

**Final Report**

**COMPREHENSIVE REVIEW  
OF THE  
ORTHOPTIC WORKFORCE**

**REPORT OF THE  
PROJECT GROUP**

*February 2003*

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## **EXECUTIVE SUMMARY**

In September 2001, the DHSSPS commenced a series of uni-professional workforce reviews, which, over the period of one year, would cover the main clinical professions within the HPSS. There were a number of drivers behind the initiative and these included, the publication of the Hayes Report on the future of Acute Hospital Services and the DHSSPS consultation document 'The Employer of Choice'. Both documents highlighted the urgent need to put in place structures that will support workforce planning within and across all of the HPSS Professions. While it was determined that the initiatives, at this stage, would be taken forward on a uni-professional basis, the information and recommendations from this work would provide an important baseline in terms of developing workforce planning within HPSS across service sectors and professions.

### **Introduction**

The document presented sets out a comprehensive review of the HPSS Orthoptic profession. The review was undertaken during the period July-October 2002 and was co-ordinated by a Project Group, which comprised of representatives of the DHSSPS, providers, education, commissioners and staff side. The content of the report includes background details (including terms of reference), the project methodology, and a detailed profile of the current Orthoptic workforce, a projection of the supply and demand for Orthoptics within the HPSS workforce over the 5-year period 2003-2007 and recommendations to address issues arising from the review.

### **Background**

The principal focus of the review was to provide the DHSSPS and service providers and commissioners with information concerning recruitment and retention issues and projection of supply and demand within the Orthoptic profession. This information is vital to assist the Department in developing strategies that will ensure that the correct numbers of professionals are trained, in place and working effectively to offer the maximum benefit to patients and clients.

In considering the above, it is also important to review the current health policy context for the delivery of health and social care services in the future. A number of strategic documents have been reviewed and highlight the focus now being given to the delivery of high quality accessible care, with the development of the HPSS workforce being key to achieving this.

## **Terms of Reference**

1. Provide a profile of the current Orthoptic workforce in Northern Ireland, including:
  - Numbers employed, specialism in which employed, grading distribution age and gender balance.
  - Working conditions and patterns, grading and distribution.
  - Continuing professional development opportunities.
  
2. Provide an analysis of current and future recruitment and retention issues, including:
  - Remuneration
  - Career development and specialisation
  - Career breaks / leaving the profession
  - Working arrangements
  
3. Provide a prediction of the future supply of Orthoptics over the next 5- years within the workforce and demand, including:
  - Number of Orthoptics required meeting service demands
  - Specialism distribution

This review will focus on providing a qualitative report and was not required to examine economic issues or carry out detailed feasibility studies.

## **Methodology**

The following methodology was employed:

- Audit of current workforce identifying the staffing profile and characteristics. This baseline information was primarily gathered from existing information held within the Department and at Trust level on the Human Resource Management Information Systems, and supplemented as possible by the respective professional bodies.
  
- Background research conducted to identify future and current trends impacting upon the staff and involved a keyword and heading search of relevant professional databases; policy document review; a review of Trust and commissioner strategies to identify proposed service developments or changes and a review of benchmark data sources.

- Consultation with stakeholders involving extensive consultation, through 8 key informant interviews and 4 focus groups.
- Analysis of data gathered to develop a workforce model to aid the prediction of supply and demand of the workforce over the period of 2003 - 2007.
- Written survey of 2 University of Liverpool graduates (2001) now residing in NI.

## **Key findings of the review – supply and demand issues**

### *Supply Issues*

#### *Current Staffing Profile*

- The Orthoptic workforce represents a total headcount of 30 in Northern Ireland (June 2002).
- The ratio of headcount to whole time equivalent for this work force is 1.2:1.
- 93% of the workforce is female.
- The age profile of the Orthoptic workforce shows that 60 is the ‘eligible’ age for retirement within the general Orthoptic profession.
- The data indicates that 65% of the workforce is under 40 years of age and 17.5% are over 55 years of age and potentially due to retire within the next 5-10 years.
- The grade breakdown of Orthoptics within Northern Ireland identifies that 55% of the workforce are at Senior I grade and there are no basic grade orthoptists.
- The total number of current vacancies within this profession was identified as 1, which equates to 3.4% of the workforce.

#### *Recruitment and Retention*

- Recruitment of new graduates is mainly from Sheffield and Liverpool University as there is no training base within Northern Ireland however there are British Orthoptic Society approved trained mentors already established within some Trusts.

- Final year students expressed a strong desire to take up employment in the NIHPSS but indicated there were poor job opportunities.
- The majority of managers have not recruited Orthoptists to the NIHPSS within the last 3 years.
- Staff requests are increasing for work-life balance practices and it is estimated that currently this accounts for a loss of 1 % of the Orthoptic workforce per annum and the trend for requests are likely to increase. However due to the small numbers and therefore the lack of flexibility within the Orthoptic Workforce, managers are experiencing difficulty to approve requests and deliver the clinical service required.

### ***Career Progression***

- Lack of career opportunities and progression is a significant factor in demotivating the work force. There is a limited career path at senior level with often the only available promotional route into management, which has very limited opportunities.
- There are no basic grade posts within the HPSS Orthoptic workforce (June 2002). In the main respondents reasons for the lack of basic post was due to the inability of often single handed Orthoptists to provide adequate supervision.
- The majority of Orthoptic posts are at a Senior I level.

### ***Lifelong Learning***

- Difficulties are encountered in ensuring continual Professional Development for post-graduate staff both from a time and funding prospective.
- There are current issues around the need for a change in clinical placement system and a requirement for Northern Ireland Trusts to become more widely involved in accepting clinical placements.

### ***Under representation***

- There is a lack of leadership representation at all organisational levels for the profession, which correspondingly means a lack of inclusion in the decision and communication process.

### **Demand Issues**

### ***Skill Mix/Workforce Review***

- A significant amount of Orthoptics time can be spent on administrative and clerical tasks.
- All managerial posts have a dual clinical role this limits the ability for managers to attend decision making business meetings and allocate time to the preparation and development of business plans.

### ***Operational difficulties***

- The small number of Orthoptists in each Trust reduces their ability to operate flexible services.
- An increase in awareness of Patient Charter rights, access to services, increasing expectation and complaints systems causes pressure on the operational service delivery.
- An ageing growing population with compound clinical complications in old age require more time for clinical evaluation and treatment. Increased dependency of patients, increased referral activity patterns are causing pressure on the clinical service.

### **Projected Supply and Demand Conclusions**

Conclusions were drawn and assumptions made concerning the future profile of the workforce and supply and demand projections have been detailed in Section 5 of this report. They have been developed into a workforce model to predict the requirement of the Orthoptic workforce over the period 2003 - 2007.

All data presented has been gathered from discussions with the project group, key informant interviews, HPSS Project Support Analysis statistics and current business cases.

### **Supply Conclusions**

It is difficult to estimate the potential supply of Orthoptists for the HPSS workforce given that training takes place at two English Universities and not within the Northern Ireland context. This combined with the small numbers (30 headcount) renders Orthoptics to a vulnerable position when changes occur within the NIHPSS workforce. It has already been identified (source HRMS) that over the 5-year period there are potentially 5 retirements due to age and statistics suggest a possible additional retirement due to incapacity. The worse case scenario this suggests a total of 6 leavers, which equates to 20% of the total workforce over the next 5 years. There is at present no evidence of succession planning in place to cope with this loss.

Due to the small numbers in the predominantly female workforce (93%) it is difficult for managers to respond positively to life work balance requests and at the same time maintain the clinical service. Temporary cover is practically nonexistent. Managers are in the pressurised position of dual-role of both clinician and manager.

In conclusion, based on the above analysis and assumptions there is not a readily identifiable supply of Orthoptists to the NIHPSS. The only potential supply sources appears to be graduates leaving English Universities who have NI addresses that wish to return to the region, attracting non – Northern Ireland address graduates and or recruiting established Orthoptists from outside Northern Ireland.

### **Demand Conclusions**

The demand for Orthoptic professionals has been presented at three Category levels:

**Category 1:** *Agreed policy context which is resource approved.* This refers to capital and developments that have been agreed within the current HPSS policy framework with resources identified and approved over the course of the 5-year workforce plan. This includes, additional posts within the Cancer Centre and Cancer Units, Regional Brain Injury Unit and as a result of funding under Priorities for Action.

**Category 2:** *Future policy context that may potentially attract investment.* This refers to service developments that have been identified via key informant interviews and the Project Group that potentially may be supported over the next 5 years although resources have yet to be identified. Areas included are additional investment in multi-disciplinary support services in the Community Care Review. Also, further support for posts in the areas of brain injury (community infrastructure), addressing resources for continuing professional development, the role played in local Health and Social Care Groups, advanced practitioner and consultant roles meeting the requirements of the working time directive would also be included under this heading.

**Category 3:** *Areas of unmet need and current demand identified via the key informant interviews and the Project Group that cannot be met within existing resources.* It is acknowledged that there is no policy context or resource identified to meet the demand areas identified. Some of the clinical services included in the Category are additional support for paediatric services, stroke patients, rehabilitation, elderly care, primary screening, visual fields and special needs services.

For the initial purposes of this workforce plan a combination of Categories 1 + 2 has been adopted. These categories include agreed and resourced capital and

service plans with identified workforce requirements and those that are likely to be resourced within the 5-year plan. The following table illustrates the workforce requirements.

**Table: Summary table of Categories 1&2 over the 5-year plan in WTE**

Workforce requirements in WTE	2003	2004	2005	2006	2007	Total
<i>Category One (capital &amp; service requirements, that have resources )</i>	-	-	-	-	-	-
<i>Category Two (future policy context that may attract investment within the 5-year plan))</i>	2.7	8.2	5	3	1	19.9
<b>Categories 1&amp;2</b>	<b>2.7</b>	<b>8.2</b>	<b>5</b>	<b>3</b>	<b>1</b>	<b>19.9</b>

Demand Category 3 has now been explored in depth in Chapter 5 of the report.

### **Supply v Demand Conclusions**

The figures identified by the Project Group should be taken as a first attempt and a baseline, which will require in-depth discussion and challenge to refine and produce the most accurate statistics.

## **RECOMMENDATIONS**

The timescale for the implementation of the key recommendations outlined below is twelve months to coincide with the follow up review:

### **Workforce Planning**

- Now that the workforce planning process is established it is recommended that the Project Board should be retained to review supply and demand on an ongoing basis. It should utilise the information gathered in the review building and expanding on it taking into account such factors as the impact on the workforce of the role extension, sub-specialisation, capital plans and service development business cases.
- The Project Board should ensure that there is a consistent and targeted approach to gathering relevant supply and demand data and should include a review of current IT capabilities and manpower recording processes.
- Trusts should be alerted to the forecast indicating the potential retirements of 5 Orthoptists from the NIHPSS within the 5-year plan. This should be further investigated by Trusts with an Orthoptic service collaboratively and a worse case scenario position should be identified and contingency plans explored and implemented regionally to cope with anticipated loss from the workforce.
- The Orthoptic profession should establish a Regional Orthoptic Strategy taking into account the information gathered in the Workforce Planning Review. As part of the strategic planning process Orthoptists should identify their core business and explore the interfaces and related roles with the professions of optometry and ophthalmology. This activity should include all the key stakeholders and take into consideration both the existing service delivery and that of future services.

