BIOS | BRITISH AND IRISH ORTHOPTIC SOCIETY

Change NHS: Help build a health service fit for the future

Department for Health & Social Care consultation on a new 10 Year Health Plan for England

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

Q1. What does your organisation want to see included in the 10-Year Health Plan and why?

We would like to see a 10-year plan that fully recognises Allied Health Professionals (AHPs), including orthoptists, as an essential part of the clinical workforce, alongside doctors and nurses. AHPs make up one third of the workforce and provide a huge range of services, many of which are essential for getting people back into employment and improving general health. In many Trusts the skills of AHPs are neither recognised nor fully utilised as there is no clear leadership or a voice at board level. Symptomatic of this is that a Medical Director and a Director of Nursing are mandated posts on every Trust board. We believe a Director of AHPs in every Trust would help to ensure true representation of the entire clinical workforce and improve use of the cost-effective and creative AHP workforce as well as further enable multidisciplinary working.

Recognition of the importance of and investment in the delivery of modern, efficient eye care should be a major priority. To ensure a population is able to access education, employment and fulfilled independent lives eye health is paramount. People with visual impairment are less likely to access higher education, more likely to suffer mental illness and less likely to be employed than their sighted peers.

Orthoptists are autonomous eye care professionals leading, supporting and contributing to a number of all-age eye care pathways in Secondary and Community settings. They are therefore well placed to address some issues facing the Visually impaired community.

For example here are three of the many ways orthoptists lead and contribute but not all Trusts or Local Authorities invest in these cost effective services:

- Orthoptic led vision screening in schools of 4-5 year olds ensures children with amblyopia (lazy eye) are identified early enough to respond to treatment and prevent life long problems and risks.
- Orthoptists working with stroke patients are able to train patients to manage impairments to vision (visual field loss, double vision etc) following stroke which in turn supports their mobility and subsequent recovery and return to home and a normal life.
- Orthoptists delivering Low Vision services enable visually impaired children to access mainstream education and adults to access the workplace.

The new 10 year plan must recognise this and support orthoptists to fully deliver on their potential.

Q2. What does your organisation see as the biggest challenges and enablers to move more care from hospitals to communities?

AHPs are ideally placed to provide greater care within the community, closer to where people live. One of the barriers to this role is the focus on doctors and nurses, reflected in the wording within this consultation, at the expense of other healthcare professionals. Establishing AHP Director positions within ICSs, on par with those for doctors and nurses, would ensure that the perspectives of allied health professionals are taken on board in the planning of services.

In eye care, the specific challenge is the focus on ophthalmology, at the expense of the recognition of orthoptists as autonomous practitioners. One major step towards this would be the granting of independent prescribing responsibilities to orthoptists. For example, Advanced orthoptists delivering community glaucoma services assess and manage patients in accessible sites close to home but are unable to prescribe the eye drops needed for this treatment. Therefore, despite the orthoptists having the relevant expertise and knowledge, they have to request an ophthalmologist or the patient's GP to prescribe, which is time consuming for the doctor and causes unnecessary delay for the patient.

We would also like to see a recognition and support for the work already done by orthoptists in the community, providing eye care services. For example, in some local authorities, services such as glaucoma monitoring, low vision services, screening and special school paediatric services are already provided by orthoptists via the Community Eye Service. Many of these services go unrecognised but provide a vital role in ensuring that safe care is provided to patients closer to their homes.

Greater access to eye care services, such as glaucoma or stroke rehabilitation, can help people with visual impairment in living independently and remain in their homes. For example, older

people suffering from diplopia, or double vision, are at greater risk of falls around the home. Early detection of these problems through orthoptic assessment helps them to understand their visual difficulties and better manage them. Furthermore, these services need to be located within the community in Health Centres and clinics with access for the disabled, close to where people live, rather than in locations such as shopping centres that can be difficult to access, particularly for those with reduced or impaired vision.

With an aging population and improving life expectancy for children born with physical disabilities the projected numbers of people with visual impairment is likely to grow over the next ten years. To ensure these people are able to live independently it will be essential to invest in these eye care pathways and orthoptists and orthoptic workers offer efficient and cost-effective workforce solutions.

Q3. What does your organisation see as the biggest challenges and enablers to making better use of technology in health and care?

The biggest challenges we have identified to the shift to making better use of technology in health and care stems from the focus on this being led by the provider companies, rather than being genuinely clinician-led. This results in systems that are not tailored to the actual requirements of the clinicians. This also potentially leads to funds shifting towards consultants and IT professionals that should be being sued to fund urgently needed clinicians.

