registration number and practice details on a spreadsheet. For those practitioners who work in more than one practice, the entry in the Register

<table>
<thead>
<tr>
<th>Table 1. Categories of people eligible for NHS sight tests in the UK</th>
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<tbody>
<tr>
<td>Persons aged 60 years and over</td>
</tr>
<tr>
<td>Children aged 0–15 years</td>
</tr>
<tr>
<td>Students 16–19 years</td>
</tr>
<tr>
<td>Adults/partners receiving</td>
</tr>
<tr>
<td>Income support</td>
</tr>
<tr>
<td>Income-based jobseeker’s allowance</td>
</tr>
<tr>
<td>Pension credit guarantee credit</td>
</tr>
<tr>
<td>People entitled to, or named on, a valid NHS tax credit exemption certificate</td>
</tr>
<tr>
<td>Low-income certificate holders (HC2). People who are named on a valid HC3 certificate may receive some help towards the cost of a private sight test</td>
</tr>
<tr>
<td>Registered blind/partially sighted</td>
</tr>
<tr>
<td>Diabetic/glaucoma sufferers</td>
</tr>
<tr>
<td>Close relatives of glaucoma sufferers aged 40 or over</td>
</tr>
<tr>
<td>Patients considered to be at a risk of glaucoma by an ophthalmologist</td>
</tr>
<tr>
<td>Patients who require complex lenses</td>
</tr>
</tbody>
</table>
should list all the practices at which that practitioner works. In these cases, we selected the practice that appeared at the top of the list.

As noted above, we had deliberately over-sampled to obtain more practice addresses than were needed in case some could not be contacted. To obtain the 200 practices for the telephone survey from the 500, we applied a second level of randomisation. The 500 were divided into batches of five, and we selected the final list of practices to contact as the first and third in every batch of five. Of the 200, only three practices could not be contacted (owing to incorrect or unavailable telephone numbers) and for these the next practice in the list of 500 was contacted instead.

**Scenario 1: Child aged 1 year**

**Scenario 1: Introduction** The aim of this scenario was to establish the availability of a GOS sight test for a child aged 1 year whose mother is concerned due to a family history of strabismus.

We sought to investigate the accessibility of a GOS sight test for this particular group because the first few years of life are critical for visual development, and strabismus and uncorrected refractive error are common causes of amblyopia (Levi, 1994). It is widely acknowledged that a family history of strabismus greatly increases the risk of this being present in a child: if one parent has suffered from strabismus or amblyopia then the risk of a child being affected is 40% (Evans, 2002). This fact should be well known to optometrists who will also be aware of concerns over the adequacy of children’s vision screening in the UK (Thomson, 2002). An investigation of the role of heredity as a risk factor in different subtypes of strabismus found that heredity had the highest risk in accommodative strabismus (Ziakas et al., 2002), the type of strabismus which is most amenable to treatment in community optometric practice.

The inclusion of children as a group of patients for whom the NHS will fund primary eye care (Table 1) indicates an expectation that optometrists will provide eye care to this group. We therefore selected for Scenario 1 a description of a young child in an ‘at risk’ group, with the goal of determining the availability and willingness of primary eye care practices to provide GOS sight tests for such a case.

**Scenario 1: Methods** One hundred practices, selected as described above, were telephoned by the researcher (R.S.) acting as a member of the public who is concerned about her 12-month-old son. The information in Table 2 was obtained from any respondent who answered the phone. If during the enquiry further information was requested regarding the family history of strabismus, the respondent was advised that the mother (R.S.) had an ‘eye turn’ as a child.

The responses to the questions in Table 2 were recorded in a spreadsheet. The results were analysed for all respondents taken together and then after dividing the respondents into those with a London telephone number (0207 or 0208) or not. There were 14 practices with London telephone numbers, leaving 86 practices based outside London.

**Scenario 1: Results** The vast majority of the practices telephoned were in England (94), with four in Scotland, one in Wales and one in Northern Ireland. The mean age at which practices declared that they start examining children was 3.1 years (range <1–7 years, SD = 1.70). This was not significantly (t-test, $p = 0.24$) different in the London area (3.1 years, range 1.50–6 years, SD 1.14) compared with the rest of the country (3.1 years, range <1–7 years, SD 1.78).

In answer to question 2, ‘Should he have an eye test?’ there were three typical answers. Some practices simply said ‘no’ and did not advise a sight test elsewhere, some said ‘yes, at our practice’, and some said ‘yes, but at another establishment’ (typically, the Hospital Eye Service via a GP or Health Visitor).