### **Recruitment & Retention**

- All employers should put in place policies to incorporate planned induction, consolidation and mentorship programmes for all new staff and review the effectiveness of these in a quantitative and qualitative manner.
- Employers and the profession should put in place a consistent approach to the implementation of work-life balance policies and procedures and this should be factored into workforce planning.

- There is no readily available supply of Orthoptists from within Northern Ireland so it is necessary to recruit from outside the region.
- Employers should plan their Orthoptic requirements using the information collated within this Review and put a strategy in place to cope with the anticipated supply and demand issues.

### **Utilisation of the available Workforce**

- A co-ordinated approach should take place with regard to workforce planning of Orthoptists, particularly in relation to role extension and development issues.
- Consideration should be given to the model of providing area services for Orthoptics across the NIHPSS to ensure optimum use of the limited clinical, managerial and administrative resources within a small profession.

### **Education & Development**

- Further discussions should take place between the DHSSPS, Trusts and Universities to establish a more effective way of providing additional clinical placements for students throughout each year of the degree programme. It is imperative that a programme for clinical placements is established within the NI context to ensure that students have formed connections with Trusts that ensure posts which become vacant within the 5-year plan attract new graduates incorporate succession planning within the profession.
- Clinical Placements should be initiated at the Royal Group of Hospitals Trust as exposure to neurological conditions is pivotal to undergraduate education. Results of the Clinical Placement Survey (DHSSPS May 2002) should be used in conjunction with this exercise to progress the position of Trusts to better accommodate the clinical placements required.
- There should be an increased focus placed on Continuing Professional Development (including leadership development) and all employers should ensure that the recommended hours provision is accounted for through the workforce planning process.
- The professionals should work towards an Orthoptic Regional Strategy to ensure a future focus and direction is incorporated into the progression of the Orthoptic profession. This strategy should be factored into the Workforce Planning Process.

- Employers should provide training to all staff that will be required to provide mentorship or coaching support as part of their role.
- The Department should take forward the development of the AHP consultant role to acknowledge the high levels of clinical expertise within the profession.

## **CONCLUSION**

This Orthoptic workforce review can only be viewed as the starting point, or a baseline for further work to be carried forward. This includes the development of an action plan to take forward the recommendations outlined above. The models presented in the report will need updated and refined on a regular basis to continue to inform decision-making and priorities concerning the investment in the NIHPSS Orthoptic workforce over the 5-year plan.

## **1. INTRODUCTION**

An in-depth review of the Orthoptic workforce in Northern Ireland took place between May and September 2002 and was co-ordinated by a Project Group, which comprised of representatives of the DHSSPS, HPSS commissioners and providers, education and staff side. The report includes:

- A background to the project
- The project methodology
- A summary of the recruitment and retention issues arising from the review and a projection of the supply and demand for Orthoptics over the next five years within HPSS.

The report concludes with a list of recommendations, which seek to contribute to addressing current and future workforce issues within the NI HPSS Orthoptic workforce.

The Department of Health, Social Services and Public Safety Northern Ireland's aim of the review is to develop strategies that can assure the correct numbers of Orthoptics are in place and working in the most effective way to offer optimal benefit to the overall healthcare team and the patient.

### **1.1 Terms of Reference**

The following specific terms of reference were applied when carrying out this review:

Provide a profile of the current Orthoptic workforce in Northern Ireland, including:

- Numbers employed, grading, distribution, age and gender balance.
- Working conditions and patterns.
- Continuing professional development commitments.
- Provide an analysis of current and future recruitment and retention issues, including:
- Remuneration.
- Career development and specialisation.

- Career breaks/leaving the profession.
- Working arrangements.
- Provide a prediction of future supply over the next 5 years and demand for Orthoptics, including:
  - The number required meeting service demands,
  - Specialism distribution.

The requirement for this piece of work was to review issues at a generic, strategic level and provide sound conclusions and recommendations relevant to the workforce as a whole. This review was not required to examine economic issues or carry out detailed feasibility studies.

The aim of the report is to provide a starting point and baseline for workforce planning which could then be built on and expanded through future analysis and focus using identified workforce representatives at all levels throughout the sector.

## **1.2 Methodology**

The methodology for the review focused on consulting with those within the current workforce, across the geographical regions of Northern Ireland. The views of under graduate students were also sought as they represent a substantial part of the future supply of the workforce.

All representatives were identified by the Project Board, Appendix 1, set up to manage this review.

The methodology adopted for this review contained the following:

- Key Informant Interviews: Semi-structured in-depth interviews were carried out with 7 key representatives, Appendix 2.
- Focus Groups: 4 focus groups were held made up of a representative mix of disciplines, grades and primary and secondary sector employees, Appendix 3.
- Literature Review and Desk Research: A comprehensive literature review was undertaken and it was key that these references were utilised to inform the project, Appendix 4.

## 2. CONTEXT

It was important to set this review within an appropriate context before carrying out any data gathering to inform the design of pertinent survey tools and ensure relevancy of conclusions and recommendations. This necessitated looking at the current situation with regard to the wider Health Policy context and the roles that Orthoptics could play within this.

### *Health Policy Context*

The overall aim of the Department of Health, Social Services and Public Safety is to improve the health and well being of the people of Northern Ireland within the resources available. It seeks to achieve this in ways which

- Are fair and equitable, targeting resources towards those in greatest need
- Listen to the views of users, carers and the public.
- Continuously improve the quality and clinical excellence of services
- Stimulate and support the formation of partnerships across all sectors to promote and improve health and well being.

It must also seek to increase the effectiveness of clinical intervention. That is to maintain or improve health and to secure the greatest possible health gain from available resources. Those HPSS employees, which fall within the Allied Health Professions, specifically Orthoptic, are key to achieving this overall clinical effectiveness.

In order to develop strategies that can ensure the correct numbers of these skilled employees are in place, working on an integrated basis and in the most effective way, offering maximum benefit to the health care team and optimal patient outcomes. Sir Maurice Hayes has further reinforced this in the Acute Services Review consultation document (May 2001) (1) where he states that the DHSSPS, in consultation with the service, should as a matter of urgency undertake an assessment of service needs and the skills and staff required to deliver these services efficiently and effectively. The report also stressed that there is the need to build up adequate contingency or even over supply of adequately prepared professionals so as to ensure that there is no repeat of difficulties of the past.

It is within this context that the workforce review for Orthoptics is set.

### ***Great Britain and Northern Ireland Context***

The strategic focus outlined above was first detailed in ‘The New NHS – Modern and Dependable’ (2) which set out the Government’s vision for the National Health Service (NHS) in England. The Government plans for NHS modernisation are intended to ensure a high quality, national service that is clinically sound, cost-effective and equitable. This was emphasised by Alan Milburn, speaking at Farnborough Hospital on 13 October 1999, saying, “By the time we finish our 10-year programme of modernisation, the NHS of 1948 will be unrecognisable. It will remain true to its values but they will be delivered in new and modern ways”. The NHS white paper (3) and subsequent quality consultation document (4) identified requirements for consistent, high quality care throughout the health service and all health organisations, including primary care. This will mean that all areas of healthcare, including Orthoptic deliver care to the patient in the most timely and most cost effective ways possible.

In line with the above, the Northern Ireland Executive in its Programme for Government 2001-2004 (5) identified “Working for a Healthier people” as one of its priorities and has stated that “we will work to reduce waiting lists, implementing new management arrangements, and recruiting additional front line staff”.

The Programme focuses specifically on the following:

- Reducing preventable diseases, ill health and health inequalities
- Ensuring that the environment supports healthy living and that recreational facilities are improved
- Modernising and improving hospital and primary care services to ensure more timely and effective care and treatment for patients
- Enabling those who suffer from disability, chronic mental or terminal illness to live normal lives.

The Programme commits the Executive to the following actions, which affect Orthoptics directly:

- Providing 40-50 extra specialist medical, nursing and other staff to improve treatment of people with breast, lung and colorectal cancers.
- Addressing workforce shortages in the health service.

The document 'Priorities for Action' (6) details the DHSSPS planning priorities for 2001-2002, in the context of the Programme for Government as outlined above. It states the objectives, and targets that will ensure their achievement. In meeting its responsibility for setting strategic direction, overseeing the delivery of the health and social services, the DHSSPS has set targets for Boards and Trusts. These include:

- Increasing capacity, improving flexibility and responsiveness to meeting continued demand.
- Improving access to services, particularly reducing waiting lists.
- Tackling shortages of skilled staff, particularly in hard-pressed specialist areas. This includes not only increases in the supply of qualified staff but also measures to improve recruitment and retention of staff within the HPSS.
- Developing partnerships with other statutory and voluntary sector organisations.

### ***Secondary Care***

In the provision of secondary services, the Acute Hospital Review Group Report 2001(1) is the most recent document to address the structure of the HPSS as a whole in Northern Ireland. The Report highlights key recommendations, which include:

- To significantly shift the balance of care from secondary care to primary care.
- To provide acute hospital services that are consultant delivered rather than consultant led.
- Primary care organisations should be given the responsibility for the commissioning of community services and non-regional hospital services in the context of the strategic plan.

### ***Quality and Primary Care***

These principles outlined above have been reinforced in the context of Northern Ireland in the recent Consultation Paper, "Best Practice – Best Care" (7). This paper, published in April 2001, focuses on the three interlocking strands of setting standards (improving services and practice), delivering services (ensuring local accountability) and improving monitoring and regulation of the services. In addition, identifying new ways for health professionals to be involved in the delivery of NHS services has been a key

principle identified in the Consultation Paper “Building the way forward in Primary Care” (8), which clearly sets out a number of priority areas for development in primary care relevant to this review.

In Northern Ireland these proposals have been supported by the ‘Allied Health Professions’, which includes Orthoptic. The position paper ‘Primary Care – Professions Allied to Medicine’ (9), endorses the priority given to breaking down traditional boundaries so that all care professionals use their skills in the most appropriate way to treat and care for people, the development of new and innovative models of service delivery and the support of emerging new professional roles. However in order for this to happen it is argued that there must be greater representation of the Allied Health Professions to influence the decision making process in strategic planning, policy formulation, commissioning and in the general management of the HPSS (10).

### ***Public Health***

In the UK, public health strategies have recently been produced for Scotland (Working together for a Healthier Scotland 1998) (11), Wales (Better Health – Better Wales 1998) (12) and England (Saving Lives: Our Healthier Nation 1999) (13).

In Northern Ireland these key issues are reinforced in the strategic documents “Investing for Health” (14), and “Well into 2000: A positive agenda for Health and Social Well-being” (15) which underpin the government’s vision for the Health Service. The proposals encourage professions to work with the community to promote health and well-being rather than focus on the treatment of ill health. Orthoptics have a key role to play in health promotion starting from childhood on.

## **THE ORTHOPTIC PROFESSION**

The United Kingdom Parliament formally acknowledged the professional status of Orthoptists under the Professions Supplementary to Medicine Act 1960. This gives a considerable degree of professional autonomy to Orthoptists, enabling them to maintain their own professional discipline, set standards of conduct and to set standards of education and training for entry to the profession.

