Improving eye health and reducing sight loss – a call to action

Who we are

The Optical Confederation represents the 12,000 optometrists, 6,000 dispensing opticians, 7,000 optical businesses and 45,000 ancillary staff in the UK, who provide high quality and accessible eye care services to the whole population. The Confederation is a coalition of five optical representative bodies: the Association of British Dispensing Opticians (ABDO), the Association of Contact Lens Manufacturers (ACLM), the Association of Optometrists (AOP), the Federation of Manufacturing Opticians (FMO) and the Federation of (Ophthalmic and Dispensing) Opticians (FODO). As a Confederation we work with others to improve eye health for the public good.

The Local Optical Committee Support Unit (LOCSU) provides expert advice and quality, practical support to Local Optical Committees in England, to help them work with Clinical Commissioning Groups and Local Eye Health Networks to develop and implement local objectives, in respect of primary eye care services. LOCSU has developed a number of eye care pathways based on best practice and has developed clinical training packages and implementation tools to assist with the commissioning and governance of services based on these pathways. LOCSU has produced a map of community eye health services in place across England[1].

Introduction

The Optical Confederation and LOCSU welcome this Call to Action. Without it, the NHS will not be able to cope with the welter of eye health needs, which are driven by an ageing population and the arrival of new technological developments to treat conditions which were previously untreatable, and to save sight.

Achieving these goals requires a radical re-think about how the NHS commissions eye health services, using all available capacity (both physical and human) in the most effective way, re-emphasising prevention (eg school-aged children) and early intervention, in order to preserve health, well-being and independence throughout life and into older age.

[1] www.locsu.co.uk/community-services-pathways/community-services-map

Uniquely the eye health sector – through the Clinical Council for Eye Health Commissioning (Clinical Council), Local Eye Health Networks (LEHNs), NHS England, LOCSU and Clinical Commissioning Groups (CCGs) – already have systems in place to effect change, which include patient voice, all relevant professions, institutions and systems.

The UK has a high level public health strategy for eye health endorsed by all the professional bodies and stakeholders in health and social care, as well as charitable organisations: The UK Vision Strategy (refreshed in 2013). NHS England together with the Department of Health and Public Health England should visibly support and promote its implementation and progress towards achieving its objectives for preventing sight loss and improving population eye health.

The Optical Confederation and LOCSU have seen and support the responses made by the Clinical Council and the VISION 2020 UK Public Health Committee, with whom we are delighted to work in partnership to achieve change. The Optical Confederation and LOCSU are ready to take on a leadership role as members of the Clinical Council to support NHS England at national level working with Local Eye Health Networks at local level, to develop and implement plans resulting from the Call to Action.

Our detailed responses to each question below expand on the Call to Action themes from the perspectives of the 12,000 optometrists, the 6,000 dispensing opticians and 7,000 optical businesses, 45,000 ancillary staff and 81 Local Optical Committees which the Optical Confederation and LOCSU represent.

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Survey questions

Financial investment

1. How can we secure the best value for the financial investment that the NHS makes in eye health services?

The NHS must ensure that:

- pathways are commissioned to reduce unnecessary referrals to hospital eye services. See our answer to **Question 6**
- capacity is deployed at the most appropriate and cost effective level to meet individual and population needs. See our answer to **Question 6**
- commissioning services becomes more efficient and effective (avoiding duplication and higher and unnecessary transaction costs). See our answer to **Question 6**
- services are properly integrated and communication systems are networked – IT is key to achieving this. See our answer to **Question 12c**
- everyone who needs vision correction can access it. See our answer to **Question 9**
- people with sight loss are properly supported
- current and anticipated levels of avoidable sight loss are radically reduced
- episode and clinical data are effectively gathered, retained and then harvested to enable audit of outcomes, evaluation of pathways and future commissioning decisions. See our answer to **Question 6**
- existing technology is better utilised and innovation is embraced. See our answer to **Question 8**

Health & Wellbeing Boards, LEHNs and CCG commissioners all have major, interlocking roles and duties here.

Earlier detection and intervention of eye conditions is necessary to reduce levels of avoidable sight loss, which will in turn reduce the economic cost to the country of caring for people who are blind or partially sighted currently around £22 billion per year in the UK.

People with sight loss must be properly supported so that barriers to care and social inclusion are overcome, both on equality grounds and to minimise downstream costs to the health and social care systems.

Pathways, prevention and integrated services

2. How can we encourage a more preventative approach to eye disease to reduce the burden of blindness and vision impairment?

A more preventative approach to eye disease, to reduce the burden of blindness and vision impairment, can be encouraged by:

- ensuring there is equitable access to General Ophthalmic Services (GOS) for the whole of the eligible population including seldom heard groups
- promoting optical practices as the first port of call for people with eye health problems
- addressing capacity issues in hospital eye clinics to ensure equitable access to surgery and other sight preserving treatments for those who would benefit
- ensuring that systematic population-based screening is implemented as recommended by the UK National Screening Committee (NSC)
- implementing eye health awareness campaigns targeted at high risk groups, particularly groups known to have a low uptake of sight tests
- increasing the understanding of eye health issues and the impact of sight loss among health and social care practitioners to ensure that eye health becomes part of routine general health care and not an optional add-on

GOS

GOS plays an important public health role in providing vision correction for the majority of the population who need it and opportunistic case detection for those who need further investigation or treatment. For those who qualify for NHS support and who do need spectacles or a prescription change, the NHS voucher is sufficient to meet all of a patient's basic requirements for good quality, suitable and acceptable eye wear.

GOS offers three other major benefits that need to be understood:

- it ensures a sight test for all who need one on a demand-led basis
- it offers the same standard of sight tests to NHS and private patients (eliminating health inequalities for those who access the sight testing service)
- it plays a key role in identifying pathologies early where intervention can prevent or ameliorate deterioration, saving significant NHS and social care costs downstream

More details on ensuring equitable access to GOS can be found in our response to **Question 9**.

Screening

Systematic population-based screening must be implemented where it has been recommended by the NSC), and should be supported by robust high level indicators such as population coverage of the screening programme; proportions offered screening; proportion taking up screening offer.

Current screening programmes recommended by the NSC are listed below along with improvements required:

i. Orthoptist-led screening for vision defects in children, aged 4 – 5 years:

- Currently this has not been implemented in all areas and performance indicators have not been developed. Commissioners must be held to account where screening has not been implemented, and robust high level indicators such as population coverage of the screening programme need to be agreed at a national level.

ii. Diabetic eye screening:

- There is variation in the percentage of people with diabetes offered screening and the percentage who take up the offer. Underlying causes of persistent variation need to be identified as a priority and action must be taken to reduce the variation.

Details on education of the public and implementing eye health awareness campaigns can be found in our response to **Question 3**.

Increasing the understanding of eye health issues and the impact of sight loss among health and social care practitioners is dealt with in our response to **Question 4**.

3. How do we encourage individuals to develop personal responsibility for their eye health and sight?

We can encourage individuals to develop personal responsibility for their eye health and sight by:

- providing high quality eye care services and ensuring that those services are easy to access
- delivering education about eye health and care from an early age
- working with patient groups and the public to understand their views on how individuals can be encouraged to develop personal responsibility for their eye health and sight

- changing the public's perception that the purpose of a sight test is only to correct refractive error and increasing awareness that it is important in detecting causes of preventable sight loss
- promoting optical practices as part of primary care and as the first port of call for eye health problems
- providing information on eye health and eye conditions in a range of accessible formats
- ensuring people with sight loss have access to an effective Eye Clinic Liaison Officer (ECLO) service
- encouraging employers to inform employees about their right to sight tests under Health and Safety (Display Screen Equipment) Regulations[2]

Education

Education about eye health care needs to be delivered from an early age to achieve levels of public awareness about the dangers presented by smoking, diabetes, UV light and genetic factors akin to levels of awareness the public have about the dangers of the sun with regard to skin cancer.

Education of the public is needed to increase awareness of the fact that fifty percent of avoidable blindness in the UK is currently missed through late presentation by patients, particularly through their not attending for regular sight tests. Awareness campaigns should be particularly targeted at the at risk groups.

We also need to increase awareness among the public that being fit and well can help your eyes stay healthy, and that maintaining a healthy weight and blood pressure may help with eye health. The public need to be educated on the role nutrients such as Omega 3 fatty acids, Zinc and vitamins C and E may play in preventing age related vision problems such as macular degeneration and cataracts.