Table 3 shows 76 practices (76%) responded that the child ‘Should have an eye test’. However, there was a difference in response that was location dependent, with 68 practices (79%) telephoned outside London suggesting the child ‘Should have an eye test’, compared to 57% (8/14) of practices within London. The difference between proportions in the London and non-London groups approached significance (chi-squared test, $p = 0.075$). This result should be interpreted with caution because of the small London sample. Of the 76 practices across the country that recommended an eye test, 61% (46 practices) stated that they would...
examine the child themselves and 39% (30 practices) recommended that the examination should be elsewhere. This result was very similar (chi-squared test, \( p = 0.90 \)) for the areas assessed, with 48% (41 practices) outside London and 36% (five practices) within London, offering to examine the child in their own practice.

In answer to the question ‘Will I be paying for the consultation?’, 98% of the practices who offered to provide eye care to a 1-year-old child responded that there would be no charge, with most stating that NHS sight tests for children aged under 16 were available at that practice. In fact, there was only one practice where the respondent reported that they would charge a fee, as the practice only offered private examinations. This practice was within the London area.

When practices did not recommend routine eye care for the 1-year-old child or were unable to provide an eye test at their practice, they were asked three further questions (Table 2). From question 4, the mean age at which the respondents from this subgroup of practices stated that they felt this child should have a sight test was 3.5 years (range 1.5–7 years, SD 1.30). This mean age was not significantly different for outside London telephone codes (3.4 years, range 1.5–7 years, SD 1.31) compared with London codes (3.6 years, range 2–6 years, SD 1.31) (\( t \)-test, \( p = 0.70 \)).

Fifty-four of the practices contacted were asked questions 5 and 6 (Table 2), of which 50 responded to both questions. Of these 50, 24% (12 practices) recommended that the child should be seen by the General Medical Practitioner and/or health visitor for further advice. There was no significant difference in the responses to this question between the London and outside-London practices (Figure 1). Interestingly, only one practice (4% of those based outside London replying to this question) recommended going straight to the Hospital Eye Service if an ‘eye turn’ was noticed in the child, compared with three practices in the London region. Only one practice recommended that the child should have a sight test from a specific community optometrist: this practice recommended asking for an appointment with a specific optometrist who visited their practice on a certain day.

### Table 2

<table>
<thead>
<tr>
<th>Eye test recommended ((n = 76))</th>
<th>Eye test offered at contacted practice</th>
<th>Eye test suggested elsewhere</th>
<th>Eye test not recommended ((n = 24))</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total sample ((n = 100))</td>
<td>46</td>
<td>30</td>
<td>24</td>
</tr>
<tr>
<td>Practices outside London ((n = 86))</td>
<td>48</td>
<td>31</td>
<td>21</td>
</tr>
<tr>
<td>Practices within London ((n = 14))</td>
<td>36</td>
<td>21</td>
<td>43</td>
</tr>
</tbody>
</table>

Values are expressed in percentage.

Figure 1. Responses to the question: “What should I do if I see his eye turning? Is there somebody you can recommend I may be able to contact/visit?” 50 practices responded to this question and the proportions quoted are of the number of these practices within each geographical area.

**Scenario 1: Discussion**

The average age at which practices across the country will carry out a first sight test on a child is 3.1 years. Fifteen per cent of practices telephoned would examine neonates aged from birth to 6 months, but it is worrying that 2% of practices would not carry out a sight test until the child is 7 years of age. Having explained the scenario above to the respondent, the majority (76%) of practices advised that the child should have an eye examination. These results show that most practices appreciate the need for early primary care for this category of children ‘at risk’ due to the presence of family history of strabismus. Approximately half of the practices telephoned were willing to carry out the sight test themselves. Table 1 shows ‘children under the age of 16’ are a category of patient eligible for a GOS sight test and it was noted above that the DoH takes the view that it is not permissible for optometrists to deny categories of patients the opportunity to receive a sight test in their practice. Yet our data indicate that 54% of practices do effectively exclude young children.

