Association of British Dispensing Opticians

The Association of British Dispensing Opticians (ABDO) is the professional body for dispensing opticians delivering clinical eyecare across the UK and worldwide. We represent over 6000 members working in both primary and secondary healthcare settings. Dispensing opticians are healthcare professionals registered with the statutory regulator for the optical professions, the General Optical Council.

In responding to the consultation ABDO have sought views from across its membership and most importantly reached out to DOs who have been involved in delivery of the service throughout the proof of concept. We have also listened to the views of sector colleagues, third sector organisations such as SeeAbility, the two colleges, and other interested parties. Where possible we have asked our members to reflect the views of the children they have cared for within the service whilst giving their feedback.

Special Schools Eye Care Service- Consultation response.

1. **Creation of eye care teams.**

   We recognise that it would not be feasible for NHS England to be involved in the ongoing creation of the eye care teams as the service rolls out nationally. This would be best left to local arrangements by the providers stepping forward to offer the service at ICB level.

   However, we do not understand (or agree) that in the move to simplify the creation of the teams the vital role of the dispensing optician in the service has been overlooked, become "optional" and removed from the suggested specification.

   Dispensing opticians are the only registered professionals with the key specialist skills to interpret the optometrist's prescriptions and apply this to the specific circumstances of the patient. Perhaps nowhere is this more vital than in paediatric dispensing and in this

service the pairing of the optometrist with the dispensing optician was seen as vital from the outset.
The role of the dispensing optician in this service is to undertake the prescription analysis, look at the patients specific needs (working distance, task analysis etc), help with appropriate frame choice (including allowing for special frame adaptions and special facial characteristics), lens choice (which includes both visual and safety factors) ensure correct fitting and adaption/adjustment of frames on collection of spectacles, undertake adjustments and repairs on a "walk-in" basis for other children at the schools, as well as a 6-8 week review with the child to ensure their visual and comfort needs were being met.

Feedback we have obtained from eye care teams working in these settings is that the dispensing optician is "often the busiest professional in the team" supporting the efficient completion of the sight testing process and communicating those results to patients, parents, teachers and support workers.

By removing the mandate for a registered dispensing optician to be part of the eye care team NHS England have stated that they wish to be "less prescriptive" however this runs a high risk of some providers utilising unqualified support staff who cannot either be expected to offer the same expertise as a Level 6 qualified DO; nor be adequately supervised by an optometrist who is fully occupied testing these children in often quite challenging circumstance in comparison to the High Street sight testing model.
Dispensing to children under 16 years of age is a regulated function, so if a dispensing optician is not part of the service the optometrist has to perform all of the dispensing duties as legally, they cannot be undertaken by an unregulated member of the team. From a delivery perspective this will require a significant amount of optometry time or risk a reduction in the standard of the dispensing element of the service which in turn leads to worse patient outcomes.

The work undertaken in Special Schools dates back many years to a 2013 Dept of Health funded innovation programme and has progressed through to the most recent proof of concept- all involving the two registrant optical professionals working together to produce the best outcomes for patients. All this work has been endorsed over the previous years by professional bodies, Public Health England, Clinical Council for Eye Health Commissioning etc. This reassures us and the service users that this model of care is established and fit for purpose, and we have seen nothing in the feedback within the engagement documents to support making this substantive change.

ABDO believe that there are real risks to the visual and longer-term outcomes including socialisation and access to education, for these children by allowing this change in the make-up of the eye care teams and would urge NHS England to recognise the unique setting and circumstances of this service and the need for the highest clinical standards in its delivery.

We do also have concerns regarding the "tendering" of this service. Many of the excellent teams already working delivering care in these schools may well be put off applying to

continue delivery by what they may perceive as a complex and burdensome tendering process. We would ask instead that NHS England and local commissioners consider allowing local providers who meet the criteria to express an interest to supply the service to schools (in particular schools were they have already have an established relationship) and are then supported to make arrangements for provision.