Patient and public view

When eliciting the patient and public view, we need to engage with four main groups: people with eye conditions living with sight loss, people attending hospital clinics/receiving treatment for eye conditions (but who are not visually impaired), people who need an optical correction but have no eye health problems, and the wider public who have not had the need to access eye health services but who we very much need to develop personal responsibility for their eye health and sight.

[2] *Health and Safety (Display Screen Equipment) Regulations11992 as amended in 2002 which implemented European Directive (90/270/EEC)*

Simplifying access

Essential to simplifying access to eye health services is the delivery of more services in the community. For these services to be successful, understanding and knowledge that optical practices are part of primary care and are providers of NHS eye health services in the community must be promoted. Key to this is allowing optical practices to use the NHS logo. Streamlined integrated referral pathways must also be implemented for patients that require specialist care.

Information

Information on eye health and eye conditions needs to be readily available in a range of accessible formats to ensure that people trying to take responsibility for their own health can easily access information presented in the way they prefer. An Accessible Information Standard is being developed by NHS England and community optical practices look forward to playing their part in this.

ECLOs

Where eye disease and/or sight loss has been identified, an effective ECLO service should be available in both the hospital and community setting to help people understand how to care for themselves and protect their sight after a diagnosis. This should be jointly funded by the NHS and social care and may be a recommended use of the Better Care Fund.

4. How can we increase an understanding of eye health amongst health and social care practitioners in the wider professional network, particularly amongst those who are working with groups at higher risk of sight loss?

In order to increase understanding of eye health amongst health and social care practitioners in the wider professional network, particularly amongst those who are working with groups at higher risk of sight loss, we need LEHNs) to ensure health and social care practitioners are made aware:

- that dementia, diabetes, smoking, and falls in the elderly can have serious implications and co-morbidities with eye health
- of the high prevalence of undetected refractive error and potentially sight-threatening disease among people with dementia and of the increasing incidence of diabetic eye disease
- that smoking can almost double the risk of developing wet Age-related Macular Degeneration (AMD) and that people are almost twice as likely to fall if they have impaired vision

- that eye health problems and sight loss can have an impact on a patient's health, for example, by the increased risk of falls and social isolation

LEHNs need to work with stakeholders to take forward recommendations from the College of Optometrists on how falls teams should be supported in checking patients' vision and also how better connections between them and local optometrists can be encouraged.

LEHNs need to ensure General Practitioners understand:

- The signs and symptoms of eye conditions and treatments and referral pathways, particularly for the leading causes of blindness.
- What eye health services have been commissioned in their local area and how to refer or signpost patients to them.

LEHNs need to work with their Local Pharmacy Networks to increase awareness among community pharmacists of the role they can play in health education, re-enforcing key relevant messages for eye health, as well as providing information and assistance on use of eye medications, and facilitating compliance with medication. For example, where pharmacies supply ophthalmic products or ready-made reading glasses, those pharmacists are well placed to publicise the additional public health benefits of regular sight testing so that eye health pathologies, often imperceptible to patients, can be identified and treated.

Work should also be done to encourage all health and social care professionals to remind patients of the importance of good eye health and regular sight tests. For example:

- Eye heath should be included in the personal child health record (also known as the PCHR or the 'red book'), the national standard health and development record given to parents/carers at a child's birth.

- Care home staff and GPs who visit care homes should check whether residents have had an up to date sight test, particularly those with Alzheimer's disease or dementia, where family members may have assumed there is no value in a sight test because the patient does not read or watch much television for example.

- GPs and falls prevention teams should ensure that they check that every patient who has had a fall or who is deemed to be at risk of falling has had a recent sight test, and if not, encourage them to do so.

- Hospitals should implement as a key priority recommended by the National Institute for Health and Care Excellence (NICE), multifactorial assessments, including assessment of visual impairment, to identify a patient's individual risk factors for falling in hospital that can be treated, improved or managed during their expected stay.

5. How can we ensure that all relevant NHS services identify and address potential eye health problems for patients with long term conditions where eye health problems are a known possible outcome?

By ensuring:

- LEHNs work in collaboration with other Local Professional Networks to increase the understanding of eye health, and the association of sight impairing conditions with systemic diseases responsible for premature mortality and morbidity, amongst health and social care practitioners. For more information, see our response to **Question 4**

- a check that the patient has had a sight test by an optometrist within the past year (or shorter interval if recommended), or is booked to have one , is incorporated into the health checks 'named GPs' will carry out for all 75 year olds

- healthcare professionals encourage people with diabetes or who are at a higher risk of diabetes, to attend regular sight tests

- all people who have diabetes are invited to attend annual screening for diabetic eye disease by their local diabetic eye screening programme

- assessment of eye health and visual performance is included in the falls pathway and the dementia pathway

- health and care professionals involved in dementia care are aware that good vision can significantly improve the quality of life of a person with dementia and may have a positive effect on behaviour, and ensure that people with dementia have regular sight tests

- health and social care practitioners involved in providing care for people with learning disabilities are aware that visual impairment is often a contributing factor in challenging behaviour and ensure that people with learning disabilities have regular sight tests

- evidence is used to dispel the misconceptions among health and social care professionals and the families and carers of people with learning disabilities and people with dementia, that lead them to conclude sight tests will be of no value, such as the patient cannot cooperate or will not wear glasses even if they are prescribed

- the LOCSU Community Eye Care Pathway for Adults & Young People with Learning Disabilities is universally commissioned to provide tailored eye examinations for people with learning disability. See our answer to **Question 9**

- the visual performance of patients with stroke is regarded as key to their rehabilitation by all professionals involved in the care of stroke patients, and that community optometrists and orthoptists are involved as part of the multidisciplinary team supporting the rehabilitation of patients with stroke once the patient has been discharged back to the community setting

In addition, community optical practices provide an ideal location, with accessible facilities and expertise, to also undertake risk assessments for various long term conditions. For example, evidence from South London community blood pressure identification projects shows that many high risk adults who are reluctant to access conventional healthcare services can be identified and offered treatment as a result of accessing eye care services. Similar benefits could be derived from the utilisation of community optical practices to provide the NHS Health Checks available to people between the age of 40 and 74.

6. How do we develop an approach to commissioning that makes the best use of the skill mix that is available in hospital and community resources?

In order to develop an approach to commissioning that makes the best use of the skill mix that is available in hospitals and the community, we should look at the success of services that have already been commissioned by many CCGs in England to better utilise community optometrists and opticians. We should also learn from the successful of models of primary eye care services that have been implemented in Scotland and Wales.

LEHNs have a key role to play in providing independent advice and support to commissioners.

Integrated IT and effective communication between primary and secondary care are key. See our response to **Question 12c.**

Reduction of unnecessary referrals

Pathways that utilise the core skills of optometrists and opticians to reduce unnecessary referrals to secondary care should be commissioned nationally to remove the current "postcode lottery" that exists for patients when not all CCGs commission such services. This includes services for minor eye conditions, glaucoma repeat readings, and cataract referral refinement as outlined in the LOCSU pathways[3]. These services have already been commissioned by a number of individual CCGs[4] and have shown to be effective in retaining patients in delivering patient choice, care closer to home as well as reducing referrals to secondary care.

Service	Number of CCGs commissioned
Cataract Referral	119 (57%)
Glaucoma Repeat Readings	139 (66%)
Minor Eye Conditions Service	58 (28%)

Utilisation of primary care workforce

In addition to the services mentioned above, non-specialist work should be transferred from the hospital sector to the community so that the skills of optometrists, opticians, orthoptists, nurses and GPs with a special interest (GPSis) in ophthalmology working in the community, are better utilised to introduce much needed capacity to meet the rising demand for eye health services. Cataract post-operative checks and the monitoring of Ocular Hypertension both utilise the core skills of optometrists, whereas other services such as monitoring of patients with low risk glaucoma need optometrists with higher qualifications and/or robust arrangements for supervision by an ophthalmologist.