At March 2002 there were 1,304 Orthoptists registered with the Health Professions Council (lay CPSM). (16)

## SUPPLY ISSUES

England experienced an increase in qualified allied health professional staff, including Orthoptists during September 1999 and 2001, of approximately 7 per cent (17). Despite the increase in staff, the Department of Health has recognised that there are still areas of the country and professions where there are shortages. The shortfall in meeting the demand on the NHS was recognised beyond doubt in the NHS Plan (18). The Plan highlighted a commitment to increasing PAMs numbers, suggesting that by 2004 there would be:

- Over 65,000 more therapists;
- 4,450 more therapists being trained and
- new therapist Consultant posts.

A recent report by the Chairman of the British Orthoptic Society (BOS) in *Parallel Vision*, the BOS Journal indicated, “At the recent Vision for the Future roadshows, the shortage of Orthoptists was highlighted in every area we visited.” (19) The British Orthoptic Society (BOS) undertook its’ first manpower survey in November 2001, with data collection forms being sent to every Head of Service in England, Scotland, Wales and Ireland. At that time there were 1006 Orthoptists, 746.07 whole-time equivalents (WTE). The form also asked Heads of Service to predict the staffing needs for the next 5 years- 337.86 WTE staff were identified as being required. (20)

The workforce numbers in Northern Ireland has remained static from 1998 with 23.32 WTE Orthoptists in posts at 31 March 2002 and 21.93 WTE in 1998, a variance of less than 1 WTE.

The issues associated with the supply of Orthoptists are detailed in subsequent paragraphs.

### ***Remuneration***

The pay structure for Orthoptists provides three main clinical grades (Basic Grade/Senior II and Senior I) followed by Head Grade (I-IV) and District Grade (I-II). Management grades are identified at Chief and District Grade Level. Agreement was reached however during 2001/2 on the introduction of Allied Health Professions Consultant Posts.

The salary structure is the same as that applied to the other PAMs professions of Occupational Therapy, Physiotherapy, Podiatrists, Dietitians and Radiographers with pay awards determined by the National Pay Review Body for Nursing Staff, Midwives, Health Visitors and Professions Allied to Medicine. The Pay Review Body recommended a 3.7 per cent increase to basic salaries and an increase in on-call and standby allowances in 2001/2. One

Discretionary Point was consolidated into the pay scales, introduced as a mechanism for staff to achieve recognition for having developed their role and skills. Staff are eligible if they meet the criteria after serving for 1 year at the top of the scale to apply for discretionary points from Senior 2 to Head 3 grades. (21)

Like other NHS professions, the remuneration of Orthoptists will come under new arrangements proposed under *Agenda for Change*. The timeframe for introduction of these arrangements within NI HPSS has not yet been determined.

### ***Recruitment***

There is evidence to suggest that the Orthoptics profession is experiencing difficulties recruiting staff. The Review Body for Nursing staff, Midwives, Health Visitors and Professions Allied to Medicine *Nineteenth Report* (2002) (21) indicated that 6 per cent of Trusts in England and Wales indicated that during 2001 they had had ‘specific difficulties’ recruiting Orthoptists.

Statistics from the *Department of Health Vacancy Survey* (22) indicated that at 31<sup>st</sup> March 2001 England had a vacancy rate of 0.4% for Orthoptists. In Northern Ireland at 30 June 2002 there was 1.0 WTE Orthoptic vacancy equating to a 3.4% rate.

The BOS Manpower Survey (November 2001) indicated that at that time there were 30 vacant WTE posts across England, Scotland, Wales and Ireland. The report concludes, “the information on current staffing levels and shortfall form the basis of our evidence in substantiating the urgent need to increase training places to meet demand.” (20)

### ***Education and Training***

A number of strategic documents review education, training and development for health professionals in England and Wales. The National Audit Office (NAO) report *Educating and Training the Future Health Professional Workforce for England* (23) concluded that achieving the planned expansion set out in the July 2000 NHS Plan depends on increased investment in teaching staff and accommodation at higher education institutions; achieving value for money in the provision of training courses; a reduction in student drop out rates and a larger number of good quality practice placements.

England has also experienced problems with recruitment and retention for undergraduate places, with an average 20% under recruitment against available places. (23) The BOS Strategy Document *Vision for the Future* (2002) highlights the need to increase the number of students applying to University places, and asks “all members to promote the profession as a chosen career”

through career information packs, career exhibitions and work experience in Hospital clinics. (20)

*Vision for the Future* (2002) also highlights the need for an additional university undergraduate education centre for Orthoptics, given the recruitment difficulties, and the closure of Glasgow Caledonian University. The two current providers- the University of Liverpool and the University of Sheffield- have an intake of only 30 students per year to each University course. However the strategy document indicates, “there is one major obstacle to this. The courses at Liverpool and Sheffield Universities are currently struggling to place existing undergraduate students for clinical placement experience.” The report indicates that in total 50 extra clinical placement sites will be required to sustain one additional university education centre. (20)

The availability of suitable practice placements was also highlighted by NAO as a critical limiting factor on the number of training places that can be commissioned. (23) The lack of appropriate numbers of clinical placements for Orthoptists was also highlighted in *Parallel Vision*, in March 2002. The Chairman of the BOS stated “the current number of available clinical placements has reached a dangerous level...the number of clinical placement sites are reducing... We can only train Orthoptists if we have adequate clinical placements for them to go to.” (19) The February issue of the journal made a plea for those considering taking students to “act now and apply for validation.” (24)

Another critical issue recognised as having an impact on manpower planning has been student attrition rates. Student attrition rates for PAMs staff range from 6 to 10% for PAMs (23) This issue is again highlighted in the BOS strategy document: “both Universities recognise there is an attrition rate within their course. Normal attrition rate would be expected at 10-15% per academic course per year.” (20) The Department of Health’s *Human Resource Performance Framework* (25) includes targets to reduce attrition rates, with the 2000/1 intake non-completion rate of pre-registration training not to exceed 10% for allied health professionals nationally.

Universities in Northern Ireland do not provide a BSc (Hons) course in Orthoptics. Courses are provided at 2 universities in England, Liverpool and Sheffield.

### ***Returners***

The need for an improved supply of Orthoptists was also highlighted in the British Orthoptic Society's Journal *Parallel Vision*, which reported on the Department of Health's initiative to attract returners to the areas of the country experiencing the most challenging recruitment and retention issues. (26)

### ***Retention***

The Review Body for Nursing staff, Midwives, Health Visitors and Professions Allied to Medicine *Nineteenth Report* (2002) (21) indicated that 2 per cent of Trusts in England and Wales indicated that during 2001 they had had 'specific difficulties' retaining Orthoptists. However, the turnover rate amongst orthoptists was 11.5 % of staff, with 1.6% of staff leaving to non- NHS employment. The wastage rate (leavers excluding transfers to other NHS Trusts as a proportion of all staff) amongst orthoptists in England and Wales during 2001 was therefore 7.2%.

The BOS strategy document indicates that encouragement of career development and development is essential to staff retention. Flexibility in working practice is also highlighted as paramount. (20)

### ***Family Friendly Policies***

The Orthoptic workforce in Northern Ireland is 93% female, and this has significant implications for both part-time working and the need for family friendly working policies. The importance of having regard for the needs of a predominately female workforce is well documented in the Hayes Report. (1)

In England and Wales, this is documented in the *Third Report of the House of Commons Select Committee on Health* (27). The report details the government's commitment to introduce a range of family friendly policies including childcare facilities, flexible hours and job share opportunities and promotes the idea that because the NHS operates a comprehensive 24-hour service, this provides greater opportunities for flexible working.

The Review Body for Nursing staff, Midwives, Health Visitors and Professions Allied to Medicine *Nineteenth Report* (2002) highlighted that three quarters of Trusts had implemented family-friendly policies such as flexible working, annualised hours, term-time working and job-share. Almost two-thirds of those who had implemented these policies said that they were 'effective.'(21)

## DEMAND ISSUES

Understanding the current and future demand issues within HPSS as they relate to Orthoptists is essential in projecting future requirements for staff. The issues associated with the demand of Orthoptists are detailed in subsequent paragraphs.

### *Societal Changes*

The Department for Education and Employment, *Employers Skills Survey Report* (28) highlighted that there has been steady growth in demand that is expected to continue in the medium term for the services of Allied Health Professionals. Factors contributing to this demand include ageing population, rising expectations of patients and government reforms including a move towards care in the community, more integrated multi-disciplinary services and the introduction of clinical governance. The report identifies that the picture within HPSS is one of changes in technology and ways of working requiring staff to have a greater range of skills and a higher level of skills.

### *Service Demands*

Several growing areas of demand will impact upon the future provision of Orthoptic services. They can be detailed as follows:

➤ **Waiting Lists:**

Waiting Category	0-3 mths	3-6 mths	6-12 mths
Number of patients waiting assessment	1078	134	45
Number of patients waiting for treatment/review	1165	167	0

Patients waiting 0-3 months and 3-6 months are within patients charter limits and therefore acceptable. However, patients waiting in Category C fall outside charter limits and this group has a total of 45 patients.

- **Children's Screening:** The recent *Guidelines for Children's Eye Care* prepared jointly by the Royal College of Ophthalmologists, British Orthoptic Society and College of Optometrists (2002) report that orthoptists should provide a universal screening service for all children between the ages of 4 and 5 years. It goes on to say that such screening should take place at school or a preschool facility to ensure maximum coverage of population. (29) Screening of this age group in Northern Ireland is currently carried about by School Nurse and Health Visitors, and not orthoptists. Thus, if these guidelines are to be followed, this has a substantial resource implication.

- **Children's Services:** Research funded by the Department of Education and Employment identified that caseloads and waiting lists were highest for under 4's. This includes the increasing number of children diagnosed with autism and children with special needs. There is also increasing emphasis on the need for significantly more early intervention services within Orthoptics, brought about by initiatives such as Surestart.
- **Special Needs:** Figures provided by the South Eastern Education and Library Board. for the period 1985 to 2001, indicate that there was a 114% increase in the number of children attending special schools in the area (604 to 1291). Between 1997 and 2001, the number of children with a statement of special education needs increased by 14% (2592 to 2943). This has a substantial resource implication if Orthoptic services are to continue to diversify into special needs.
- **Elderly:** The average life span is increasing by about two years every decade (30). OPCS data suggest that 16% of the population are aged 65 or more. The number of people in this age category has also increased by 6.15% during the last 10 years. As the ageing process occurs vision becomes a problem and this can result in trips and falls, amongst other difficulties. Orthoptists are beginning to provide services under the *National Service Framework for Older People*, in elderly care and Accident and Emergency Departments for falls clinics. (31)
- **Diabetes:** The World Health Organisation's report 'The World Health Report 1997' indicated that by 2005 cases of diabetes will double globally (32). The development of the *National Service Framework for Diabetes* (33) indicates that a core of highly skilled NHS Orthoptists will be required for the glaucoma screening initiative.