Early primary eye care in children is particularly important: vision plays a major role in a child’s sensory and motor development, therefore, any undetected visual or ocular anomalies are liable to impede normal visual development (Donaldson, 2002). The importance of early optometric care in children has been recognised...
by the profession for many years. The Directorate of Optometric Continuing Education & Training (DOCET) is a DoH special committee that oversees the management of government funds set aside for the provision of continuing education and training for all UK-registered optometrists. DOCET has periodically focused on paediatric optometry and a recent update (DOCET, 2006) publicised the launch of a new Paediatric Optometry Project. In this publication DOCET stressed that they consider training for optometrists in dealing with child patients and their visual problems to be a high priority. The objectives of the new project are to equip optometrists with the skills to examine a child patient, to increase the awareness of specific requirements for patients and to increase significantly the number of optometrists prepared to provide appropriate care to their child population.

The responses from London practitioners were generally similar to those of practitioners from other parts of the country. An exception is the proportion of practices who recommend that if a parent observes a turning eye in a 1-year-old child then they should be advised to go directly to the Hospital Eye Service. Two of the seven London practices that responded to this question suggested that the child should go straight to Moorfields Eye Hospital. One practice in the London region recommended a different hospital. Of the 43 practices that responded to this question outside the London region, only one practice recommended going to an eye hospital. It is possible that this discrepancy is related to the presence of Moorfields Eye Hospital in the London area. However, in view of the small London sample this conclusion is tentative.

Scenario 2: Patient aged 90 years with dementia

Scenario 2: Introduction The aim of Scenario 2 was to investigate the accessibility of a GOS sight test for an older person described as suffering from dementia. Dementia is a structurally caused permanent or progressive decline in several dimensions of intellectual function that interferes substantially with the person’s normal social or economic activity (Berkow, 1992). Well-known diseases that cause dementia include Alzheimer’s disease and Creutzfeldt-Jakob disease. Dementia affects individuals in different ways depending on the type and severity of the condition. The disease usually begins after the age of 60, although it can occur earlier in some cases.

Vision loss in older people due to natural ageing is a major concern in the healthcare professions. A recent review of vision screening in older people concluded that between 20% and 50% of older people have undetected reduced vision (Jessa et al., 2007). The majority of these people have correctable visual problems (refractive errors or cataract). Age-related changes also occur to structures such as the eyelids and cornea. All these changes not only cause a reduction in the expected quality of vision but also make examination of the eyes more difficult.

Patients with dementia not only suffer the general visual problems associated with ageing but also experience visual disturbances as a result of the damage to, or degeneration of, the brain. These patients have difficulty in perceiving what they see rather than how well or sharply they see it. Problems most commonly occur in perception of motion, depth, colour and contrast (Solomons, 2005).

For Scenario 2, practices were asked if they could examine a patient aged 90 years who suffers from dementia. If on questioning further information was required, the practice was advised that the patient has moderate dementia and lives with her daughter (R.S.). The practice was informed that the patient would be brought into the practice in a wheelchair, but was able to walk short distances if required.

The Disability Discrimination Act 1995 protects disabled people in the following areas: employment, access to goods, facilities and services, and in the management, buying or renting of land or property. Following changes to the Act in 2004, discrimination under the Act by the community optometrist can occur in one of two ways. First, by treating a disabled person less favourably, for a disability-related reason, than a person who is not disabled. The following could be considered to constitute less favourable treatment: refusing treatment, providing a worse standard of service or offering service on worse terms. The Disability Discrimination Act section 19(1a) also states that it is unlawful for a provider of services to refuse to provide ‘to the disabled person any service which he provides, or is prepared to provide, to members of the public’ (Office of Public Sector Information, 2006). The second cause of discrimination is failing to comply with the duty to make reasonable arrangements for the disabled person. Service providers are required to provide extra help or make changes to the way they provide services. Specifically, as from October 2004, all service providers need to make reasonable adjustment to physical features of the premises in order to overcome physical barriers that may prevent someone from using their service. We sought to investigate the extent to which optical practices meet their obligations under this Act.

Another aim of Scenario 2 was to establish the accessibility and/or awareness of domiciliary visits. In order for a domiciliary visit to be deemed necessary, the criteria in the GOS Terms of Service state that it is the practitioner’s responsibility to establish that a domiciliary visit is absolutely necessary (National Health Service (General Ophthalmic Service, 2006). However, the
professionals will not be expected to exercise any clinical judgement in deciding whether the condition is as disabling as the patient alleges (Hirji et al., 2001). The patient or carer will be required to certify that they have requested a domiciliary visit because the patient is unable to leave home unaccompanied.