Service	Number of CCGs commissioned
Cataract Post-op	48 (23%)
Ocular Hypertension Monitoring	16 (8%)
Glaucoma Monitoring	5 (2%)

[3] www.locsu.co.uk/community-services-pathways
[4] www.locsu.co.uk/community-services-pathways/community-services-map

CCGs should work with stakeholders through the LEHN to identify the skill mix available locally in the community. The local mix of ophthalmologists, orthoptists, hospital optometrists and opticians, ophthalmic nurses, technicians, ECLOs, GPSis, community optometrists, opticians, and other eye health professional should be considered. An understanding of competencies is important as some optometrists, opticians, orthoptists and nurses will have developed higher qualifications such as independent prescribing or glaucoma management and can play a pivotal role in delivering more services in the community. Support should be provided for clinicians to develop skills beyond core competencies and to undertake higher qualifications where appropriate.

Multi – disciplinary teams in the acute sector

Specialist ophthalmology services in the acute sector should be delivered by multi-disciplinary teams making full utilisation of the skills of hospital optometrists and opticians, as well as ophthalmic nurses, orthoptists, technicians and trained healthcare assistants to support ophthalmologists.

Streamlining commissioning

To secure best value for the NHS from the implementation of more primary care based eye health services, the commissioning of these services must be carried out more efficiently and with greater effectiveness. This will require striking the most appropriate balance between national and local commissioning. Evidence to date suggests that for “core primary care services” national commissioning is by far the most effective means for providing appropriate health care to the entire population. Local variation leads to fragmentation and adds to cost and risk without necessarily leading to better outcomes.

National commissioning

Commissioning community services that utilise the core skills of optometrists and opticians at a national level will significantly reduce costs and administration as CCGs currently have to engage the services of commissioning support units to develop service specifications, negotiate fees, and draw up contracts for each individual community service they commission.

Community services should be commissioned with a standard national service specification, including pathways, accreditation and clinical governance requirements, for which frameworks already exist.[5] Standardised electronic data collection, reporting,

[5] http://www.locsu.co.uk/community-services-pathways/
http://www.qualityinoptometry.co.uk/
www.locsu.co.uk/training-and-development/enhanced-services-training

clinical audit, performance monitoring and evaluation of outcomes should be integral to the commissioning of these services.

Local Commissioning

Local commissioning, supported by LEHNs, is valuable in the commissioning of joined-up services according to specific local needs and ensuring primary care is properly connected to and works in partnership with reformed acute hospital care and social care. LEHNs should have a pivotal role here. It is at these ‘seams’ between services that local commissioning can add most value.

Incentives

The current misalignment of incentives and budgets across health and social care needs to be addressed for commissioners to realise the benefits of a preventative approach to eye health.

Incentives must be provided for primary and secondary care (and in some cases the voluntary sector) to collaborate to deliver integrated care, and focus on commissioning based on outcomes. Incentives should be implemented to support collaboration. For example, hospital based clinicians could be supported to spend some of their time delivering and/or overseeing services in the community. This could apply not only to ophthalmologists, but also to clinicians such as orthoptists, ophthalmic nurses and optometrists and opticians with higher qualifications and specialist skills gained in the hospital environment.

Perverse incentives that hinder the development of community services must be removed, such as a follow up tariff paid for patients being monitored in hospital, where it could be done in primary care.

Improving hospital diagnostic data

The quality of the diagnostic data recorded by hospital trusts under Hospital Episodes Statistics (HES) for admissions and out-patient attendances needs to improve as these records are used proxies for need, for service development and to inform commissioning decisions. Hospitals should be tasked with ensuring diagnoses are accurately recorded for all patients and performance management measures should be implemented to support this.

Community eye health service data

Robust data collection systems need to be a mandatory funded requirement of all commissioned community eye health services so that outcomes and costs effectiveness can be evaluated.

GPs and pharmacists

GPs and pharmacists have an important role to play working together with optometrists and opticians to achieve better outcomes and improve public health. Many patients choose to consult their GP in the first instance with an eye problem. However, given the increasing demands on GPs to provide out of hospital care for more patients with long term conditions and the predicted shortage of GPs to meet demand, it is essential that pathways are implemented to ensure that the community optometrist becomes the first port of call for patients with eye problems.

Many of the patients attending community pharmacies for the 438 million visits that take place per year are attending for eye-health related issues. Whilst it is quite appropriate for pharmacy colleagues to be the first point of call for relatively simple eye conditions, e.g. seasonal ocular allergies, these symptoms can sometimes mask more significant eye health problems and the aim should be to ensure that such patients are not lost in the system. A simple pathway should be implemented which ensures pharmacy staff advise patients carefully according to a simple eye health protocol and refer patients to an optometrist or optician (rather than a GP) if they need further advice.

7. Can we develop more widely the integrated role of eye health professionals in primary care in the identification and management of chronic or acute disease?

Yes, indeed we must. In order to develop this integrated role at scale we need:

- integration of IT systems between primary and secondary care so that data can be exchanged securely and efficiently between primary and secondary care. Please see our answer to **Question 12c**
- national commissioning of community services that utilise the core skills of optometrists and opticians. Please see our answer to **Question 6**
- incentives to encourage collaboration between primary, secondary and social care providers. Please see our answer to **Question 6**
- standard national service specifications for community management of conditions such as glaucoma and medical retina. Please see our answer to **Question 12b**
- support for clinicians to develop skills beyond core competencies and to undertake higher qualifications where necessary. Please see our answer to **Question 6**

- implementation of standardised robust clinical governance and quality assurance arrangements across all services. Please see our answer to **Question 12b**

In addition, clinicians must be encouraged to develop a culture of working as part of an integrated whole looking after the care of the patient.

More information on overcoming barriers to discharging patients back into the community can be found in our answer to **Question 8**.

When commissioning wide scale management of chronic or acute disease in the community, CCGs also need to consider the implications for local hospital eye services.

8. What can we do to relieve pressures in ophthalmology departments because of difficulties in discharging patients back into the community?

Overcoming the current difficulties in discharging patients back to community optical practices is essential to relieve pressures in ophthalmology departments as overall capacity in the hospital sector is limited, whereas capacity in the community optical sector is more flexible and can be harnessed for the greater benefit of patients and the NHS.

Subject to proper underpinning by clinical governance and audit, the default should be that whatever services can safely be delivered in the community should be, thereby freeing up scarce hospitals resources to cope with the growing pressures from more serious conditions and the emergence of complex technologies.

Communication

The main barrier to discharging patients back into the community is the lack of integrated IT, resulting in difficulty in exchanging data securely and efficiently between primary and secondary care. Details of how this barrier can be overcome are provided in our answer to **Question 12c**.

Collaboration

Incentives to encourage collaboration between primary and secondary care providers (and in some cases the voluntary sector) are required to develop effective and efficient discharge mechanisms and/or shared care pathways. See our answer to **Question 6.**

Better use of technologies and innovation

Utilisation of telehealth should be increased to develop greater efficiency in integrated pathways by enabling hospital consultants to take on an advisory role where a primary care colleague needs advice on the appropriate action to take for a particular patient.

With integrated IT, ophthalmologists can view patient records and diagnostic results remotely, including retinal images and visual field pots, This approach could be used to both minimise unnecessary referrals and support community management services.

Developments in telemedicine and innovation in technology should be integrated within pathways where appropriate to bring efficiency. For example, image capture and transfer for diagnosis and monitoring of ongoing conditions.

<u>Development of governance frameworks</u>

A clinically (normally ophthalmology) led model with accredited community optometrists, opticians, orthoptists and GPSis working within their level of competency, would allow patients with conditions such as 'low risk' glaucoma and treated wet AMD to be safely monitored in the community. Ophthalmology oversight and/or training for optometrists and opticians beyond core skills are required for more specialist services that can be provided in primary care. See our response to **Question 12b**.

The Clinical Council needs to take a lead role to support NHS England, CCGs and LEHNs in agreeing national governance standards and service delivery frameworks for community monitoring of patients with certain conditions such as 'stable' glaucoma and wet AMD.

Access

9. How can we appropriately increase access and uptake of timely routine sight tests for the general population, including for people at higher risk?

The GOS system provides a high-quality, accessible and needs-led sight-testing and case detection service for the majority of the population. It is one of the most cost-effective public health programmes in the NHS. GOS forms the first level of the Primary Ophthalmic Services (POS) contract structure implemented in 2008.

The other levels of POS – additional and enhanced services – were intended to be used to supplement GOS for 'seldom heard' groups and specialist services. Level 2 – additional services – for example, provides a domiciliary GOS service to those who are unable to leave home unaided through physical or mental illness or disability.