### *Service Developments\Role Extensions*

The realm of ophthalmology has grown considerably over recent years leading to new roles/role extensions for Orthoptists. Vision for the Future (2002) indicated the diverse roles that orthoptists are now becoming involved in. These can be identified as:

- **Special Needs:** This is perhaps one of the biggest growing areas in which Orthoptists have extended their role. 14.8% of Orthoptists have diversified into Special Needs provision. This often involves Orthoptists having a planned programme of screening in Special School settings.
- **Neuro:** 10.43% of Orthoptists now work in neurology. This can involve them working with Brain Injury\Trauma teams.
- **Learning Disability:** 9.6% of Orthoptists in the BOS Manpower Survey reported working in Learning Disability.
- **Stroke:** 7.4 % of Orthoptists have diversified into stroke care.

- **Glaucoma:** Shared glaucoma clinics are beginning to be led by Orthoptists due to their high-level of clinical expertise and reliability. 5.06% of Orthoptists have diversified into glaucoma care.
- **Biometry:** A small number of Orthoptists (3.5 %) have diversified into biometry. of Orthoptists have begun to provide a biometry service.
- **Refraction:** The smallest number of Orthoptists has diversified into Refraction. (2.7%)

\* All figures sourced from the BOS Manpower Survey (2001) (20)

### ***Continuous Professional Development***

In the UK, although there has been no statutory requirement, the Orthoptist's code of professional conduct makes it clear that all Orthoptists must continue to maintain and advance their knowledge and skills throughout their careers. An article published in *Parallel Vision* (34) highlighted the Orthoptist professions' involvement in an 18-month competence and CPD project, which it is hoped will "inform the thinking of the new Health Professions Council when considering re-registration requirements for all the professions." A final report of this project will be submitted to the Department of Health in June 2003. The University of Sheffield's commitment to continuing professional development was highlighted in June 2002 when they introduced a MmedSci/Postgraduate Diploma in Orthoptics, due to commence in September 2002.

The British Orthoptic Society also set up a BOS Mentoring Scheme during 1999, to provide trained mentors to support newly qualified orthoptists and those returning to Orthoptics, during the first 6 months of their practice. There were 87 trained Orthoptic mentors, covering 70 Departments in March 2001. (35)

### ***Research***

Evidence-based practice through good quality audit and research is vital if Orthoptics is to develop as a profession. A recent report completed by the Research and Development Office in Northern Ireland (37) found that the ratio of Orthoptics staff involved in research was 1:9. However not one Orthoptist surveyed had a masters degree or PhD, compared to several professional staff in other PAMs group. The report concluded that much more needs to be done to support PAMS in this area.

### ***Skill Mix***

Recently collated data from the November 2001 BOS Manpower Survey indicates that "many Orthoptic Departments are Senior I heavy." (20) The report recommends that Heads of Service should be encouraged to develop a

broader base of skill mix to ensure positive career progression starting at Basic Grade level. It appears that in the past the lack of skill mix has resulted in new graduate Orthoptists being appointed to Senior I posts. The BOS strategy document Vision for the Future recommends that “new graduate Orthoptists are not appointed to Senior I posts but to Basic Grade and Senior II positions.” (20)

### **3. FINDINGS – DATA ANALYSIS**

This section details the findings of the analysis of the workforce profile information.

#### **3.1 Workforce Demographic Profile**

Available information was compiled of the current demographic profile of the Orthoptic workforce of Northern Ireland to use as baseline information. The key sources utilised are highlighted below:

- The DHSSPS Project Support Analysis Branch sourced from –
  - HRMS – current HR system in use by the Trusts across Northern Ireland.
  - PMIS – current HR system in use by the Department at a regional level.
- DHSSPS – Workforce Questionnaire, June 2002.
- Sheffield University, Liverpool University – Students statistics.

#### **3.2 Current Regional Profile of the Orthoptic Workforce**

In Northern Ireland there are currently 29 state registered Orthoptists working in 13 of the NIHPSS Trusts:

Ulster Community & Hospitals HSS Trusts  
Royal Victoria Group of Hospitals Trusts  
Mater Hospital HSS Trust  
Down Lisburn HSS Trust  
Craigavon Area Hospitals Trust  
Craigavon & Banbridge Community Trust  
Armagh & Dungannon Trust  
Newry & Mourne Trust  
United Hospitals HSS Trust  
Causeway Hospitals Trust  
Homefirst Community Trust  
Sperrin Lakeland HSS Trust  
Altnagelvin Hospitals Trust

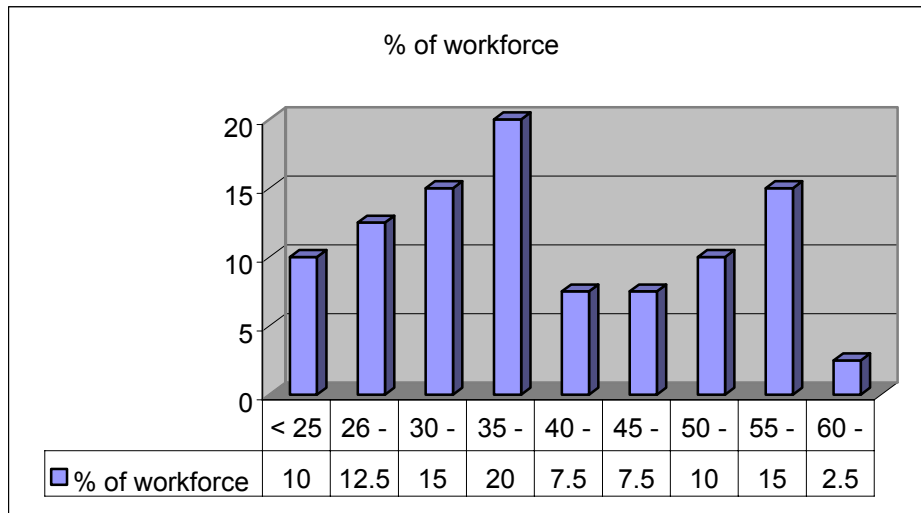
93% of the Orthoptic workforce is female.

There are no Orthoptic assistants within the service.

### 3.3 Age Profile

The age profile of the workforce is detailed below:

Graph 3.3:1: Age Profile of Orthoptics (June 2002)

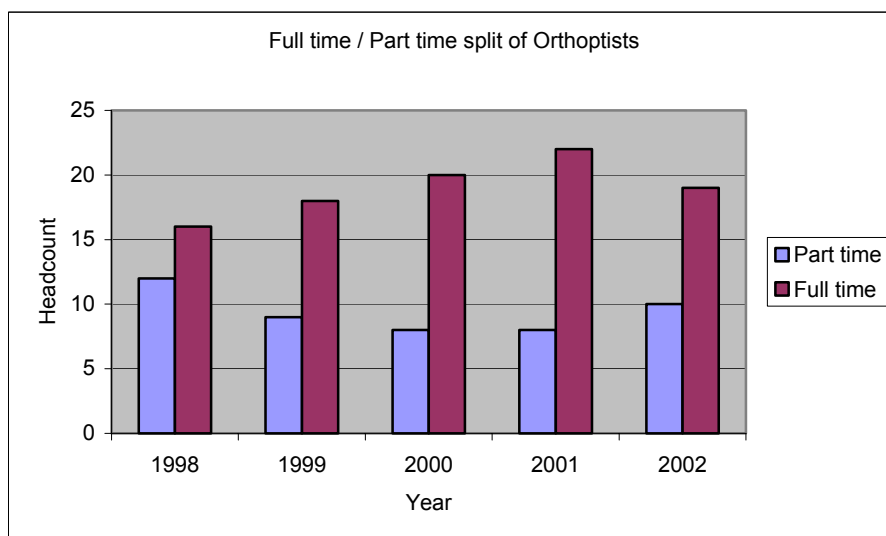


Source: HRMS

The data indicates that 65% of the workforce is under 40 years of age.

### 3.4 Full Time/Part Time Profile of Orthoptics Workforce

Graph 3.4:1: Profile of full time/part time Orthoptic Workforce in headcount



Source : HRMS

The data indicates a decrease in the number of part-time posts since 1998 and there has correspondingly been an increase in full-time employment.

### 3.5 Headcount to Whole Time Equivalent Breakdown

Based on the available date, information can be presented on the ratio of current numbers of full time to part time Orthoptic staff, shown as actual headcount to whole time equivalent.

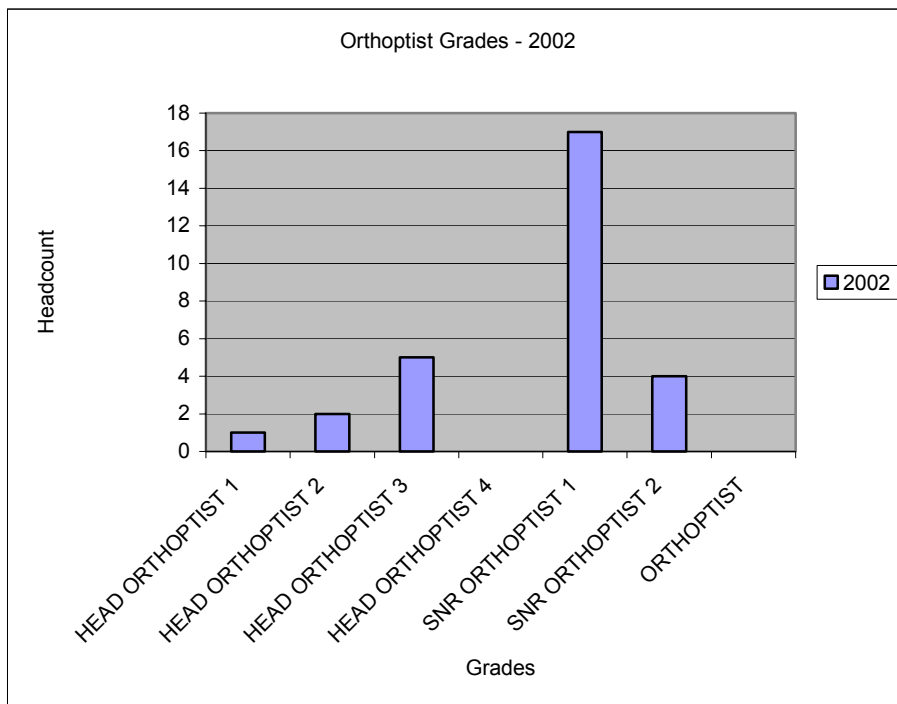
**Table 3.5.1: Headcount to WTE ratio**

Total Headcount	29
Total WTE	23.32
WTE / Headcount	WTE = 1.20 Headcount

The figure indicates that for every WTE Orthoptic post, the equivalent of 1.2 staff must be employed within the service.