**Scenario 2: Methods** The researcher (R.S.) telephoned another 100 practices (a different data set to that used in Scenario 1) acting this time as a member of the public who would like to arrange an eye examination for her mother. The person who answered the phone (respondent) was advised that the patient had dementia and lived with her daughter (R.S.). The questions in Table 4 were asked and results recorded in a spreadsheet. The results were analysed for all respondents together and then by dividing the respondents into those with or without a London telephone number.

**Scenario 2: Results** The vast majority of practices telephoned were in England (95), with four in Scotland, one in Wales and none in Northern Ireland. Of the 100 practices, 93% responded that it was possible to arrange an eye examination for the patient with dementia. At this point, the issues of physical access (e.g. wheelchair, stairs) had not yet been raised. There is no difference (chi-squared test, $p = 0.25$) in the responses for practices telephoned outside London ($n = 78$) when compared with practices within London ($n = 15$).

The 93 practices who responded ‘yes’ to question 1 were asked question 2, ‘Will she have to cope with stairs?’, and 27 said there were stairs. Additionally, of the seven practices who had said in response to question 1 that they would not see the patient, three had volunteered the information that this was because of steps. Therefore, a total of 31% (30/96) of practices have some form of stairs and/or steps, either to access the practice or within the practice to access some consulting rooms. This figure was not significantly different (chi-squared test, $p = 0.31$) for outside London (27/81, 33%) when compared with practices within London (3/15, 20%). Most of the practices with stairs or steps to some areas of the practice also had at least one consulting room on the ground floor. Altogether, 89% of practices responding ‘yes’ to question 1 have a consulting room at ground level, with no significant variation between the areas assessed. Furthermore, some of the practices with steps to the consulting room had lift, ramp or stair lift access. So, altogether 95% of practices responding ‘yes’ to question 1 could provide access to a consulting room for a patient who cannot cope with steps.

Only one practice, out of a total of five practices who responded ‘no’ to question 3, responded positively to question 4, and recommended a nearby practice with a downstairs consulting room.

Fifty responses were obtained in answer to question 5, ‘Do you know of an “optician” who may be able to make a home visit to examine the above patient?’ Approximately a third of these were a suggestion that was made without prompting by the respondent as an alternative to bringing the patient into the practice for a sight test. Half of those who responded could either arrange for a domiciliary visit themselves or recommend companies and/or optometrists who perform domiciliary visits. The difference between the proportions in the London and non-London groups was not statistically significant (chi-squared test, $p = 0.68$).

Figure 2 illustrates the percentage of practices responding to question 5 that perform domiciliary visits as opposed to recommending another organisation. Only 16% of those practices that recommended a

<table>
<thead>
<tr>
<th>Table 4. Questions asked in Scenario 2</th>
<th>Data</th>
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<tbody>
<tr>
<td><strong>Question</strong></td>
<td></td>
</tr>
<tr>
<td>1. I would like to book my mother in for an eye test. She is 90 years old and has dementia. Is it possible to arrange an appointment?</td>
<td>Yes/no</td>
</tr>
<tr>
<td>If answer to question 1 is ‘yes’, then proceed to question 2 If answer to question 1 is ‘no’, obtain reason for declining and then proceed to question 4</td>
<td></td>
</tr>
<tr>
<td>2. Will she have to cope with stairs?</td>
<td>Yes/no</td>
</tr>
<tr>
<td>For all those who are asked question 2, proceed to question 3</td>
<td></td>
</tr>
<tr>
<td>3. Do you have a room on the ground floor where she can be seen?</td>
<td>Yes/no</td>
</tr>
<tr>
<td>If answer to question 3 is ‘yes’, then proceed to question 5 If answer to question 3 is ‘no’, then proceed to question 4</td>
<td></td>
</tr>
<tr>
<td>4. Do you know of a practice that can accommodate her? If answer to question 4 is ‘yes’, then note down the practice details For all those who are asked question 4, proceed to question 5</td>
<td>Yes/no</td>
</tr>
<tr>
<td>5. Do you know of an ‘optician’ who may be able to visit her at home to examine her eyes? If answer to question 5 is ‘yes’, then note down the details &amp; finish If answer to question 5 is ‘no’, then proceed to question 6</td>
<td>Yes/no</td>
</tr>
<tr>
<td>6. Is there anyone I can speak to who may be able to give me this information?</td>
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</table>
domiciliary visit specifically mentioned they would only perform a domiciliary visit if the patient was housebound.