There are currently 5,400 community optical practices in England and over 10,000 optometrists delivering around 13 million NHS sight tests, and a further 5.6 million private sight tests, per year. Over 400,000 domiciliary sight tests are provided for those who are unable to visit a practice unaccompanied due to a mental or physical disability. For those who qualify for NHS support and who need spectacles or a prescription

change, the NHS voucher is sufficient to meet all of a patient's basic requirements for good quality, suitable and acceptable eye wear.

GOS offers three other major benefits that must be understood:

- it ensures a sight test for all who need one on a demand-led basis
- it offers the same standard of sight tests to NHS and private patients (eliminating health inequalities for those who access the service)
- it plays a key role in identifying pathologies early where intervention can prevent or ameliorate deterioration, saving significant NHS and social care costs downstream

More work could be done under GOS, making greater use of the skills and expertise of those in the community optical sector, but this would be dependent on appropriate remuneration.

<u>Access to sight tests</u>

In order to appropriately increase access to routine sight tests for the general population, including for people at higher risk of developing eye conditions, we must ensure that high quality eye care is easily accessible to all; in ways, locations and times that suit the patient. The majority of optical practices are open Monday to Saturday, with many open evenings and some open on Sundays, and they are generally well located for public transport links and have access to parking facilities.

Further research is needed to understand the links between deprivation, access and how these can best be overcome. A study in Leeds found that there were no optical practices located in some less affluent parts of the city and proposed that an alternative model of GOS provision was required. However, anecdotally, this is not thought to be the case in other areas; a link between correlation and causation has not yet been made; and NHS commissioners have always had powers to encourage GOS in any locations they judge necessary.

As outlined in our response to **Question 9**, work needs to be done to ensure GOS is universally accessible to seldom heard groups and groups who have particular needs, possibly through Level 3 – enhanced services (now known as community services) as they were originally intended to be deployed.

This includes:

- Commissioning of a national service, based on the LOCSU pathway for Adults and Young People with Learning Disabilities, as developed with the charity SeeAbility, to ensure people with learning disabilities have universal access to GOS.

- Commissioning of a national service to make GOS more accessible for children in special schools or those with special educational needs. Access to GOS for this group could be simplified by designating schools for children with special needs as “Day Centres”.

- Some flexibility to improve access to GOS for homeless people, gypsies and travellers, vulnerable migrants and sex workers.

- Targeting of ‘at risk’ groups, who have a higher incidence of certain eye conditions, such as people of African, Caribbean and South East Asian descent.

Uptake of sight tests

In order to appropriately increase uptake of timely routine sight tests for the general population, including for people at higher risk increase awareness of the importance of regular sight tests among the public and all health and social care practitioners. See our response to **Questions 3 and 4** for more details.

To a certain extent the inverse care law applies in eye health as in other NHS services Although all community optical practices provide NHS sight tests and high quality spectacles to meet all needs within NHS voucher values, the challenge is to encourage those at risk or outside the system to take up the service. NHS commissioners have always had the powers to commission, part-fund or otherwise encourage community sight-testing services in communities where access appears to be a problem. These do not need to be in traditional premises (although this is desirable because of the high standards of equipment) but outreach services can be provided in church halls, schools, mobile units and other community facilities as they are, for example, in some parts of Scotland and other rural areas.

CCGs, as part of their LEHNs should consider, along with Area Teams, where such services might be commissioned and establish pilots to assess whether access, better eye health and identification of higher levels of preventable sight loss are achieved. NHS England can designate any premises as GOS premises for these purposes and, with appropriate local leadership and encouragement, many high street practices will be willing to provide outreach services on this basis. In some cases it might be sensible to co-locate sight testing and case-finding services in GP practices or other health care facilities. However the opportunity costs of losing other services that might have been provided in those premises need to be carefully considered as well as equipment and other costs to ensure the service is cost effective in outcomes terms.

The current NHS sight testing service is subsidised by the sale of spectacles, contact lenses and other optical products. Without significant public investment, this is likely to remain the case for the foreseeable future. However the retail aspect of optical services could inhibit some patients, especially those on low incomes, from accessing the service. As above, LEHNs should consider these issues and work with the Local Optical Committees to see how these issues could be addressed.

Access to domiciliary sight tests

The domiciliary eye care service is commissioned national as an *Additional Service* by NHS England and is provided for those who are unable to visit a high street practice unaccompanied due to a mental or physical disability. Older people, among whom eye conditions are more prevalent, make up the majority of this patient group and it is essential that they receive regular eye care as early detection can lead to the prevention of sight loss.

Good eye care and wearing the appropriate glasses can make a big difference to a person's independence and sense of well being. It is vital that this patient group have the same access and choice of quality eye care as that available to someone visiting a community optical practice. Access to domiciliary eye care services must be simplified to meet an increasing demand associated with demographic change.

The domiciliary patient must also have the choice of who provides their eye care services. They may already have their preferred optician but if not, there should be a listing available of all those providing domiciliary eye care services in their area. This should be available as it is for the other health professions on NHS Choices.

A key barrier to access for the domiciliary patient is the pre-notification system. When a patient requests a sight test, the provider has to notify the NHS Area Team 48 hours in advance for 1 or 2 patients, and 3 – 8 weeks for 3 or more, of their intention to visit those patients. This system does not allow the patient or the provider the freedom to arrange an appointment at their mutual convenience as they would be able to on the high street. It can also cause an unnecessary delay between a patient deciding they want a sight test and them actually receiving one.

As the pre-notification is not used to check that a person is due for a sight test or to check procedures conducted during a sight test in the form of a 'spot check', it is not clear what value this system adds for the patient. It also puts an enormous administrative burden on the NHS and the domiciliary provider. It should be noted that this administrative burden will increase as the demand for domiciliary sight tests increases in line with demographic change.

To ensure that the domiciliary patient enjoys the same flexibility as the person visiting the high street as to when they have a sight test, the pre-notification system should be abolished. If the NHS feels that further verification of the domiciliary eye care service is required, then these funds currently used for administering the pre-notification system would be better used in post payment verification (PPV).

Uptake of domiciliary sight tests

Many of the issues mentioned elsewhere in this response with regards to the promotion of eye health awareness are particularly relevant to the domiciliary patient group. Often, for this patient group, eye health will take less of a priority in the presence of other health conditions.

NICE Quality Standard 50 acknowledges that sensory impairment is common in older people and is frequently perceived as an expected feature of ageing rather than as potentially disabling. The standard states that it is important that sensory impairment is not considered as acceptable for older people in care homes and that this may need to be emphasised during training to increase awareness and recognition of sensory impairments.

NICE Quality Standard 50 also states that recognition and recording of needs arising from sensory impairment in older people by staff in care homes is essential to ensure timely access to health services and improve the quality of life of older people and avoid isolation, which can have a detrimental effect on mental wellbeing.

Therefore more awareness among health and social care professionals regarding the wider impact that eye health problems and sight loss can have on the health and wellbeing of patients in this group is essential. Health and social care professionals can play a vital role in reminding patients of the importance of regular sight tests.

More work on awareness is also needed amongst relatives and primary carers as many are not aware that the domiciliary eye care service actually exists and that it is possible to have an eye test in your own home.

10. How can we improve timely access to eye health treatments and sight loss services for vulnerable or seldom heard groups?

Homeless people

Homeless people often find it difficult to access community-based health care services and as a result are 5 times more likely to attend emergency departments in England compared with those who are not homeless.[6]

Where homeless people can access health care, many feel uncomfortable, for a complex range of reasons, in exercising that right. One reason may be that homeless people can stand out in a variety of ways and may feel they are not treated as equals in certain health care settings[6].

As only an estimated 15% of homeless people receive state benefits, the majority of homeless people are currently unable to access NHS sight tests.
Currently, the population of rough sleepers and those in sheltered housing only access eye care through A&E or the charity Vision Care for Homeless People (VCHP) which funds centres in some cities. The VCHP model of charitable subsidising of the care of non-NHS patients is not sustainable and does not reach the vast majority of homeless people.

A UK Vision Strategy paper drafted in May 2013, following a call for evidence from members of Ophthalmic Public Health Network, highlighted the need for more systematic, commissioned solutions to improve access to primary ye care for homeless people. This can reduce secondary care costs and more importantly improve equity in access to care and reduce the risks of avoidable blindness.