### 3.6 Workforce Profile By Grade

Graph 3.6.1: Profile of Orthoptics workforce by grade in headcount



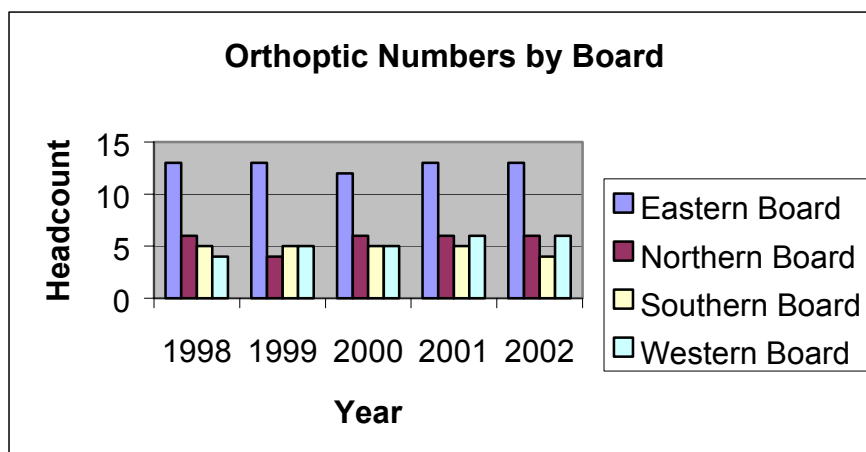
Source: HRMS June 2002

The table indicates that the highest proportion of staff are graded at the senior clinical grade (ie Senior 1). There are no Head Orthoptists IV posts which usually would be indicative of a post of managerial responsibility combined

with clinical duties. The statistics indicate there are no basic grade Orthoptic posts within the NIHPSS.

### 3.7 Workforce Profile by Board

Graph 3.7.1: Profile of Orthoptics Workforce by Board in headcount



Source: HRMS

### 3.8 Vacancy Analysis/Total Workforce Numbers

There was only one vacancy at a Senior 1 level identified within the Orthoptics workforce at 30 June 2002.

**Vacancy Analysis / Total Workforce** The information from the workforce questionnaire at 30 June 2002 indicates current vacancy rate of 3.4% within the NIHPSS Orthoptic workforce. This is calculated as follows:

➤ Staff in post	29
➤ Vacancies	1
➤ Total workforce	30
➤ Vacancy % rate	3.4%

### 3.9 Recruitment and retention of Staff

Managers were asked within the questionnaire to identify the number of staff they had been able to recruit from universities or employers outside of N.I.

- The majority of managers had not recruited any staff in the last 3 years and no staff recruited came from outside Northern Ireland.

In relation to retention of staff, managers returned the following information:

- There was only one leaver in HPSS workforce during 1999 – 2001 and that was for incapacity reasons.

### **3.10 Undergraduate Education**

There is no local education provision in Northern Ireland for the degree course in Orthoptics. There are two courses leading to State Registration in Orthoptics. A 3-year degree course is provided at the University of Liverpool (BSC Hons) and at the University of Sheffield which provides a (B.Mus.Sci Orthoptics).

### **3.11 Undergraduate Clinical Placements**

At present only one Trust in NI take students on clinical placement. The professional managers recognise the issues that this then presents including the difficulties encountered in recruitment. No formal framework has been established for student clinical placements but discussions regarding placements and the associated issues would be welcomed.

#### **Orthoptic student clinical placement system**

It has been identified that staff participating in student placements should have an allocated time requirement to teach and mentor students. It is suggested this requirement equates to 3-hours per week over the course of the student placement.

The figures provided in this section will inform the future supply projections for the workforce over the 5-year period 2003-2007.

## **4. KEY SUPPLY & DEMAND FINDINGS IN KEY INFORMANT INTERVIEWS AND FOCUS GROUPS**

### **4.1 SUPPLY ISSUES**

This section provides details of the views expressed throughout the 7 key informant interviews and 4 focus groups involving 13 Orthoptists. Many of the issues raised by different individuals were consistent and provided valuable information, which has informed the development of the recommendations and conclusions contained in the report.

#### **4.1.1 HPSS Recruitment**

Nearly all Managers interviewed indicated that they had not recruited staff in the last three years, because of lack of service developments in Orthoptics. When the Managers did last recruit they experienced several difficulties, primarily caused by the lack of a spare pool of staff that were not working. Managers reported experiencing difficulties recruiting for maternity leave cover. Difficulties were also experienced if Managers were not recruiting at graduation time.

The majority of Managers indicated that recruitment difficulties had always been there, but had become more acute recently. Recruitment was a matter of *“robbing Peter to pay Paul”* from other Trusts within NI HPSS, and most posts only received 1-2 applicants.

When asked to identify any grades and/or areas of work where it is harder to recruit staff, difficulties were being experienced at Senior I level. This it appears is because the majority of posts within Northern Ireland are at this level.

The main reasons why difficulties in recruitment were occurring, were identified by Managers as being the fact that there is no spare capacity within the Orthoptic workforce, that graduates that who train in England, take up their first post in England, and the fact that there is no Bank/Agency of Orthoptists with which to recruit from. In addition, NHSSB Manager presented location as a difficulty for recruiting to some posts in NHSSB area.

Of utmost concern by the Managers was the fact that up to 5 staff were retiring in the next 5 years, and Managers were not at all confident that the vacancies caused by this exodus from the workforce would be filled:

“We have mopped up all that is out there.”

#### **4.1.2 HPSS Retention**

Almost all Managers (5) reported difficulty retaining staff, despite the fact that there had been limited movement in the last 3 years. The Managers that reported this indicated that difficulties were being caused by the fact that staff were being headhunted by the ROI and incentives were being offered, difficulties were being experienced because there was no career progression for Senior II staff, the location of a post was causing staff to leave. The lack of funding for continual professional development was a causal factor in one case.

#### **4.1.3 Family Friendly Policies/Career Breaks**

With a 93% female workforce, the majority of respondents in the key informant interviews, reported requests for flexible working. The requests for flexible working were reported as relating to unpaid leave (1), term-time working (2), an 11-month contract (2), and to facilitate lecturing opportunities for a member of staff.

The number of requests for flexible working per Trust\Area service, was approximately 1-2 per annum. All of the key informants interviewed reported taking a positive approach to requests, along as the requirements of the service were met. However, Managers also cited the fact that the small workforce made requests increasingly difficult to facilitate.

#### **4.1.4 Private/Voluntary Sector**

The impact of the voluntary sector on the recruitment and retention of Orthoptists was reported as non-existent in Northern Ireland. However, some Managers did report that voluntary agencies, such as RNIB had begun recruiting in England.

Nearly all Managers reported that they were aware of staff working in private practice alongside a Consultant Ophthalmologist. It was clear that this was in a dual role with HPSS work, and there were not currently the opportunities for staff to work solely in the private sector.

#### **4.1.5 Working Hours, Terms and Conditions**

Key informants indicated that staff worked 36.5 hours per week; largely between the hours of 9 am and 5 pm. Almost half (3) Managers indicated that clinics were also provided in the evening or on a Saturday morning. Overtime was paid for the Saturday morning clinic, and in a small number of cases, for example for waiting list initiatives. Time off in lieu was given for the evening clinics.

Participants in the focus groups reported that their Managers were in the main flexible in their approach to working hours, and to start and finish times.

A number of issues were raised within the focus groups with regards to the remuneration package. The most reported issue was that staff hit the glass ceiling at Senior I very quickly, and have limited opportunity to enhance their remuneration thereafter, with the exception of Discretionary Points. A further issue was the lack of parity in salary with other AHPs, such as speech and language therapists. A further perception was that there was no incentive/reward for taking on additional duties, developing a service, or diversification of role.

#### **4.1.6 Career Progression**

Career progression was a common area of concern expressed in both the interviews and the focus groups sessions. The largest area of concern highlighted during the key informant interviews and focus groups was the lack of development for staff at Senior I level. As one focus group participant suggested:

*“I’ve been a Senior I for years, and there is no chance of getting beyond that.”*  
In relation to this, focus group participants cited the need for the development of clinical specialist posts, because of the lack of interest in management positions.

A further area of concern highlighted was the lack of development opportunities for Senior II staff because of the lack of movement of Senior I staff. A further area was the limited opportunities for progression at Head III level. At the other end of the scale Managers alluded to the lower level of clinical skills that graduates had entering the service.

#### **4.1.7 Continuing Professional Development (CPD) and Research**

All staff acknowledged the importance of CPD in terms of ensuring their ability to perform and meet the demands of the service. The issues raised in relation to CPD opportunities can be highlighted as follows:

The main issue raised by over half of the key informants and focus group participants was one of limited funding per person per Trust. There were clear differences in the funding opportunities available between Trusts/Area services, which were highlighted in the focus groups:

*“It’s frustrating when we compare ourselves to other Boards.”*

The limited availability of specialist course within Northern Ireland also made the funding problem more pertinent.

The issue of not having any designated/protected time was also raised by over half of the interview respondents, and in half of the focus groups. This resulted

in some instances in staff continuing with a clinic rather than availing of CPD opportunities. A further concern raised was the limited opportunities for research within the profession, and the fact that the lack of an academic centre in Northern Ireland meant that if someone wished to undertake a Masters programme it had to be carried out through distance learning.

On a more positive note, staff in the focus groups pointed to the use of staff meetings and journal clubs as being useful for CPD, and in most Trusts/Area services there were organised opportunities for CPD in this format.

## **4.2 DEMAND ISSUES**

All of the key interview respondents expressed concern about the inability of HPSS to meet the demand for Orthoptic services both currently and into the future.

### **4.2.1 Current Services**

The evidence from the key informant interviews suggested that there were a large number of areas of current unmet need/demand for Orthoptic services, which were documented as follows:

- General workload
- Stroke
- Elderly
- Primary screening
- Brain injury
- Special needs
- Visual fields screening
- Management issues.

### **4.2.2 Administration**

Five out of seven Managers raised the issue of limited clerical support when issues of skill mix were discussed. In all of the focus group sessions the lack of appropriate clerical support was also raised, and staff highlighted the fact that it was impacting on their ability to provide an efficient service. Some of the issues raised are highlighted in the following quotes:

“There’s no full-time Secretary here, and we’re not even computerised.”  
“It took me 2 years to get a girl to do filing for 3 hours per week.”

### **4.2.3 Increased Focus on CPD**

Both the key informants and participants in the focus group sessions highlighted the increasing role of continual professional development, given the introduction by the new Health Professions Council of a requirement for a minimum number of CPD days to be undertaken by qualified staff, and the growing emphasis on clinical governance within HPSS organisations.

#### **4.2.4 Provision of Clinical Placements**

Only one out of seven Managers currently provides clinical placements. Two other Managers have in the past provided placements, but do not currently do so. There reasons for not doing so are that one site was not accredited because of the lack of accommodation for students. The second site has refused to provide placements because of the lack of funding for placement providers. Managers participating in the key informant interviews raised a number of barriers to clinical placements. They can be detailed as follows:

- ***Funding for placement providers*** – Over half of Managers raised this as an issue. In addition, the ongoing expenses for travel and accommodation needed for the training placement supervisors, was also highlighted.
- ***Time pressures on staff*** – Almost half of interview respondents raised this as an issue, particularly given the amount of paperwork associated with supervision.
- ***Accommodation*** – Clinical accommodation for students was raised by a small number of key informants. This issue had caused one Trust to lose accreditation for placements in the past.
- ***Depth of Experience*** – This was raised by a small number of key informants who indicated that their Departments would not be able to provide the depth of experience, including surgery for final year student placements.

A small number of key informants also indicated that there was limited diversity in the students coming for clinical placements to Northern Ireland, in that they were all from Northern Ireland. This, they perceived impacted on their ability to attract job applications from students from Scotland, England and Wales.