2.Provision of equipment

ABDO would support the suggested changes and feedback from providers that we have received is that it is most unusual to have to store any equipment at the schools beyond access to a filing cabinet to store some paperwork.

It would appear that the original equipment list was felt to be too prescriptive and therefore we would suggest a list of "suggested equipment" to meet the clinical requirement of the service and the professional guidelines of both the College of Optometrists in relation to sight testing, and Association of British Dispensing Opticians in relation to paediatric dispensing.

We would hope that provision can be made either via "start up funding" or an agreed fee process which will allow providers to obtain the equipment required to deliver this service (including specialist dispensing equipment such as facial rules, head callipers, frame measurement equipment etc) and equipment is not seen as a barrier to providers coming forward.

3.Professional requirements and training

ABDO would not recommend the revised approach to professional requirement and training based on the experience within the service to date.

There is no indication that in isolation the Oliver McGowan training for optometrists, dispensing opticians, or non-clinical support staff would cover the requirements of the specialist skills for the delivery of this service in the school setting for this cohort of patients We note that it does not cover eyecare, SEND nor the more general work of special schools.

Feedback we have received from the clinical teams working in schools is very clear- this is not similar to working within a High Street setting and that the initial Special Schools training they received, including familiarisation visits to the school, were vital to them in being able to develop and offer the appropriate level of care for that specific setting.

We agree that all clinical staff (i.e. registrants) should complete safeguarding training and this should extend to any non-clinical support staff that are in attendance.

Looking through the suggested changes it would appear that it will be possible to offer this service without any prior experience of working with this cohort of children nor in the specialist setting of a special school.

Whilst recognizing the importance of getting providers on board in the least burdensome manner, we would ask NHSE to consider amending this oversight by including requirements for addition training and familiarisation/mentoring visits to exist services and schools.

4.Consent to sight testing

ABDO do not agree that a move to an "opt-in" model will best serve the needs of this cohort, nor do we recognize that in the existing service the parents/carer's voice was lost with decisions being taken without their involvement. We understand that there was only one case raised as a concern throughout the whole of the proof of concept and it seem unreasonable to cite this as a factor in comparison to the many thousands of tests that were undertaken without concern.

We have received particularly strong feedback on this issue, and we are in agreement that every effort should be made to obtain consent.

However, parents require a multitude of ways to give consent and often need support to understand the value that the sight testing and dispensing service at the school could add above and beyond the High Street offer. The opportunity to show the value that the service brings to a child is most often after they have engaged with the service, so parents who have never opted-in never can experience the benefits the service can bring to their child.

On balance of risk our view is that a move to an opt-in service would leave an increased number of children not having equitable access to the service. Data already shows that parents do not engage with the NHS sight testing service on the High St whereby they are arguably "opted-in" as an NHS service for all children, so to move the Special Schools service to an equivalent position seems counterproductive.

Members fed back that the schools need to be engaged to actively speak to parents at the child's annual reviews, and they shared that they are often contacting parents/carers to obtain previous eye care history so there is no reason why parents cannot be engaged in the process. All of our members would wish for parents and carers to contribute to and support the testing and dispensing process.

5.Selection of glasses where required

Overall, we disagree with the suggested revised process- money should not be changing hands in the school environment to allow those parents/carers who can afford it purchase the most appropriate eyewear whilst others cannot.

The premise of this service accepted there was a clear clinical need for these children to be supported in access to the most appropriate frames and lenses, dispensed in an environment

where the child could be encouraged, along with the parents, to be involved in the process of suitable frame and lens selection.

Many of our respondents pointed out that these frames are not available on the High St and that the dispensing process outside of the school setting was the most stressful part of the whole process- they were delighted this could be completed by an expert in the school who had access to a wide range of suitable frames

Therefore, by removing the barriers for children to receive spectacles within the schools it has ensured that the children's exceptional eyecare needs can be met by a registrant dispensing optician.

We would encourage DHSC and NHS England to utilise the expertise of the OFNC to find an equitable funding process for these children to receive the best possible visual outcomes.