The problem is equally acute when homeless people need hospital treatment and follow-up e.g. for cataract surgery, or regular eye drops following an intervention.

- Anecdotal evidence (gathered through the call for evidence) suggests that homeless people are often prepared to make great efforts and travel long distances to keep hospital appointments, sometimes only to be refused care when they arrive due to a lack of having a home/GP address (and therefore an NHS commissioner) or a way to communicate follow up appointments/care.[7]
- They may also encounter barriers if they need follow-up care in the community over a certain number of days.

[6] A general practitioner and nurse led approach to improving hospital care for homeless people. Nigel Hewett et.al BMJ 28/09/12
[7] Rebecca Marsden – Head of Development and Training for Envision-i-Care and formerly Low Vision Support Services Manager in West Midlands.

National Pathway - A nationally agreed eye health and sight loss pathway for homeless people is needed. This could then be planned and promoted by the LEHNs and implemented for every NHS Area Team.

LEHNs should work with all stakeholders including homelessness agencies to ensure timely access to treatment to prevent permanent sight loss and tackle health inequalities.

Flexibility in the GOS regulations is required to permit a patient to self-declare as homeless and thereby qualify for an NHS sight test and an NHS voucher for spectacles and repairs as clinically necessary.

It is highly likely that some optical practices would wish to specialise in this area of activity and publicise the service through charities and networks for homeless people and social services.

The pathway should also encompass referral to the Hospital Eye Service for diagnosis, treatment, follow-up and discharge or when appropriate, further referral to support individuals with permanent sight loss.

It may be that a specified optical or GP practice or practices could be designated for a given catchment area as accredited centres for ophthalmic follow-up service where homeless people could attend/return for necessary eye drops, post-operative checks etc. This would provide vulnerable homeless patients a "clinical base" for the duration of their care episode even if they are unable to establish a "domicile base".

Please see the response to the Call to Action from Vision Care for Homeless People for further information.

People with learning disabilities

People with learning disabilities are 10 times more likely to have a serious sight condition than the general population, yet least likely to receive appropriate eye care on a timely basis.

Many people with learning disabilities, both adults and children, may not realise they do not see well, and may not be able to tell others about their vision. Sometimes behavioural problems or changes in behaviour can be attributed by carers and healthcare professionals to a person's learning disability, when undiagnosed sight loss might in fact be the cause.

A national service, based on the LOCSU pathway for Adults and Young People with Learning Disabilities[8] should be commissioned to ensure people with learning

[8] http://www.locsu.co.uk/uploads/enhanced_pathways_2013/locsu_pwld_pathway_rev_nov_2013.pdf

disabilities have universal access to GOS. This Pathway utilises accredited optometrists to provide a tailored service to make sight tests more accessible to adults with learning disabilities. The pathway is supported by the charity SeeAbility.

A national service should also be commissioned to make GOS more accessible for children in special schools or those with special educational needs. At present this is not possible, as schools are not currently considered by NHS England to be 'day centres' as defined in the General Ophthalmic Services Contract Regulations 2008. Access to GOS for this group could be simplified by designating schools for children with special needs as "day centres".

Hospitals must have well-established procedures for assessing Consent and Capacity for eye surgery for adults with learning disabilities. Uncertainty over how to manage this issue can cause unnecessary delays in access to eye surgery for adults with learning disabilities.

When planning eye surgery for a person with learning disabilities, it must be ensured that a multi-disciplinary approach is adopted involving the person, carers and supporters, ophthalmologist, Learning Disability Nurse, anaesthetist and pre-assessment nurse. This multi-disciplinary group should assess whether the person will require any additional support before, during and after surgery.

Please also see the response from SeeAbility to this Call to Action.

User involvement

11. How do we best involve service users and their carers in the development, design and delivery of NHS services for eye health?

When considering how to engage service users and their carers in the development, design and delivery of NHS services for eye health it is important to engage with four main groups, as outlined in the answer to **Question 3.**

It is important to work with patient groups set up by charities supporting patients with particular eye conditions and/or sight loss. Examples are the Macular Disease Society, International Glaucoma Association, Royal National Institute of Blind People (RNIB) and Guide Dogs. It is also important for CCGs to engage patient representatives of local societies in their area.

LEHNs should include both local charities and local branches of national charities as outlined in the Getting Started Guide produced by LOCSU with the support of NHS England, the Clinical Council for Eye Health Commissioning and the UK Vision Strategy. [9]

Local Healthwatch has a key role to play, as have patient advisory groups that many CCGs have set up.

An important consideration when consulting patients with sight loss is how information is presented, thought needs to be given to ensure it is in an accessible format.

12. In stimulating debate about the potential for transferring more elements of eye care from hospitals to the community we want your views on:

a) What is the evidence base to support the suggestion that providing more eye care in the community will prevent eye disease and reduce unnecessary expenditure elsewhere in the health and social care system, and how do we ensure the services are safely delivered?

When considering the evidence base for community eye care services it is important to look at the success of services that have already been commissioned by many CCGs in England to better utilise the skills of community optometrists and opticians. We should also learn from the successful of models of primary eye care services that have been implemented in Scotland[10] and Wales. A comprehensive summary of evidence in England and Wales has been compiled by LOCSU and has been submitted with this response.

It is extremely important to acknowledge the value of services that reduce the volume of unnecessary referrals to secondary care as well as considering pathways and services that enable the transfer of more elements of eye care from hospitals to the community.

There is a strong evidence base to support the commissioning of community services for minor eye conditions, glaucoma repeat readings, and cataract referral refinement and post operative assessment, all of which utilise core skills of optometrists.

Historically, it has been difficult to obtain evidence from Primary Care Trust commissioned paper-based "enhanced services", but since CCGs have taken over responsibility for commissioning of these services, a number of areas now collect activity and outcomes data from community services electronically via the OptoManager IT platform designed by LOCSU and Webstar Health.

[9] http://www.england.nhs.uk/wp-content/uploads/2014/01/lpn-eye-get-start-guid.pdf

[10] http://www.aop.org.uk/uploads/Scotland/the_economic_impact_of_free_eye_examinations_in_scotland.pdf

When considering the benefits of transferring elements of care from hospital to the community, it is important to recognise that community based eye care provides a more patient centred service and improves patient experience. Therefore even if you cannot demonstrate savings, if a community service achieves the same clinical outcomes at the same cost, but gives the patient a better experience, it is worth implementing.

It must also be recognised that if we do not transfer more elements of eye care from hospitals to the community then we will not be able to tackle existing health inequalities or meet the rising demand for eye services. This will result in a greater risk of late or inaccurate diagnoses of eye health problems, which will increase pressures elsewhere in the health and social care system – and will jeopardise good clinical outcomes.

Minor Eye Conditions Service (MECS) - also known as Primary Eyecare Assessment and Referral Service (PEARS)

As many as 78.1% of cases attending eye casualty are deemed 'non serious', with 50-70% of cases not constituting either an accident or an emergency. Implementing a minor eye conditions service (MECS) that allows conditions such as infections, styes, dry eye, abrasions, trichiasis and symptoms suggestive of retinal tears to be managed or investigated in the community, is known to reduce the number of people attending A&E departments with minor eye conditions if signposting takes place correctly.[11]

As well as helping to address A&E pressures, the MECS service also reduces unnecessary referrals to ophthalmology outpatient clinics and enables GPs to retain patients in primary care even when they do not have the equipment or expertise to manage eye problems themselves.

Evidence from OptoManager

Combined data from 7,861 episodes across 6 services commissioned since April 2013 showed 78% of patients were managed by the optometrist, 17% were referred on to secondary care and 5% were referred to their GP.

92% of patients were likely or extremely likely to recommend the service to friends or family.

[11] http://www.college-optometrists.org/filemanager/root/site_assets/guidance/urgent_eye_care_template_25_11_13.pdf

At an average of £54 per MECS consultation, the costs of this service are at least 40% less than what they would have been if all patients had been referred to secondary care.

Audit of the similar PEARS service in Wales (Sheen et al, 2009 and 2012) shows very similar figures. Only 1% of patients were managed inappropriately in optometric practice. A recent (unpublished – data available) audit of the Stockport service reviewed the 4.55% of patients who needed referral to eye casualty after assessment in the community. Of those referred, 70% were judged to be appropriate referrals.