Scenario 2: Discussion Patients with dementia, particularly Alzheimer’s disease, are prone to certain visual problems (Armstrong and Syed, 1996; Mort, 2000). Hence we sought to investigate the willingness of practices to examine an older person with dementia. The majority (93%) of practices telephoned are willing to examine a patient with dementia, with no significant variation between the areas assessed. All practices that were willing to examine the patient informed the caller (R.S.) that it would be advisable if the patient were accompanied when she attended for the sight test, in case any assistance was required.

Seven per cent of the practices declined to offer an appointment at a stage in the questioning when all they knew was that the patient was aged 90 and had dementia. Presumably, an appointment was declined in most cases either because of the age of the patient or because of the presence of dementia, and it seems more likely that dementia was the reason. If so, this appears to be a contravention of the Disability Discrimination Act section 19(1a) stated above. The Disability Discrimination Act also discusses disability in relation to premises, which relates to the subsequent telephone questions regarding wheelchair and step-free access. The Disability Discrimination Act 1995 section 21(2) states that ‘Where a physical feature (for example, one arising from the design or construction of a building or the approach or access to premises) makes it impossible or unreasonably difficult for disabled persons to make use of such a service, it is the duty of the provider of that service to take such steps as it is “reasonable” to remove, alter, provide a means of avoiding, or provide a reasonable alternative to make the service available’ (Office of Public Sector Information, 2006). Only five practices from the 100 telephoned had stairs with no step-free access into a consulting room. Of the five, two practices performed domiciliary visits and the other three recommended contacting the local health authority for a list of practitioners who provide domiciliary visits. Whether offering domiciliary services constitutes a ‘reasonable’ alternative to making the service available is not known and Hirji et al. (2001) noted that it remains for the courts to establish a definition of ‘reasonable’ in particular cases.

Approximately half of the practices telephoned were asked question 5 (Table 4), of which half were able to organise a domiciliary visit or give contact details to obtain further information. Only 6% (three practices) of respondents to question 5 specifically mentioned that domiciliary visits were only possible if ‘the patient is housebound’.

General discussion

Primary eye care for children at an early age is an important provision, especially when there is a family history of strabismus (Evans, 2002). The inclusion of the under-16 age group as a category of patients eligible for GOS sight tests emphasises the need for primary care optometrists to provide paediatric eye care. In the UK, optometrists are the main providers of eye care to children during the school years, a period during which refractive errors or binocular vision anomalies quite often occur (Logan and Gilmartin, 2004). It is hoped that the recent launch of DOCET’s Paediatric Eyecare Project will lead to an increase in the proportion of optometrists who provide eye care to pre-school children. It would be interesting to carry out a follow-up telephone survey using a similar scenario 6 months after the launch of the DOCET project.

With the ageing population in the UK, our category of an older patient with dementia is likely to be an increasingly common presentation to the primary care optometrist. It is therefore reassuring that 93% of practices felt able to cope with such a patient. The majority of practices meet the requirements of the Disability Discrimination Act 1995. With reference to the NHS Terms of Service, practices need to be aware that domiciliary visits can only be made if the patient is substantially housebound and is unable to leave home unattended.

Exclusion of categories of patients

Fifty-four per cent of practices in our sample declined to provide GOS services to young children. As noted in the Introduction, the DoH has expressed the view that it is not permissible for practitioners to exclude categories of patients from GOS services (Hirji et al., 2001). We could not find any explicit statement to this effect in the GOS
regulations and we asked the DoH for the source of this view and asked whether, for example, they consider it permissible for practitioners to decline to examine pre-school children. Their reply cited section 13A(1) of the National Health Services (General Ophthalmic Services) Regulations 1986: ‘An eligible person who wishes to have his sight tested under general ophthalmic services may make an application to any contractor for his sight to be tested’. The next section (2) of the regulations says that this application should be on the form provided by the PCO; this is the sight test form that will be familiar to UK optometrists. The Department argues that ‘if a contractor were excluding a category of patient then that would mean eligible patients could not apply to any contractor’. This would seem to be an equivocal interpretation. It could equally well be argued that it is implicit in the concept of an application that there is the facility for a rejection of the application, regardless of whether the reason is because the patient belongs to a certain category. Furthermore, if the practitioner were always to exclude members of a certain category, then it would be sensible for the practice to inform the patient of this at the initial telephone enquiry, rather than requiring them to attend the practice, complete a sight test form and then be refused.