The implementation of systems, such as electronic patient records (EPR) has need extremely inconsistent, with different systems being introduced at hugely varying rates across the country. This leads to inefficient information sharing, often we are still having to rely on clinicians having to write and send letters rather than have shared access to records, in the case of sharing information with Optometrists in Primary Care this may still not even be by email. There is also an issue of the variable quality of the record dependant on the system procured by individual Trusts. Many clinicians are still spending a great deal of time handwriting patient notes and then uploading them onto an EPR that is not able to properly electronically record their clinical findings. Many services are still using paper records only.

A further barrier is restrictive IT systems meaning that clinicians are unable to access potentially beneficial software while using computers on a Trust network as the network is unable to support the software. This is also a barrier to information sharing if a neighbouring organisation is using the software, for example when it is necessary for a community or primary care service to share retinal images with a secondary care service.

Q4. What does your organisation see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health?

The third shift, towards spotting illness earlier, requires a greater focus on the screening of vision at points throughout the life span.

The UK National Screening Committee recommends orthoptic-led vision screening of all children of reception age. This is primarily aimed at identifying amblyopia, a condition affecting

one in ten children that causes reduced vision. The provision of services in England is currently the responsibility of local authorities, with many providing services that do not meet the recommended specification, and an increasing amount offering no screening service at all, affecting an estimated 75,000 children every year. A mandatory national orthoptic-led vision service, as is currently provided in Scotland, Wales and Northern Ireland, would ensure that children have the best chance to being diagnosed and treated for reduced vision at an age when this is still effective, increasing their ability to access education and live a full life, and preventing potential visual impairment in later life.

Similarly, orthoptists should be involved as a key part of multi-disciplinary teams across a number of areas, to ensure that vision defects are identified and treated. There should be increased access to multi-professional eye care for children and adults with learning disabilities, as it is recognised that this vulnerable group of individuals have difficulty accessing primary eye care services. This is particularly important as they have a greater incidence of vision problems, for example SeeAbility found that children with learning disabilities are 28 times more likely to have a serious sight problem. Orthoptists are specialists in assessing vision in children and those with communication difficulties, and therefore should recognised as a core part of these teams.

Vision and low vision rehabilitation should be given the same priority and funding as physical rehabilitation as we know that this can impact on mental health and quality of life. Patients in rehabilitation, following a stroke or serious fall, benefit directly through understanding their visual deficit and being given access to treatments and management techniques. It also assists with their wider rehabilitation as other professionals can consider and use this knowledge when planning and carrying out their own plans.

Q5. Please use this box to share specific policy ideas for change. Please include how you would prioritise these and what timeframe you would expect to see this delivered in, for example:

- **Quick to do, that is in the next year or so**
- **In the middle, that is in the next 2 to 5 years**
- **Long term change, that will take more than 5 years**

The changes that would be quickest and have the most immediate benefit for orthoptists and orthoptic services would be giving orthoptists independent prescribing responsibilities and the ability to prescribe spectacles within hospital eye services. The first of these can be implemented by the Secretary of State under the powers given to them by the Medicines and Medical Devices Act (2021), to extend prescribing responsibilities to new professions where it is safe to do so. Similarly, the right to prescribe spectacles could be implemented by Ministers, subject to consultation.

These changes would both have an immediate effect in allowing patients to receive the appropriate medication or glasses correction in a timely fashion and release more time to medical staff who otherwise must sign off the prescriptions, which in many cases means a duplicated and unnecessary appointment further lengthening waiting lists.

Another quick change would be the mandating of child vision screening ensuring that every child in Reception Class has access to a quick, safe vision screen delivered by a trained Vision Screener led by a qualified Orthoptist. This would include a safe and appropriate multi-disciplinary management pathway for those children identified as having a vision deficit.

In the medium to long term we would hope to see standardised truly clinically led IT solutions investment should be directed to procurement of the best most appropriate hard and software and supporting clinical services to be involved in planning and implementation and not additional ‘IT champions’ who are neither IT nor clinical experts. Resources should be given to clinical services to allow release of staff to engage with the IT experts.

Also, within the next 2-5 years we would want to see mandated AHP leadership within all Trusts, we would hope to see Orthoptic services managed with in AHP directorates rather than subsumed into Ophthalmology or Childrens services which are always nurse or doctor led and where creative orthoptic solutions to problems in service delivery are not always understood.

In the long term we would expect that Orthoptics is recognised as an autonomous highly trained profession who can deliver a range of cost effective and appropriate eye-care across a wide range of all age eye care pathways in a number of settings. Orthoptic services led by highly qualified, appropriately renumerated, orthoptists free to manage budgets and develop services would contribute to cost-effective, safe, efficient and timely eye-care pathways.

Generally, over the next 10 years we would want to see an NHS that does not use private services, is properly funded, maintains efficient information sharing with colleagues in primary and social care and has clear shared pathways with voluntary and third sector organisations