Glaucoma Repeat Readings

The NICE guidelines on the management of glaucoma (CG85 – April 2009) had the side effect of implying that any pressures above 21mmHg be referred for investigation in the manner described by NICE. Until then, many optometrists had not referred those patients who were slightly above 21mmHg if there were no other indication of glaucoma. The number of referrals soared. Although NICE advised investigation where the pressures were repeatedly high as measured by the gold standard of Goldmann contact tonometry, there was no provision within the NHS to fund optometrists to repeat the pressure readings. Although not related to NICE guidance, a similar situation arises where a visual field defect is noted. It is advisable to ensure this is repeatable before referral, but there was no funding for seeing patients for further appointments.

Glaucoma repeat readings services fund optometrists to repeat pressures twice by Goldmann tonometry and to only refer when the pressure is above 21mmHg in the same eye on both occasions. This is extremely effective at reducing referrals.

Evidence from OptoManager

An analysis of data aggregated from 10 services shows that of 6,600 episodes, just 28% ultimately needed referral.

At an average of £30 per Repeat Readings consultation, the costs of this service are around 50% less when compared to all patients being referred to secondary care.

An audit of the service in Cheshire (Patel 2013) showed that 73% of suspicious visual fields were deflected by repeating on another occasion.

A paper by Edgar and Parkins (2011) showed cost saving of 62% with this type of service.

The referral deflection rate from 583 episodes in a Visual Field Repeat Readings service was 39%.

Cataract Referral and Post Op

An ideal cataract pathway minimises secondary care appointments and also ensures that only patients who wish to have cataract surgery are referred. Funding for the NHS sight test does not allow for the time needed to fully discuss the options with a patient and then allow them to reflect for a few days before returning to make a decision. A funded cataract direct referral service allows time to be spent with the patient for dilated fundoscopy and full discussion.

A paper by Tattershall and Sullivan (2008) showed that additional discussion was desirable prior to a hospital visit whilst an article by Sharp et al (2003) demonstrated that the surgery listing rate increased markedly during a pilot of a direct referral service. Lash et al (2006) recommended that all referrals for cataract should confirm a detrimental effect on lifestyle and the patient's willingness for surgery, which requires discussion time.

Post cataract surgery follow-up by community optometrists provides the advantages of care closer to home and avoids unnecessary hospital visits for patients undergoing uncomplicated cataract surgery.

Ocular Hypertension (OHT) Monitoring

Ocular hypertension is a state in which intra-ocular pressures are higher than the norm, but there are no other signs of glaucoma. Such patients are at slightly higher risk of glaucoma. Currently these patients are usually managed in secondary care, being seen at 6 to 12 monthly intervals, yet they do not have disease. The OHTS study showed that for patients with a pressure of 24mmHg or higher, about 1 in 10 will develop glaucoma over a 5 year period.

Monitoring these patients in the community is a very similar function to monitoring patients who have an immediate relative with glaucoma, which optometrists already do. A community service would free up secondary care time and would enable care closer to home for patients Mandalos et al (2012) showed that a community OHT monitoring service would free up hospital capacity.

Low Vision

Patients with low vision are a group for whom care closer to home is important. Low vision services provide advice and aids to people whose best corrected vision is poor.

The largest community service in the UK is that provided in Wales. Ryan et al (2013) showed that patients judged their disability to be reduced after interacting with the community low vision service which is well described by Margrain et al (2005). A further paper by Ryan et al (2010) showed that waiting times and journey times had reduced for most patients.

Learning Disabilities

People with learning disabilities are 10 times more likely to have a serious sight condition than the general population, yet are least likely to receive appropriate eye care on a timely basis.

The LOCSU pathway for Adults and Young People with Learning Disabilities utilises accredited optometrists to provide a tailored service to make sight tests more accessible to adults with learning disabilities. The pathway is supported by the charity SeeAbility.

Interim findings from SeeAbility's current pilot of the LOCSU pathway in the tri-borough areas of Kensington and Chelsea, Hammersmith and Fulham and Westminster show that a majority of patients who accessed the service had not received an eye test in the last 2 years; 55% were prescribed glasses (17% for the first time); 33% had a new eye health issue identified and 29% were referred on to another eye care service. Patients and carer satisfaction with the service is high.

Please see SeeAbility's response to the Call to Action for case studies and patient and carer testimonies.

Low Risk Glaucoma and other Community models

Cases of glaucoma assessed as being low risk can be monitored in the community by optometrists working under the supervision of a consultant ophthalmologist as defined by the Joint Colleges of Optometrists & Ophthalmologists, or by optometrists with the appropriate higher qualification. This frees up secondary care time and moves care closer to home.

Glaucoma monitoring in the community has been commissioned in a few places but the barriers, particularly the lack of IT connectivity mentioned in **Question 8**, mean that it has not been tested at scale in many areas.

Azuara-Blanco et al (2007) showed that community optometrists with suitable training made satisfactory decisions in respect of diagnosis and treatment of glaucoma.

A poster by Lewis K A, Davison C R (2013) submitted to the UK & Eire Glaucoma Society concluded a paper-based; low technology model of community glaucoma care, based on simple biometrics can be safe and effective.

A number of different models of shared care glaucoma monitoring have been trialled and implemented, but there is minimal data available from the commissioned services. Robust audit and evaluation of these models is required to inform a national framework of best practice models.

Other community services

It has been proposed that community optometrists should also be utilised to monitor patients that have received ant- VEGF treatment for wet age related macular Degeneration (AMD), macular oedema or diabetic maculopathy. Shared care models need to be piloted and evaluated to inform a national framework of best practice models.

Cost effective commissioning

Community services for minor eye conditions, glaucoma repeat readings, and cataract referral refinement and post op, all of which utilise core skills of optometrists, should be commissioned nationally. See our response to **Question 6.**

Equipment required for core competency pathways is already common place in community optical practices, therefore set up costs for these services are minimal. The cost of equipment required to deliver more specialist services and/or shared care in the community needs to be considered.

Safety

Patient safety is paramount. All clinicians providing services should do so within their level of competency to ensure services are delivered safely. See our response to **Question 12b**.

b) What are the workforce implications (development / re-structuring / training) to ensure safe and effective services for patients, and how would these be delivered?

Workforce planning

Workforce supply in the community is far more flexible and can be expanded rapidly outside centralised NHS controls. One of the factors which operates in favour of eye health is that community optical practices, optometrists and dispensing opticians operate in an open market-driven system, which is much more flexible than public sector institutions. This means that if there is demand, the market will respond.

In our sector, front-line needs are very closely connected to planning and supply and, by working with the seven UK optical universities, the College of Optometrists and the ABDO College, we are able relatively easily to flex numbers in training to meet likely future demand. At the same time, as optical professions, we have continually increased practitioners' skills and competences to the benefit of patients and the NHS. Our ambition is to continue that trend and to play an even greater role in the delivery of NHS eye care.

There are areas for development where greater synergy between optical workforce planning and the wider NHS workforce planning could be developed with regard to public health, leadership development and in hospital optometry training posts.

The challenge in moving services safely to the community is to ensure that the normal time-lags in market responses are shortened and do not inhibit necessary progress. Clarity from NHS England about the direction of travel will encourage community eye health providers to make the necessary investments in work-force training, development and facilities to take up the demand created by system re-design.

Accreditation for community services

Many of the services that can be provided in primary care utilise core skills of optometrists and opticians. National peer reviewed accreditation modules[12] to support the implementation of community services have been developed by LOCSU with the Wales Optometric Post-graduate Education Centre (WOPEC) involving a mix of distance learning and practical skills assessment. These modules act a refresher for clinicians and provide assurance of quality for commissioners. Key benefits of the modular approach are that it is accessible for practitioners and is not restricted by the academic timetable so services can be rolled out swiftly.

This cost-effective accreditation system should be universally adopted for services that utilise the core competencies of optometrists and opticians so as not to waste resources or reinvent the wheel.

Higher qualifications

Ophthalmology oversight and/or training for optometrists and opticians beyond core skills are required for more specialist services that can be provided in primary care. The College of Optometrists has a system of higher qualifications at three levels that can enable optometrists to take a more advanced role in the community management of

[12] www.locsu.co.uk/training-and-development/enhanced-services-training

conditions such as glaucoma and medical retina. Additionally the College of Optometrists and the Association of British Dispensing Opticians offer higher qualifications in the management of Low Vision. Higher qualifications are currently available for low vision, medical retina, and glaucoma[11]. Further qualifications on paediatrics and primary care are being considered. This system should be adopted for services that require optometrists and opticians to obtain competencies beyond core level, and to allow hospital optometrists to take on advanced roles.