#### **4.2.5 Increasing Patient Expectations**

It was clear from focus group respondents that parents and patients' expectations have increased through availability and access to information. Respondents commented that parents and patients are now more 'vocal' and knowledgeable about their 'rights.' As a consequence, focus group participants explained that parents and patients expect more discussion and more explanation of why a particular decision has been taken.

#### 4.2.6 Role Extensions

Examples of where the role of Orthoptics has had an impact or could in the future are detailed below:

- Primary screening of children under 5 years of age;
- Glaucoma screening;
- Fundus photography;
- Biometry.

#### 4.2.7 Skill Mix

There is currently no Orthoptic Assistant role in operation in Northern Ireland or the United Kingdom. Only two of the seven Managers interviewed perceived that there was a role for an Orthoptic Assistant, and staff participating in the focus group sessions were divided on the issue. Of the two Managers that saw potential for the development of an Orthoptic Assistant role, they argued that the staff could be involved in testing of visual fields, patch clubs, or accompanying qualified staff in a special school setting.

The key issue in terms of skill mix, which was raised by over half the Managers interviewed, was the need for there to be linked development opportunities from Senior II to Senior I grade, and from Senior I grade to Head III/Clinical Specialist role. Managers also reported that the lack of depth and fluidity in the current system, coupled with the fact that most staff work single-handed means that opportunities to develop skill mix are limited.

#### 4.2.8 Changing Service Provision

Participants in both the key informant interview and focus group sessions highlighted a number of different ways in which they envisaged the provision of Orthoptics services changing and/or developing in the future. These were outlined as follows:

- **Role Development** – The development of Clinical Specialist roles, and the opportunity to diversify into new roles such as biometry and fundus photography, were raised by both Managers and focus group participants. A number of focus group participants, also indicated that they could develop their role by training other professional staff such as Health Visitors and School Nurses. Both interview and focus group participants also highlighted the development of roles as part of the ophthalmic team.

- **Clinical Placements** – The majority of Managers and some focus group participants indicated that there was a requirement for the provision of more clinical placements in Northern Ireland in the future.
- **Different Service Provision** – A number of ways in which the service could be provided differently, were also raised by Managers and focus group participants. These included the provision of an orthoptic service in all special schools, an increase in clinics in community settings, and a one-stop shop for children requiring an Orthoptic service.
- The possibility of the Orthoptic service being provided on a regional basis, in the future, with the benefit of creating flexibility within the service was raised.

#### 4.2.9 Graduate Survey

This review did not include a focus group containing final year students given that there is no training programme within NI. However within the last year two students with Northern Ireland addresses qualified as Orthoptists from mainland UK Universities. Both these graduates completed a survey regarding their training indicating the following outlining results:-

- The Academic entrance grades required at B, B+C Advanced Level Qualification for a university place
- Only 1 out of their 9 possible undergraduate clinical placements over the 3-year course were based within Northern Ireland.
- Graduates indicated that they had each had good experiences in their clinical placements, which included 9 different locations throughout Scotland, England and Northern Ireland.
- There was “extreme difficulty” in achieving a Northern Ireland placement due to the limited sites accepting students.
- One student indicated that only one of the 9 clinical placements was a placement in a location of their choice.
- It was stated that a clinical placement was the most valuable when conducted on a one-to-one basis.
- Both graduates stated that the primary difficulties with placements was the constant transfer of locations to different parts of the country and travelling difficulties “driving from base time ranged from 2-7 hours”.

- When asked what changes could be made to clinical placements to improve the experience they replied:-
  - making specific site placements constant for each year
  - more placements located closer to home
  - longer period of placements at one time in the same location
- Both graduates identified the NIHPSS as the employment of choice but the barrier to achieving this was the lack of posts and opportunities.
- Both graduates have subsequently taken up posts outside the NIHPSS.

A number of assumptions have been made as a result of this survey although these assumptions should be tested more widely with both the student population and the UK training Universities:-

- the students appeared keen to have clinical placements in Northern Ireland.
- a more consistent approach to placements with a single location during an academic year would be welcomed.
- students would welcome more of a choice in regards to their placement location.
- there appears to be a potential small available source of Orthoptists for the HPSS if entry posts at Trusts were identified and established.

## **5. WORKFORCE SUPPLY AND DEMAND PROJECTIONS**

The Project Board agreed a set of assumptions around key supply and demand factors that are and will affect the Orthoptic workforce in the next 5-years. These assumptions were then used to formulate a “ model” from which certain predictions around projected supply and demand could be calculated. The key assumptions utilised have been outlined.

### **5.1 SUPPLY PROJECTIONS**

#### **5.1.1 Supply assumptions for those entering the workforce**

The view from Orthoptic Managers in the Project Group and evidence gathered from the key respondents interviews indicated that there would rarely be any qualified Orthoptists entering the overall Northern Ireland HPSS sector from outside of Northern Ireland. This has been projected to remain the status quo over the 5-year workforce projections included in the report.

#### **5.1.2 Supply assumptions for those leaving the workforce**

There has been 1 Orthoptic retirement over the last 4-years. To calculate the numbers of expected retirees over the 5-year workforce plan a projection has been made based on the earliest eligible retirement age (ie 60 years). All Orthoptists over 55 years at present have been assumed as leaving the workforce over the next 5-years which is 6 staff in total. This figure equates to 20% of the Orthoptic workforce. Evidence from the DHSSPS Project Support and Analysis Branch would support this assumption.

There were no incapacity leavers in the last 4-year period.

Based on anecdotal evidence from the key informant interviews and feedback from the project group, it has been suggested that, at present, 1% of the total workforce capacity is lost due to an increase in the uptake of part-time working and work-life balance policies.

Also based on evidence from the key informant interviews and feedback from the project group, it has been estimated that there will be no depletion of the Orthoptists workforce each year if past and present trends continue [for reasons other than retirement/medical].

## 5.2 DEMAND PROJECTIONS

### 5.2.1 Demand Assumptions Utilised

The demand projections for additional Orthoptists required within the HPSS over the next 5 years have been based on the following:

**Category 1. Agreed policy context which is resource approved:** This refers to capital and service developments that have been agreed within the current HPSS policy framework with resources identified and approved over the course of the 5-year workforce plan. This includes, additional posts within the Cancer Centre and Cancer Units, Regional Brain Injury Unit, and as a result of funding under Priorities for Action.

**Category 2. Future policy context that may potentially attract investment within the 5-year plan:** This refers to service developments that have been identified via key informant interviews and the project group that potentially maybe supported over the next five years, although resources have yet to be identified. Areas included are additional investment in multidisciplinary support services in the community care review. Also, further support for posts in the areas brain injury (community infrastructure), addressing resources for continuing professional development and the development the role played in local Health and Social Care Groups of the clinical specialist, advanced practitioner and consultant roles. Meeting the requirements for the Working Time Directive would also be included under this heading.

**Category 3.** Areas of unmet need and current demand identified via the key informant interviews and the Project Group that cannot be met within existing resources. It is acknowledged that there is currently no policy context or resource identified to meet the demand areas identified. Some of the clinical services included in this category are additional support for paediatric services; stroke; patients rehabilitation; elderly care; primary screening; visual fields screening; special needs services.

**Category 1** *Agreed policy context and resource approved.*

The Project Group were unable to identify capital or service developments from this Category for the Orthoptic service.

**Category 2** *Future policy context that may potentially attract investment within the 5-year plan.*

Within the context of Category 2 the group identified the demands on a four Board regional basis to align with the configuration of area services.

The following areas were identified by the Project Group as Category 2:-

- **Health and Social Care Groups:** The group considered both the time allocation for membership and subgroup activities would equate to 0.4 WTE for each Board area over the period of year 1&2 of the plan. This equates to 1.6 WTE regionally. It was felt that this figure would need reassessment on a yearly basis as the process developed over the period of the plan.
- **Clinical Placements:** The time required was identified by the project group as 0.2 WTE for the existing student clinical placements within the Northern Board for 1<sup>st</sup> and 2<sup>nd</sup> year. It was recognized that in order to improve the student placement framework within the Northern Ireland context an extension of existing placements to include 3<sup>rd</sup> year would be vital. This was seen by the group as being the avenue by which new staff could be attracted to within the HPSS workforce. Clinical placements should be considered and coordinated on a regional basis so that placements from the mainland Universities would in fact be a Northern Ireland placement rather than to any one specific Trust. This would allow a placement package to be established incorporating elements of clinical experience from satellite providers. To extend the existing clinical placement scheme an increase to 0.6 WTE Orthoptist would be required (an increase on 0.4 WTE).
- **Continued Professional Development:** It is suggested the time spent on Continuing Professional Development should equate to 36.5 hours per Orthoptists per annum. This translates into approximately an additional 0.8 WTE Orthoptist. This figure was divided across boards identifying 0.2 WTE for each Board area.
- **Life Work Balance:** Evidence from the key informant interviews suggest that requests would equate to 1% per annum. This would equate minimally to 0.03 WTE Orthoptist per annum. This figure would be constrained by the numbers of Orthoptists working single-handed or in small teams and the inability to continue the level of clinical service provision and has therefore not been factored into the workforce numbers. It is however recognised that work-life balance requests will impact upon this small workforce and therefore this figure should be noted and reviewed on a regular basis during this span of the plan.
- **Clinical Specialist Post:** The group identified within the context of role extension there would likely be 3 clinical specialist positions within the 5-year plan (3 WTE). These are identified on a regional basis rather than by Board at present.
- **Consultant Post:** The group considered that one such post would be established by year 5 of the plan.

- **Fundus Photography:** At present a 2-year fundus photography pilot scheme is ongoing at the Ulster Hospital. It diagnosis Diabetic Retinopathy which is the most common cause of blindness and partial sightedness among people of working age in the UK. Detection of sight threatening retinopathy and treatment by laser has been estimated to prevent 260-300 new cases of blindness every year in England and Wales. Over the period of the 5-year plan it is estimated to provide this firstly within the Eastern Board it would require an Orthoptic Workforce increase total of 1 WTE. It is predicted that in the future this service may well role out on a regional basis therefore the Fundus Photography service to other Boards provision will be considered as a Category 3 demand as at present a policy context has not been identified.
- **Primary Screening:** This is a nationwide screening of all 4-5 year olds for ocular defects by an Orthoptist. The workforce requirements would equate to 10 WTE from year 2 to year 4 of the plan. The Board requirements, as identified by the group, would be 3 WTE NHSSB, 2 WTE SHSSB, 3 WTE EHSSB and 2 WTE WHSSB.
- **Biometry:** This is the measurement of the axial length and corneal curvature of the eye by using ultrasound techniques. The purpose is to enable the selection of the correct lens implant to meet refractive needs of the individual patient. The workforce requirements for Biometry would equate to 0.2 WTE for the EHSSB in year 1 of the 5-year plan.
- **Visual Fields:** Visual field clinics are undertaken by Orthoptists throughout the Northern, Southern and Western Health and Social Services Boards and in the Down and Lisburn Trust, Mater and Ulster Hospitals.

The test assesses a patient's central and peripheral vision using a computerised field analyser. The vast majority of patients have glaucoma, diabetic retinopathy or retinal problems and are referred for these conditions by the Ophthalmologists.