Another difficulty is the definition of a category. It is possible that by ‘category’ the DoH are referring to those groups of individuals who are entitled to GOS sight tests (e.g. those under 16 years of age), although the word category is not used in the GOS regulations. The authors believe that the term category, when used in the DoH’s response, has its more general everyday meaning. It is perhaps debatable whether a question about a specific 90-year-old patient with dementia would identify a response by practitioners to a category of patient. However, it does seem unequivocal that the question ‘at what age do you start testing children’ will identify practitioners who might exclude a category of young patients.

As with any equivocal interpretation of legislation, the validity and significance of the DoH interpretation of the regulations can only be established by case law and therefore remains uncertain. Other factors will also need to be considered, such as ethical guidelines and most importantly the welfare of the patient. It can be argued that the Department’s assertion that practitioners cannot exclude categories of patients conflicts with the first point of the code of conduct of the General Optical Council (2006a), ‘the practitioner should make the care of the patient their first and continuing concern’ and with the first principle stated in Code of Ethics and Guidance for Professional Conduct published by the College of Optometrists (2006), ‘the optometrist has a duty to place the welfare of his/her patients before all other considerations’ (College of Optometrists, 2006).

The key issue is whether the care and welfare of a patient are best served by a practitioner managing a patient who falls outside the limits of the practitioner’s clinical expertise. This issue is recognised by the College of Optometrists who also inform the profession; ‘practitioners should recognise their limitations and where necessary seek further advice or refer the patient elsewhere’ (College of Optometrists, 2002). For example, if optometrists know that their clinical skills and experience are not adequate for examining young children, then it is in the patient’s best interest for the practice receptionist to decline requests for an appointment from parents of children within this age group. This is confirmed by point 1.5 of a joint document issued by the Royal College of Ophthalmologists, College of Optometrists, and British Orthoptic Society (2002) which states: ‘All members of the ophthalmic team should be confident that they have the appropriate skills and expertise before managing any child. Any member of the ophthalmic team who does not spend a significant proportion of their time in the management of children is discouraged from participation in children’s eye care’.

This is also an issue (Dr M. Woodhouse, personal communication) for people with special needs (physical and intellectual disabilities) where there are simply not enough patients for it to be practical for every optometrist to have adequate skills, let alone the necessary experience, to provide eye care for these patients. Yet optometric anomalies are prevalent (Woodhouse, 1998) in people with special needs (e.g., Down’s syndrome) and it is important that this group of the population receive regular eye examinations (Woodhouse et al., 2003).

It is important to note that our research was based on responses received during a telephone conversation during which full information about the patient scenario was provided. If however an appointment was made for either of the above scenarios without any detailed information being provided, the practice would only be able to make a decision as to whether to test the sight of the person upon the patient’s arrival.

Of the 200 practices that we contacted in the survey, in both scenarios there was one respondent from Wales and four from Scotland. It would be interesting to conduct further studies in future to look at the impact of the various eye care schemes that have recently been set up in both Scotland and Wales. Based on the Opticians’ Register 2005 (General Optical Council, 2005b), the proportion of UK practitioners practising in Wales (4%) and Scotland (9%) is a little higher than the proportions of randomly selected respondents from these regions.

It might also have been instructive to investigate whether there was a bias in responses depending on the type of practice (independent, small multiple, large multiple). Although these analyses were not carried out.

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in this study, this is a topic that we plan to return to in future work.

In summary, this research has highlighted an important issue for primary eye care practitioners in the UK. Practitioners who lack the skills, experience or aptitude to deal with a certain category of patient are faced with a dilemma. They could retrain to gain the necessary skills, and it is hoped that the recent DOCET project will result in increased interest in providing eye care to pre-school children. But in view of the infrequent attendance of this very young age group (Guggenheim and Farbrother, 2005) and of other categories of patient (e.g. people with intellectual disabilities) in some optical practices, it may be impossible for all practitioners to maintain sufficient levels of experience to meet the professional guidelines. In these cases it will be in the patients’ best interests for the practice reception staff to direct telephone enquiries to another practice which can provide the necessary care. The overriding ethic to place the welfare of the patient above other considerations may compel practitioners to make this decision, although it may be contrary to the current interpretation of the GOS Terms of Service by the DoH. It is hoped that this article will encourage a debate on this issue and will lead to departmental advice that is commensurate with the maintenance of high ethical standards.

Acknowledgements
The authors are members of EyeNET, the primary care eye research network supported by the DoH. The present work was funded in part by EyeNET, and also by the Association of Optometrists, Royal National Institute for the Blind (RNIB), Central (LOC) Fund, the American Academy of Optometry (British Chapter) and the College of Optometrists.

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