Independent Prescribers

Optometrists with an Independent Prescribing qualification can play an enhanced role in community pathways if they are given authority to write NHS prescriptions for medicines to treat conditions affecting the eye. However, there is currently no provision for this within the NHS.

We appreciate that the CCG as budget holder needs to agree to both the benefits and expenditure, however, as the Optical Confederation has highlighted in recent correspondence with Ministers in the Department of Health and NHS England, a national NHS England framework that CCGs can implement would save considerable work and cost for both CCGs and optical practices.

What is needed is a simple system whereby:

- registered independent prescribing optometrists are issued with FP10s by NHS England. If necessary these could be downloadable FP10(O)s (to save on central NHS printing and distribution costs) on the same model as FP10(D)s for dentists - recording also the name and address of the patient's GP
- the prescribing optometrist, in order to prescribe locally, notifies the CCG and NHS England of their intention to prescribe with an estimate of their likely annual costs of ophthalmic prescriptions
- the CCG notifies NHS Business Services Authority of the new Non Medical Prescriber
- the prescribing optometrist reports quarterly to the CCG and NHS England on prescribing and costs (including details of the patients' GPs) so that prescribing optometrists, GPs and CCGs can work together to ensure effective and efficient prescribing and that costs are kept under control

Hospital optometrist training posts

The previously available 50 hospital based pre-registration optometrists posts has reduced in recent years to fewer than 25 posts, despite the number of optometry students graduating continuing to increase. We would like to see this situation reversed to help meet growing eye health needs. Specific funding for training for around 50 two-

year hospital optometry training posts is needed to support postgraduate pre-registration optometrist entry level, year 1 posts and a corresponding number of linked basic grade, year 2, training posts along with an appropriate element of funded supervisory time in order to develop a high level sustainable and effective optometry workforce of the future.

Optometrists can, and do, benefit from training in a hospital environment by gaining the widest possible experience of abnormal ocular conditions, diagnosis, treatment and management. This also helps to modernise the delivery of hospital eye care through multidisciplinary working and in developing the wider optometry workforce.

It is therefore essential that this situation is reviewed and for training numbers to be increased and brought more in line with the likely future needs of hospital trusts.

c) What are the IT requirements to support more community care?

Throughout this response we have demonstrated the critical role that primary eye health services in the community can play. Making greater and more effective use of community eye care providers will ensure more effective outcomes for patients as well as providing a better patient experience; it will reduce bureaucracy; and it will reduce the pressure on ophthalmology departments, GPs and A&E departments.

The key to achieving these benefits is for optical practices to have robust IT systems that are closely linked to, and ideally integrated with, general medical practice and hospital systems. In line with the Government's ambition for a 'paperless NHS' by 2018, communicating electronically with all clinicians involved in the patient's care should be the norm rather than the (currently) very rare exception.

Regrettably, although they are providers of NHS services, community optical practices have been left out of other NHS and primary care IT improvements programmes. The lack of infrastructure and connectivity mean that community eye health services operate in technological isolation from the rest of the NHS and social care system. This leads to duplication and inefficiency in the system at all points and is a major barrier to improving eye health efficiency and outcomes and the achievement of the aims of this Call to Action.

A relatively small but significant investment is needed to transform the way community optical practices are integrated with the wider NHS and social care. This investment would enable speedy communications across the eye health system, more care in the community, and better shared care between primary, secondary and social care, whilst maintaining patient safety.

With this investment we would be able to:

- provide a more accessible and continuous service for the patient – in terms of both outcome and experience – and reduce avoidable sight loss
- reduce pressure on hospital ophthalmology departments, A&E and GPs
- enable cost savings and reduce bureaucracy in the NHS
- enable better use of data, to provide an evidence base to inform commissioning decisions, the planning of eye health care and contribute to research into eye health issues

The specific IT requirements that need to be addressed are:

- support for each community optical practice to become NHS Information Governance[13] (IG) compliant to level 2. IG compliance is an essential requirement for connecting to the NHS IT infrastructure, including NHSmail
- provision of an NHSmail2 [14]account to all 5000 community optical practices. A secure email system is required to transfer patient information, including images, between NHS providers
- provision of a N3/N4 connection to each community optical practice. An electronic highway compatible with the NHS is essential for allowing community eye care systems to connect to other NHS bodies
- integration of optical practices in the new NHS e-Referral Service (ERS) [15]being launched to replace the current Choose and Book[16] service
- ensuring that each community optical practice is equipped with the technology necessary for submitting GOS claims electronically to capture the epidemiological and health data claims contain and to streamline and reduce the cost to England of administering claims and payments

The funding required is minimal in the context of NHS IT, primary care IT and wider budgets, and the health benefits enormous. Ministers have given commitments that NHS England will work with the community optical sector on this but to date this has not happened. It is to be hoped that this Call to Action will finally provide the necessary stimulus to action in this essential element of reform on which so much else depends.

[13] https://www.igt.hscic.gov.uk/Home.aspx?tk=418915783048337&cb=98f0f6a6-5f0e-445e-b0a4-96d94fc5b5fd&lnv=7&clnav=YES
[14] http://systems.hscic.gov.uk/nhsmail/future
[15] http://systems.hscic.gov.uk/ers
[16] http://www.chooseandbook.nhs.uk/staff

d) What are the information requirements to support more community care?

Access to NHS numbers

The NHS number should be used as the unique identifier across all primary eye health care service providers to ensure accurate tracking of patients and eliminate duplication. Community optical practices need to be integrated with NHS IT systems to enable them to access the NHS number "look up". See our response to **Question 12c.**

Development of an evidence base

The College of Optometrists[17] and the VISION 2020 Ophthalmic Public health Committee has demonstrated that the collection and collation of data on patient profiles (demographics, geographic spread and ethnicity) is of huge importance to the assessment of public eye health needs. Data on age, sex and (via postcode) deprivation are already collected for each individual. Although captured, this data is not currently stored or analysed and doing so should be a priority. However, at present, it is inaccessible without huge resources to manually trawl through previously submitted GOS forms many hundreds of which are simply batched and then pulped.

The use of electronic GOS submissions and electronic referrals would enable this data to be more efficiently collected, stored and analysed. It would then be possible to gather additional data, for example on ethnicity and other public health data such as co-morbidity, disabilities, or caring responsibilities. This would provide a huge anonymised data resource to further ophthalmic public health planning and research, and through that improve the evidence base to deliver more and better eye care in the community.

The benefit that this would bring to our understanding of eye diseases and their prevalence within at risk sections of our population should not be underestimated.

For example, automated data capture as part of the Health and Social Care Information Centre (HSCIC) (such as the "**care.data"** programme) could be used for:

- reporting and research into eye care conditions, outcomes and patient pathway
- monitoring progress against the eye health indicators, and
- underpinning the public health role of Health and Wellbeing Boards (HWBs) and LEHNs

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[17] *Better data, better care Ophthalmic Public Health Data report 2013 College of Optometrists*

Other potential benefits include:

- Community optical practices becoming the first non-NHS data feed into the planned Care Episode Statistics (CES).
- Enabling auto-identification of patient ID (e.g. NHS Number), facilitating linking patients' records into a comprehensive Electronic Patient Record (EPR).
- The scope to properly monitor and audit the care provided and outcomes achieved.

Update the National Eye Health Epidemiological Model (NEHEM)

The NEHEM was developed by the optical professions in 2008 (by means of a generous development grant from the Central (LOC) Fund). It filled a void in public health data for health planners, commissioners and providers and, being free and open to all, was an altruistic investment from the eye health community for the public good.

The model provides prevalence data by health and social care area for the four UK countries for cataract, glaucoma, AMD and low vision. It does not include diabetic retinopathy as, at the time, the Department of Health was investing in modelling tools for diabetes and it was anticipated that these would already cover this.

The model was constructed in a transparent and dismantle-able way so that anyone using or working on it could see the evidence base used, the assumptions made and how the prevalence estimates had been built up. It was also designed to enable local commissioners to insert more up-to-date local data and model various scenarios for their own commissioning purposes.