The number of sessions a week vary from three to eight throughout the region. The waiting lists vary from none to six months reflected by the different clinic arrangements with the Ophthalmologist and the time the Orthoptist can allocate to the clinic. There has been a noted increase in referrals by medical, geriatric, obstetrics and gynaecology and rheumatology. This, coupled with demographic changes, will result in an increased demand for this service.

Additionality in this clinical service was predicted as:-

- Western Board – additional 6 sessions per week (0.6 WTE)
- Eastern Board - 3 additional sessions per week (0.3 WTE)
- Northern Board – 3 additional sessions per week (0.3 WTE)
- Southern Board – 3 additional sessions per week (0.3 WTE)

The workforce requirements to provide this service regionally has been identified in total as 1.5 WTE over the 5-year plan.

- **Glaucoma Monitoring:** As a role extension, Orthoptists could develop a Glaucoma Monitoring Service for “stable glaucoma” patients under the supervision of a designated Ophthalmologist. The workforce requirement would be an increase from 1.25 to 0.5 WTE for the Western Board Area Service initially.

It is considered that this service may well extend to the other 3 Boards and this has been considered in Category 3.

The total workforce requirement for Category 2 demand over the 5-year plan is 19.9 WTE.

**Table 5.2.2: Workforce requirements identified by the Project Group for Categories 1&2 in WTE over the 5-year plan**

<b>YEAR</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>Totals</b>
<b>CATEGORY</b>						
Category 1	-	-	-	-	-	-
Category 2:						
<u>Northern Board</u>						
HSC Groups	0.2	0.2	-	-	-	0.4
CPD	0.2	-	-	-	-	0.2
Primary Screening	-	1	1	1	-	3
Visual Fields	-	0.3	-	-	-	0.3
<b>Sub Total:</b>	<b>0.4</b>	<b>1.5</b>	<b>1</b>	<b>1</b>		<b>3.9</b>
<u>Southern Board</u>						
HSC Groups	0.2	0.2	-	-	-	0.4
CPD	0.2	-	-	-	-	0.2
Primary Screening	-	1	1	-	-	2
Visual Fields	-	0.3	-	-	-	0.3
<b>Sub Total:</b>	<b>0.4</b>	<b>1.5</b>	<b>1</b>	-	-	<b>2.9</b>
<u>Eastern Board</u>						
HSC Groups	0.2	0.2	-	-	-	0.4
CPD	0.2	-	-	-	-	0.2
Primary Screening	-	1	1	1	-	3
Fundus Photo	0.5	0.5	-	-	-	1
Biometry	0.2	-	-	-	-	0.2
Visual Fields	-	0.3	-	-	-	0.3
<b>Sub Total:</b>	<b>1.1</b>	<b>2</b>	<b>1</b>	<b>1</b>	-	<b>5.1</b>
<u>Western Board</u>						
HSC Groups	0.2	0.2	-	-	-	0.4
CPD	0.2	-	-	-	-	0.2
Primary Screening	-	1	1	-	-	2
Glaucoma	-	0.4	-	-	-	0.4
Visual Fields	-	0.6	-	-	-	0.6
<b>Sub Total:</b>	<b>0.4</b>	<b>2.2</b>	<b>1</b>	-	-	<b>3.6</b>
<u>Regionally</u>						
Student Training	0.4	-	-	-	-	0.4
Clinical Specialist	-	1	1	1	-	3
Consultant Posts	-	-	-	-	1	1
<b>Sub Total</b>	<b>0.4</b>	<b>1</b>	<b>1</b>	<b>1</b>	<b>1</b>	<b>4.4</b>

<b>TOTAL</b>	<b>2.7</b>	<b>8.2</b>	<b>5</b>	<b>3</b>	<b>1</b>	<b>19.9</b>
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The workforce requirement of Category 1 and 2 is 19.9 WTE Orthoptists. It is important to use the figures presented as a baseline and to recognise the need for further work to be carried out to refine and align them with Trusts in order to provide a more accurate projection.

*Category 3: Areas of unmet need and current demand identified by the Key Informant Interviews and the Project Group that cannot be met within existing resources.*

The Project Group considered this Category and the identified areas of need. In order to calculate the workforce requirements of these areas of need the group took the following issues into account:-

- the geographical spread of acute units
- standardisation of services to provide parity of access
- any demographic changes
- noted increases in referral rates
- throughput of patients
- education issues for carers and other professionals
- health promotion and prevention
- clinical training requirements of the workforce

The areas of unmet need are as follows:-

- *Stroke and Elderly services*

There has been a noted increase referral rates coinciding with demographic changes and the increase in the elderly population with an expanded life cycle. In particular, referrals have increased for ischaemia, haemorrhagic and thrombotic conditions to the Orthoptic service.

To meet this need it is estimated the workforce requirement would be 1 WTE Orthoptist per Board area to take into account the spread of the acute hospitals and the rehabilitation units. This would equate to 4 WTE regionally.

- *Special needs patients*

Consideration was given to the increased time needed to see patients in this client group, in which neglected irretrievable vision loss may occur.

To take into account the requirements of special needs patients regionally it is estimated the workforce requirements would be 1 Orthoptist per Board equating to a total of 4 WTE.

- Child Development Clinics. The present input to CDC was ascertained in each Board area and the additional needs then identified to meet the demands of the service. The present input equates to:

Northern Board:- 0.2 WTE

Southern Board:- 0.2 WTE

Western Board:- 0.2 WTE

Eastern Board – at present no input

It is suggested that the Eastern Board requires 1 WTE Orthoptist to meet the needs of CDC's and the other 3 Boards have a total requirement of 0.3 WTE each increasing their input to 0.5 WTE per Board. This equates to a total of 1.9 WTE Orthoptists regionally.

- *Fundus Photography*

This service has initially been identified in Category 2 and it is suggested that it may well be permanently established in the Eastern Board area after the completion of an ongoing pilot at the Ulster Hospital site. A roll out of this service may then take place regionally and the workforce requirement for this has been identified as 0.5 WTE for each of the other 3 Boards equating to 1.5 WTE in total.

- *Glaucoma Screening*

This service is being developed at present within the Western Board as identified in Category 2. The rollout of this service regionally would require 0.5 WTE in each of the other 3 Boards equating to a total of 1.5 WTE.

**Table 5.2.3: Identified workforce requirements for Category 3 for the Orthoptic Workforce in WTE.**

Category 3 Demand	2003	2004	2005	2006	2007	Total WTE
Stroke/elderly services	1	1	1	1	-	4
Special needs patients	1	1	1	1	-	4
Child Development Clinics	1	0.3	0.3	0.3	-	1.9
Fundus Photography	-	0.5	0.5	0.5	-	1.5
Glaucoma Screening	-	0.5	0.5	0.5	-	1.5
<b>TOTALS</b>	<b>3</b>	<b>3.3</b>	<b>3.3</b>	<b>3.3</b>	<b>0</b>	<b>12.9</b>

The total workforce requirements identified for Category 3 is 12.9 WTE Orthoptists.

In order to estimate the demand numbers of the professionals required to meet the workforce over the next 5 years Categories 1 + 2 will be utilised within the context of this review (these workforce requirements have either an identified funding allocation or likely to be funded within the 5-year plan) and equate to 19.9 WTE Orthoptists.

## **6. CONCLUSIONS**

### **6.1 Projected Supply of Orthoptic Workforce**

It is difficult to estimate the potential supply of Orthoptists for the NI context given that training takes place in two English Universities outside the Northern Ireland context.

Orthoptics has a small workforce (30 headcount) within the NIHPSS and has no direct supply of graduates within NI therefore it is vulnerable when workforce changes occur. Statistics have already identified (source HRMS) that over the period of the 5-year plan there are potentially 5 retirements due to age and statistics suggest an additional retirement due to incapacity. At the worst-case scenario this suggests a total of 6 leavers, which equates to 20% of the workforce over the next 5 years. There is at present no evidence of succession planning in place to cope with this loss.

Due to the small numbers in the predominantly female workforce (93%) it is difficult for managers to respond positively to life work balance requests and at the same time maintain the clinical service. Temporary cover is practically non-existent.

Managers are in the pressurised position of dual-role of both clinician and manager.

In conclusion, based on the above analysis and assumptions there is not a readily identifiable supply of Orthoptists to the NIHPSS. The only potential supply sources appears to be graduates leaving English Universities who have NI addresses that wish to return to the region, attracting non – NI address graduates and a recruiting from established Orthoptists outside Northern Ireland.

### **6.2 Demands for the Orthoptic Workforce**

Based on information gathered during the project, specific educational, capital and service developments, with associated staffing implications, have been identified over the 5-year plan by the key informant interviews, the Project Group and relevant policy, capital and service development business cases. For the purpose of identifying actual numbers required in the workforce the figures have been considered on a 4 Board basis and regionally where appropriate. In order to estimate the demand numbers of professionals the summary figures have been profiled on table 6.2.1.

The total demand for additional Orthoptics at the two categories over the 5-year period is as follows:

**Category 1:** *Agreed policy context, which is resource, approved.*

The Project Group were unable to identify capital or service developments from this category for the Orthoptic service.

**Category 2:** *Future policy context that may potentially attract investment within the 5-year plan.*

The Project Group identified 19.9 WTE Orthoptists within this category.

**Table 6.2.1: Summary of Projected Demand Figures in Category 2**

DEMAND CATEGORY 2	2003	2004	2005	2006	2007	TOTAL WTE
	2.7	8.2	5	3	1	19.9

**Category 3:** *Additional areas of unmet need and current demand identified by the Key Informant interviews and Project Group that cannot be met within existing resources.*

The Project Group identified 12.9 WTE Orthoptists within this category.

**Table 6.2.2: Summary of Projected Demand Figures in Category 3**

DEMAND CATEGORY 3	2003	2004	2005	2006	2007	TOTAL WTE
	3	3.3	3.3	3.3	-	12.9

### 6.3 Supply v Demand for the Orthoptic Workforce

The figures identified by the Project Group should be taken as a first attempt and a baseline, which will require further in-depth discussion and challenge to refine and produce the most accurate statistics.

Demand in Categories 1+2 equates to a total of 19.9 WTE Orthoptists. Concern must be raised as to how this demand is to be met as there is no easily identifiable supply of Orthoptists for the HPSS. Further consideration must therefore be given to capacity of the existing service, future needs, role development, the interface of other professionals, the role of assistants and or other healthcare workers with the Orthoptic service.

### 6.4 Sensitivity Analysis

In an attempt to explore the percentage growth and investment that would be required in the Orthoptic Workforce to meet the clinical services identified in Category 3 a sensitivity analysis was undertaken. The analysis consists of three scenarios, 10%, 15% and 25% growth levels of the Orthoptic Workforce.

The table below indicates the number of Orthoptists that would equate to each scenario growth level.

**Table 6.4.1: Scenario A, B & C indicating the percentage increase of Orthoptists in each growth level**

SCENARIOS	CURRENT HEADCOUNT	INCREASE HEADCOUNT	TOTAL INCREASED WORKFORCE
1. Increase by 15%	30	5	35
2. Increase by 25%	30	8	38
3. Increase by 40%	30	12	42

These percentage growth were applied to Category 3 (current demand and unmet need with no identified funding within the Orthoptic service).

