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Letters to the Editor

Vision screening

CATHERINE BUTCHER
Orthoptist, Vision Checks
www.vision-checks.co.uk

I write in response to the Letter to the Editor from Jill Carlton and Rosie Auld in the 2011 *British and Irish Orthoptic Journal* entitled, 'What is vision screening? And more importantly, what is it not?'[1]

'What is screening?'

I have recently been researching this subject in some detail and was very pleased to read the letter in last year's journal. I would like to make a number of observations. First, I attended a Screening Masterclass in May 2011 run by the UK National Screening Committee (UK NSC) and was reassured that vision screening falls into the category of genuine screening, that is, to screen a healthy population to identify those members of the community, in this case children aged 4 to 5 years, who are at risk of developing a long-term visual impairment. The other key element of a screening programme is that it should do more good than harm. Many screening programmes are currently being criticised for not meeting the definition of screening, for example the screening is aimed at targeted groups already identified as being at risk, and also for doing more harm than good. The Screening Masterclass is open to everyone, and for anyone involved in screening I would think it is essential. Details of future classes can be found on the UK NSC website.[2]

'Screening for amblyopia, strabismus and/or refractive error'

My view is that screening should be for reduced visual acuity to detect amblyopia and uncorrected refractive error. Strabismus is one of the target conditions when reading the UK NSC's guidelines[3] but is not specified in the Healthy Child Programme[4] and a recent statement by the Royal College of Ophthalmologists.[5] One would hope that a large cosmetically poor squint will have been detected by the parents or other health care professionals before the screening at school entry; if it has not, one must assume that it has not caused a problem. A strabismus that has resulted in amblyopia will be detected by testing vision alone. For those types of strabismus that have equal acuity, such as intermittent exotropia or congenital esotropia, one assumes that if it is not causing a cosmetic issue then it will not require immediate treatment and therefore questions the need for screening. As a profession we can all cite cases against this theory, for example a previously undiagnosed congenital IVth nerve palsy, but the incidence of this would be so low that it could not justify the cost of the screening for it.

'Which tests to include?'

I agree wholeheartedly with the statement made by the authors. Screening is not diagnostic and I would hope the whole profession feels that an orthoptic assessment is diagnostic and not a screening tool.

'Short-term challenges'

Leaping to the end of the letter, 'Short term challenges' discussing the pressing issue of referral criteria, I feel as a profession we need to come up with a united view on what constitutes a failure. There seems to be a consensus that any visual acuity below 0.2 is a fail, but it is the difference in acuity between the two eyes that produces mixed opinions. I recently set up a screening programme using the Thomson screener[6] and this test actually starts at 0.0 and works 'backwards'. I was cautious with this approach as it goes against our traditional teaching, but it really worked. But this method raised the issue of disparity: If a child achieved 0.0 and 1.8, did they warrant referral? This is a discussion that needs to take place between the ophthalmic health care professionals, and agreed.

I would now like to share with you a little of my history. I have been an orthoptist for 22 years and during that time I have done every type of vision screening and, more recently, as Head of Service I set up an orthoptic-led screening programme with the school nurse service. Last year I left my role as Head of Service and started locum work. It was working as a locum in different parts of the country that made me realise the need for better and more equitable vision screening throughout England, and for that reason I created my company Vision Checks Ltd.[7]

Vision Checks is a private provider, or a 'qualified provider' (AQP),[8] of vision screening. I can hear the sharp intake of breath all around the country! I am an orthoptist wanting to provide appropriate quality vision screening in areas that are failing to do so. I could not have picked a worse time with all the NHS reforms taking place. No one wants to take responsibility for certain areas of healthcare and I am afraid that vision screening falls firmly in that category, as it sits in different areas in different organisations. As the Primary Care Trusts disappear, and responsibility shifts, it is an opportunity for certain services to fall off the priority list. When contacting organisations to ask about the vision screening in their area, it is not unusual to receive conflicting information, to be told that another team is responsible for the vision screening service, and to follow every lead until I end up back where I started.

I am a private provider but I am still an orthoptist. I want to fill the gaps in service and ensure that quality provision is maintained. Many of my colleagues have been very supportive in my endeavour but others have made me feel like 'the enemy', which has been disappointing. I am very aware that other bodies within

the private sector are willing to take on vision screening, without orthoptic supervision, often as part of a bigger contract, and there are a number of bids out there for optometry-led screening.

Only last year the Association of Optometrists (AOP) launched its Children's Eye Health Campaign.[9] The statement by the Royal College of Ophthalmologists questioned the campaign and supported the current guidelines set out by UK NSC. At the moment all policies state that vision screening should be *orthoptic-led*, the UK.

NSC policy is due for review in 2012/2013 and we must ensure that this remains.

I would like this article to open a discussion forum on the BIOS website. I am a member of the Vision Screening Special Interest Group, which is currently quite quiet, but I am very keen to hear my colleagues' opinions.

References

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Response to 'Vision Screening'

JILL CARLTON[1] AND ROSIE AULD[2]
[1]Health Economics and Decision Science (HEDS), School of Health and Related Research (ScHARR), University of Sheffield, Sheffield
[2]Orthoptic Department, Birmingham and Midland Eye Centre, Birmingham

We read with interest your response to 'What is vision screening? And more importantly, what it is not?'.[1] We agree that the justification for screening for strabismus is a contentious issue. Some would advocate that this should be included in a vision screening programme; others would not. We have to question what there is to be gained in screening for a cosmetically acceptable or asymptomatic strabismus which is intermittent in nature and has no detriment to visual acuity. The ability to cite incidences where screening for such squints has been against this is low, as you state.[2]

There are a number of possible reasons why clinicians are against the removal or alteration of existing screening programmes.[3] The way in which health services are evaluated and commissioned has changed over recent years. We can no longer continue to carry out screening programmes without evaluating their efficiency or efficacy; and we cannot evaluate these unless we question our overall 'aim' of screening.

We hoped that our Letter to Editor would highlight some of the current issues surrounding vision screening within the UK. In particular, we wished to challenge the current inequality that exists due to continued variation in what is provided; as well as the content and referral criteria within such programmes. As you state, the current policies of the National Screening Committee and Royal College of Ophthalmologists advocate that vision screening is orthoptic-led.[4,5] However, we would encourage members of the British and Irish Orthoptic Society (BIOS) to consider their own practices, and engage in discussion about acceptable screening content and referral criterion. We would welcome a standardised approach, with guidance from members of the Vision Screening Special Interest Group.

Furthermore, we would encourage all members of BIOS to consider their own practices in line with the commissioning of ophthalmic services at local level. This may help members to address the issue of prioritisation of resources. Justification of funding universal primary vision screening, or pharmaceutical treatment of AMD, should be debated by clinicians in the same way that it will be debated by commissioners. There will be a finite pot of money for local ophthalmic services and prioritisation based on clinical outcomes will be inevitable

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