The model has been widely used in the development of eye health needs assessments and equity profiles across the country. For example, RNIB's Sight Loss Data Tool[18], which provides information about blind and partially sighted people and those at risk of sight loss at a local level throughout the UK, utilises information from NEHEM.

However the NEHEM now needs updating, for which funding is required. Proposals from the Expert Advisory Group working on this on a voluntary basis are that:

- population data should be updated using 2011 census data and projections to 2020
- the model should be updated to reflect the new NHS boundaries in England (once NHS internal boundaries and CCG boundaries have stabilised)
- epidemiological prevalence should be modified where feasible to "need for treatment and care"

[18] http://www.rnib.org.uk/knowledge-and-research-hub-key-information-and-statistics/sight-loss-data-tool

The work on updating the model to aid commissioning is inevitably constrained its reliance on voluntary gifts of experts' time and donations from eye health practitioners. This could be significantly advanced with a minimal investment from NHS England or Public Health England. Additional funding would also enable further conditions to be included such as diabetic, retinopathy, eye conditions in children, collagen cross linkage for corneal keratoconus and others.

Further details are available at www.eyehealthmodel.org.

Certificate of Vision Impairment

The Ophthalmic Sector now has a public health indicator for sight loss which is based on the Certificate of Vision Impairment (CVI). A CVI is a document stating that a person has a significant sight problem affecting both eyes that is not correctable with either spectacles or contact lenses. When a CVI is completed, one copy is sent to the Certifications Office at Moorfields for anonymised analysis. A second copy is sent to the patient's Social Service Department who contact the patient, offer them a needs assessment and if the patient agrees, will formally place them on their register for sight impairment which entitles patients to certain benefits. Certification is often the first time that patients are put in touch with social services. A real value of the CVI is that every three years, the number of new registrations at each social service department is collected by the NHS Health and Social Care Information Centre, allowing the opportunity to compare data collected within the NHS with data originating in social service departments.

The Certifications Office at Moorfields is currently funded until February 2015. Widespread cross-sector support is needed to maximise CVI coverage perhaps by including this requirement in NHS ophthalmology contract specifications or ensuring that a standard fee is paid for completion of CVIs provided that they are complete. Complete coverage of CVIs will enable regions in need of targeted efforts for prevention of sight loss to be identified and so allow preventative resources to be directed to such areas. At present patients are allowed to refuse to be registered. One public health possibility to explore might be for certification to take place automatically (as for notifiable diseases but for anonymised collation rather than follow-up) and for notification to social services to be optional for patients Once certified the patient could then take up registration at any future point they wished for social services support.

There is already an electronic CVI. Widespread implementation is not currently feasible because of the disparity between hospital IT systems. Greater efforts to ensure similarity between hospitals would facilitate more rapid uptake of new technology. The ECVI has the potential to link directly to the third sector and social care, but clearly standardisation of IT systems throughout these would also be needed.

e) How do we ensure timely and appropriate access to out-of-hours services?

Emergency eye care is an important component in the provision of a comprehensive ophthalmic service. Prompt and correct management of acute eye conditions and injuries will prevent avoidable problems and improve outcomes. It is important that where initial presentation of emergency conditions is to a general A&E department, the eye unit provides adequate training and support to the doctors and other professionals staffing that department.

The perceived urgency of an eye condition is a much stronger determinant of referral (or self-referral) patterns than the perceived seriousness of the eye condition so hospital eye departments treat large numbers of patients whose conditions could easily be treated elsewhere. For initiatives to reduce the workload of hospital eye departments by increasing the provision of primary eye care clinics for minor non-urgent eye conditions to be successful, they need to ensure that patients with minor eye conditions do not continue to bypass the primary care service on the grounds of perceived urgency and attend emergency departments. Please see Annex 2 for examples of innovative schemes for urgent conditions.

Annex 1 BIOS Innovation Fund

The British & Irish Orthoptic Society (BIOS) started an innovation fund in 2013 to encourage orthoptists to devise ways of redesigning services using technology to increase efficiency, create better patient outcomes and use technology to greater effect. Examples of pilots include:

i) a Falls Clinic in Warrington which is utilising more junior staff (Band 3 technicians) to carry out routine vision screening of falls patients in hospital using iPads. The objectives of the service are to generate cost savings, identify patients with vision loss who would otherwise have been missed, and achieve shorter hospital stays because of identification and management of visual problems

ii) creating better outcomes for stroke patients in secondary care by developing an information App for patients in stroke and neurological wards to access information about the stroke, visual impairment, visual pathway etc and provide information that can be adapted visually for their individual needs. The aims of this innovation include patients gaining independence and hospital release quicker and a more effective and potentially shorter, rehabilitation process

Annex 2 Examples of innovative systems for urgent conditions

NHS Grampian

Formation of the Grampian Eye Health Network

The walk-in service at Aberdeen's eye department was increasingly being used by the public for non-urgent eye problems. The level of walk-ins was at 6,000 annually and increasing. This led to long travel times and waits for patients, a chaotic environment and specialist resources being used to treat non-urgent cases. An audit demonstrated that only 9% of patients coming to the eye department required referral to the hospital eye clinic; over 90% could have been treated by someone other than a hospital doctor.

Improvements

Following input from all stakeholders (Local Board Advisory Groups, Community Health Partnerships, Community Forums) and to enable partnership and patient involvement, the Grampian Eye Health Network was formed which includes all optometry practices in Grampian and Shetland.

A 24 hour telephone Eye Health Network Clinical Decision/Support Line was established, staffed by specialist nurses and doctors. Afternoon consultant-led eye-assessment clinics were established and optometrist-led support sessions were formed to ensure continuous learning, high quality care. Using Patient Group Directives enabled more efficient prescribing of medications.

Outcomes

- There has been a significant shift of care in to the community.
- Only patients who require referral to the hospital eye clinic are booked into the eye assessment clinic.
- Patients are now seen as locally as possible reducing travel time.
- Lengthy waits are avoided.
- NHS resources are now used more effectively.

Wales PEARS (Primary Eyecare Acute Referral Scheme)

Optometric primary care intervention service to facilitate the early assessment of acute ocular conditions.

Patients are seen within 24hrs of making an appointment and are self-referred or directed to the service by a GP. Optometrists are paid under an enhanced services contract to detect, and in some cases manage, urgent conditions. Many GPs lack the equipment, experience

and skills to diagnose and treat eye conditions so taking advantage of community optometrists' expertise can enable patients to remain in primary care and potentially free up some GP resources.

Prompt, accurate diagnosis and triage are vital to minimising harm and sight loss from urgent eye conditions. They can improve the value of the pathway by separating out acute, emergency problems from comparatively simple cases. Diagnosing all but a small number of urgent conditions requires a slit lamp and the skills to use it. Expertise in the use of the slit lamp is **not** widespread outside community optometric practices and hospital eye departments, although a small number of GPs have an interest in ophthalmology and some hospital accident and emergency departments possess a slit lamp.

GPs do however provide first contact care for many urgent eye conditions without a slit lamp. Also optometrists who are not prescribers often refer patients to GPs for prescriptions. GPs have welcomed schemes that allow them to refer patients to optometrists for urgent, same day appointments rather than only having the opportunity to refer to the hospital eye service.

A facility for 24/7 access to assessment by an ophthalmologist is necessary for a small proportion of ophthalmic emergencies.

What are the best value treatments for urgent eye conditions?

Urgent eye conditions are mostly non-acute and relatively straightforward to treat but a significant minority are emergencies that cause acute distress and are sight threatening. As many as 78.1% of cases attending eye casualty are deemed 'non serious' with 50-70% of cases not constituting either an accident or an emergency, a figure supported by patient feedback.

Annex 3 Evidence from Community Services

As detailed in our response to Question 12a LOCSU has compiled a summary of evidence to support the commissioning of community services. This summary can be found at http://www.locsu.co.uk/communications/calltoaction and has also been submitted as a separate enclosure to this response.

The summary contains references for peer reviewed and published papers and also soft evidence obtained from current services. Historically it has been difficult to obtain evidence from Primary Care Trust commissioned paper based "enhanced services", but since CCGs have taken over responsibility for commissioning of these services, a number of areas now collect activity and outcomes data from community services electronically via the OptoManager IT platform designed by LOCSU and Webstar Health.