6.Engagement with the school community

Disappointingly we understand that the evaluation carried out in the autumn of 2022 did not involve any actual visits to the service however the feedback demonstrates a pathway that is working exceptionally well from the perspective of parents, children, clinicians and schools.

From an operational standpoint service providers do not recognise the "demands on schools" pointing out that many other services visit the schools such as SALT teams, physio's, hairdressers, vaccination teams etc and do not understand why an "eye care team should be treated differently.

We are particularly disappointed that NHSE is not intending to continue with "mandating a specific process for familiarisation days" which effectively could mean these are lost to the service going forward. The thought that a newly formed eye care team could arrive at a school having had no previous engagement with them seems to counter all the earlier points regarding "help ensure that the service runs smoothly from an operational perspective".

The relationship between the eye care tam and the school is key to its success and we remain unsure what "more engagement and clear planning" will add in place of familiarisation days for the schools, the children and the teams.

Again we would ask DHSC & NHSE to look at their own feedback and evaluations and review their stance on this issue.

7.Avoidance of potential over-treatment

We are not sure what evidence exists of children being "potentially over-treated" however do agree that the same approach to entitlement that exists on the High St should be applied where possible. Most of the eye care teams members we engaged with speak to parents/carers before the sight test takes place to ensure previous eye care history is obtained so this was not felt to be a problem within the service.

8.Cost of frames and parental / carer co-payment

Please refer to our response to question 5.

ABDOs view is that co-payment should be a last resort, only in exceptional circumstances and we hope that with the support of the OFNC a funding model can be agreed that meets the needs of these children.

In regard to the provision of second pairs and repairs we received a great deal of feedback. Many spoke of children who regularly damaged their glasses or had them damaged by other children within the classrooms and they commented "the process of requesting authorisation adds to the time required to order replacements. By being able to fix jobs on the day when we are there is an important part of the service" This respondent also added "If glasses are dispensed in the community the eyecare team may not have the relevant parts to fix them"

Another respondent said "Supplying special needs children with only one pair of specs is awful-some children could be without specs most of the time whilst they are being replaced. If they have two pairs at least the school can keep one pair safe".

A further response stated "Both teams I work with are not affiliated to a primary care optical practice. The eyecare teams were created purely for the purpose of SSECS. We are currently supplying all spectacles at voucher value. We currently do not have the provision to take payments! We lose money on some dispensing to ensure the child is provided with the most appropriate spectacles. The environment at school and the cohort of children makes trivex the lens material of choice but the cost of this is vastly more expensive than CR39. Initially we could dispense what was most appropriate for the child, so this was not a problem".

The alignment with the GOS principles in April 2023 always caused concerns, with one respondent sharing that they had regularly sort support from outside of the service to cover unmet costs for repairs and dispensing of specialist frames such as Tomato frames where the vouchers did not even cover the cost price of the spectacles.

ABDO is concerned that the innovation in the original proof of concept that allowed the patient needs to be the overarching principle in the supply of spectacles is now lost and this is disappointing to us and our members. The impact this innovative approach had on the quality of spectacles to the children in the service cannot be underestimated and we believe supplying the right fitting, quality spectacles the first time around will save money in the longer term.

We also support the position that supply of second pairs should be down to the clinical judgement of the dispensing optician/optometrist based on the child's individual needs and the assessment of the risk of loss/damage in their case not based on previous breakages.

9.Production of an eye health outcome report

The production of an outcome report beyond a copy of the prescription is vital within this service and should form part of their wider healthcare plan.

There are concerns that the present documentation is "to technical in places" for the parents/careres to understand and not relevant. There was also feedback that information is unnecessarily duplicated within the report and that teachers "rarely looked beyond the first page".

We therefore suggest that a re-draft may be welcomed by service users.

10.Please tell us more about the capacity in which you are providing this feedback

☐A school who is currently in receipt of the proof-of-concept

☐A school who is not currently receiving the service

☐Parent/Carer

☐Patient/Service User

☒Profession

☐Voluntary Sector

☐ICB/Commissioner

☐Prefer not to say