### **Scenario A**

An overall increased growth of 15% to the existing Orthoptic Workforce equates to a total of 35 staff, an increase of 5 Orthoptists. At this level of growth the Orthoptic service would be able to provide an enhanced clinical service for stroke and elderly care services identified within demand Category 3.

### **Scenario B**

An overall increased growth of 25% to the existing Orthoptic Workforce equates to a total of 38 staff, an increase of 8 Orthoptists. At this level of growth the Orthoptic service would be able to provide an enhanced clinical service for Special Needs Patients and Child Development Clinics.

### **Scenario C**

An overall increased growth of 40% to the existing Orthoptic Workforce equates to a total of 42 staff, an increase of 12 Orthoptists. At this level of growth the Orthoptic service would be able to meet all of the unmet demands identified in Category 3. This increase would provide an enhanced and comprehensive service for:-

- Stroke & Elderly Services
- Special Needs Patients
- Child Development Clinics

The sensitivity analysis provides a means of exploring the areas of existing unmet need within the Orthoptic service identified in the demand Category 3. In order to define the future capacity, direction and strategy of the Orthoptic

service all the demand categories should be examined taking into account the supply issues raised in the Review.

## 7. RECOMMENDATIONS

The timescale for the implementation of the key recommendations outlined below is twelve months to coincide with the follow up review:

### **Workforce Planning**

- Now that the workforce planning process is established it is recommended that the Project Board should be retained to review supply and demand on an ongoing basis. It should utilise the information gathered in the review building and expanding on it taking into account such factors as the impact on the workforce of the role extension, sub-specialisation, capital plans and service development business cases.
- The Project Board should ensure that there is a consistent and targeted approach to gathering relevant supply and demand data and should include a review of current IT capabilities and manpower recording processes.
- Trusts should be alerted to the forecast indicating the potential retirements of 5 Orthoptists from the NIHPSS within the 5-year plan. This should be further investigated by Trusts with an Orthoptic service collaboratively and a worse case scenario position should be identified and contingency plans explored and implemented regionally to cope with anticipated loss from the workforce.
- The Orthoptic profession should establish a Regional Orthoptic Strategy taking into account the information gathered in the Workforce Planning Review. As part of the strategic planning process Orthoptists should identify their core business and explore the interfaces and related roles with the professions of optometry and ophthalmology. This activity should include all the key stakeholders and take into consideration both the existing service delivery and that of future services.

### **Recruitment & Retention**

- All employers should put in place policies to incorporate planned induction, consolidation and mentorship programmes for all new staff and review the effectiveness of these in a quantitative and qualitative manner.
- Employers and the profession should put in place a consistent approach to the implementation of work-life balance policies and procedures and this should be factored into workforce planning.

- There is no readily available supply of Orthoptists from within Northern Ireland so it is necessary to recruit from outside the region. Employers therefore should plan their Orthoptic requirements using the information collated within this Review and put a strategy in place to cope with the anticipated supply and demand issues.
- There should be a careers campaign to encourage undergraduate applications to the Orthoptic profession targeted to Northern Ireland second level education students. The aim of this campaign would be to ultimately improve the numbers of qualified Orthoptists entering the HPSS workforce.

### **Utilisation of the available Workforce**

- A co-ordinated approach should take place with regard to workforce planning of Orthoptists, particularly in relation to role extension and development issues.
- Consideration should be given to the model of providing area services for Orthoptics across the NIHPSS to ensure optimum use of the limited clinical, managerial and administrative resources within a small profession.

### **Education & Development**

- Further discussions should take place between the DHSSPS, Trusts and Universities to establish a more effective way of providing clinical placements for students throughout each year of the degree programme. Trusts should increase the number of Undergraduate Clinical Placements as a way of attracting new graduates into the NIHPSS. Clinical Placements should be initiated at the Royal Group of Hospitals as this is the only clinical location in Northern Ireland where students can achieve experience in neurological conditions. Results of the Clinical Placement Survey (DHSSPS May 2002) should be used in conjunction with this exercise to progress the position of Trusts to better accommodate the clinical placements required.
- There should be an increased focus placed on Continuing Professional Development (including leadership development) and all employers should ensure that the recommended hours provision is accounted for through the workforce planning process.
- The professionals should work towards an Orthoptic Regional Strategy to ensure a future focus and direction is incorporated into the progression of the Orthoptic profession. This strategy should be integral to the workforce planning process.

- Employers should provide training to all staff that will be required to provide mentorship or coaching support as part of their role.
- The Department should take forward the development of the AHP consultant role to acknowledge the high levels of clinical expertise within the profession.

## **CONCLUSION**

This Orthoptic workforce review can only be viewed as the starting point, or a baseline for further work to be carried forward. This includes the development of an action plan to take forward the recommendations outlined above. The models presented in the report will need updated and refined on a regular basis to continue to inform decision-making and priorities concerning the investment in the NIHPSS Orthoptic workforce over the 5-year plan.

## **APPENDICES CONTENTS**

**Appendix 1 – Project Board Members**

**Appendix 2 – Key Informant Interviews**

**Appendix 3 – Focus Groups**

**Appendix 4 - References**

## APPENDIX 1 – PROJECT BOARD MEMBERS

NAME	TRUST/HOSPITAL
DAVID BINGHAM, DIRECTOR OF HUMAN RESOURCES	Department of Health Social Services & Public Safety
DOROTHY JEFFREY, PROJECT DIRECTOR	Department of Health Social Services & Public Safety
JOYCE CAIRNS, DEPUTY DIRECTOR OF HUMAN RESOURCES	Department of Health Social Services & Public Safety
CLAIRE McGARTLAND, ORTHOPTIC MANAGER & COMMISSIONER REPRESENTATIVE	Sperrin Lakeland Trust
MRS GERALDINE McDOWELL, HEAD ORTHOPTIST	United Hospitals Trust
MISS MARY PROCTOR, HEAD ORTHOPTIST	Craigavon Area Hospitals Trust
MRS PATRICIA BLACKBURN, HEAD ORTHOPTIST	Down Lisburn Trust
MISS ALISON KENNEDY, HEAD ORTHOPTIST	Ulster Community Hospitals Trust
ANITA McCAW, HEAD ORTHOPTIST,	Mater Hospitals Trust
MISS BRONACH COOPER, HEAD ORTHOPTIST	Royal Group of Hospitals Trust
STAFF SIDE REPRESENTATIVE MR PATRICK McCANCE, HEAD ORTHOPTIST	Altnagelvin Area Hospitals Trust
JENA MUSTON, MANAGEMENT CONSULTANT	The Beeches Management Centre

## APPENDIX 2 – KEY INFORMANT INTERVIEWS

<b>Representative</b>	<b>Organisation</b>
Miss Mary Proctor	Craigavon Area Hospital HSS Trust
Ms Anita McCaw	Mater Hospital HSS Trust
Miss Alison Kennedy	Ulster Communities Hospital HSS Trust
Mrs Patricia Blackburn	Down Lisburn HSS Trust
Ms Bronach Cooper	Royal Group of Hospitals HSS Trust
Mrs Geraldine McDowell	United Hospitals HSS Trust
Ms C McGartland	Sperrin Lakeland HSS Trust
Mr P McCance	Regional Staff Side Representative

### APPENDIX 3 – ORTHOPTICS FOCUS GROUPS

<b>Group</b>	<b>Location</b>
1	NHSSB
2	EHSSB
3	WHSSB
4	SHSSB

## APPENDIX 4 – REFERENCES

1. The Acute Hospitals Review Group Report, May 2001
2. Department of Health, (1997) *The New NHS: Modern-Dependable*, London.
3. Department of Health, (1998) *A First Class Service: Quality of the new NHS*, London.
4. Scally G. Donaldson LJ (1988). Clinical Governance and the drive for quality improvement in the new NHS in England. *BMJ* 1988;317:61-5
5. Northern Ireland Executive (2001), *Programme for Government 2001-2004*.
6. DHSSPS, (2001) *Priorities for Action 2001/2002*.
7. DHSSPS, (2002) *Best Practice Best Care: A Framework for Setting standards, delivering services and improving the monitoring and regulation in the HPSS*, A consultation paper.
8. DHSSPS, (2000) *Building the way forward in Primary Care*. A consultation paper.
9. DHSSPS *Primary Care: A position paper for the Professions Allied to Medicine*.
10. PAM Strategy (1997) – *A Regional Strategic Framework for the Professions Allied to Medicine in Northern Ireland*.
11. Department of Health, (1998) *Working for a Healthier Scotland*.
12. Department of Health, (1998) *Better Health – Better Wales*.
13. Department of Health, (1999) *Saving Lives Our Healthier Nation*.
14. Department of Health, (2000) *Investing for Health*.
15. DHSSPS, (1997) 'Well into 2000: A positive agenda for Health and Social Well-being'.
16. [www.cpsm.org.uk/info.htm](http://www.cpsm.org.uk/info.htm)
17. Buchan, J (2002) '*Rallying the Troops*' in *Health Service Journal*, 30 May 2002, pp 24-25
18. Department of Health (2000) *NHS Plan*, London: HMSO
19. Carpenter, C (2002) 'Clinical Placements- Help!' in *Parallel Vision*, Vol 39, p.1.

- 20 British Orthoptic Society (2002) Vision for the Future: Strategy Document, London: BOS
- 21 Review Body for Nursing Staff, Midwifery, Health Visitors and Professions Allied to Medicine (2002) 19<sup>th</sup> Report of the Professions Allied to Medicine, London: HMSO
- 22 Department of Health (2001) Vacancy Survey @ [www.doh.gov.uk/public/kt230001](http://www.doh.gov.uk/public/kt230001)
- 23 NAO (2001) Educating and Training the Future Health Professional Workforce for England, HC 277 Session 2000-2001
- 24 Davis, H (2002) 'Clinical Placements' in Parallel Vision, Vol.38, p.3.
- 25 NHS Executive (2000) Human Resources Performance Framework, October 2000
- 26 Harding, G (2001) 'Exciting News for Returners' in Parallel Vision, Vol.31, p.3.
- 27 Select Committee for Health (1999) Third Report- Future NHS Staffing Requirements, London: House of Commons
- 28 Department for Education and Employment (2001) Employers Skill Survey: Case Study Health and Social Care
- 29 Royal College of Ophthalmologists, College of Optometrists and British Orthoptic Society (2002) Guidelines for Children's Eye Care, London: Royal College of Ophthalmologists, College of Optometrists and British Orthoptic Society
- 30 Church et al (Eds) (1995) Social Trends, 25 London: HMSO
- 31 Burrows, C (2001) 'Visual Screening of the Elderly' in Parallel Vision, Vol.32, p.5
- 32 The World Health Organisation (1997) The World Health Report, WHO.
- 33 Department of Health (2001) National Service Framework for Diabetes, London: HMSO
- 34 BOS (2002) 'Allied Health Professions Work Together on competence and CPD Project' in Parallel Vision, Vo.40, p.1.
- 35 O'Flynn, E and Deacon, M (2001) 'BOS Mentoring Scheme Update' in Parallel Vision, Vol.3.
- 36 Research and Development Office (2001) LDM for PAMs, Belfast: Research and Development Office