THE COLLEGE OF OPTOMETRISTS

**Parliamentary Inquiry into capacity problems in NHS eye care services and avoidable sight loss in England – Call for Evidence**

**Response from the College of Optometrists**

**29 September 2017**

The College of Optometrists is the professional body for optometry in the UK. It qualifies the profession and delivers the guidance, development and training to ensure optometrists provide the best possible care.

Thank you for the opportunity to respond to the review. We hope you find our comments useful.

1. **How effective are the following at assessing the eye health needs of their local populations?**
    a. **CCGs**

Commissioners, who plan and fund healthcare services nationally (NHS England) and locally (CCGs), are not always working with accurate information on the eye care needs of their populations. Department of Health guidance states that commissioners should refer to Joint Strategic Needs Assessments (JSNAs) when making decisions. However, there is no mandatory data set to be included[i].

A range of quantitative and qualitative evidence should be used in JSNAs, including the Public Health Outcome Framework (PHOF). The sight loss indicator measures the rate of preventable sight loss by measuring the numbers of all people who are certified sight-impaired (partially sighted) or severely sight-impaired (blind) and the numbers of these who have lost their sight from one of the three major causes of preventable sight loss: glaucoma, age-related macular degeneration and diabetic retinopathy.

The College of Optometrists recommends that a comprehensive and effective Eye Heath Needs Assessments (EHNAs) should be completed by all CCGs as part of the local JSNA to provide a baseline and establish if there are specific local priorities that need to be addressed in the short term[ii].

    b. **Sustainability and Transformation Partnerships (STPs)**

STPs are groups of organisations that have agreed to develop integrated health and care systems in specific geographic areas over the next five years. There is a need for the evidence base supporting the case for change to be substantiated through

needs assessments before initiating any services commissioning and delivery transformations.

However, thirty-one of the 44 STPs offer no proper needs analysis above a few selected statistics, and fail to show that their proposals take account of the size, state of health and locations of the population. Eleven make partial reference to needs analysis or refer to local JSNA. Only two (Nottinghamshire and North-East London) appear to take serious account of such information[iii].

We also note that twenty-two of the 44 STPs mention ophthalmology and the content is often limited to a few sentences, referring to a mix of planned service redesign and review and moving services into the community[iv]. Out of these twenty-two STPs, only three have detailed plans to take eye health and care forward, i.e. Lincolnshire STP[v], Staffordshire STP[vi], North Central London STP[vii].

We suggest STPs should complete a comprehensive and effective health needs assessment including eye health needs assessments providing the best intelligence to inform local change. Ideally it would result in the production of a compelling business case for change as a basis for local agreement.

**2. Compared to other areas of health and social care what priority do you consider the following give to eye health services?**

**a. CCGs**

In 2013, NHS England launched the 'NHS belongs to the people' call to action, with a specific strand for 'improving eye health', focusing on a more preventative approach and effective management in the community[viii]. Unfortunately, this Call to Action was never published by NHS England.

Eye health and sight loss are not acknowledged as a key priority by the NHS Five Year Forward View[ix] published in 2014, and this position remains unchanged following the recent publication of Next Steps on the NHS Five Year Forward View[x].

The Five Year Forward View set out six clinical priorities – cancer, mental health, dementia, diabetes, learning disabilities, and maternity. Furthermore, CCGs have their own commissioning intentions and they have their own priorities – but eye health is not necessarily a priority. As a result, acute trusts have to cope with different pathways for patients from different CCG areas, and access to eye health services remains a postcode lottery for patients.

**b. STPs**

The College of Optometrists believes that working at STP level has significant potential to improve care and prevention, and enable commissioners to transform services at scale within likely available resources. With an average population of 1.2m, STPs provide the opportunity for groups of CCGs to work with eye care providers and Local Eye Health Networks (LEHNs) across whole pathways, and over acute trust footprints, to develop transformed and sustainable services – and deliver the ambitions of the Five Year Forward View – within a relatively short period.

Unfortunately, as mentioned in our response to question 1, only 22 of the 44 STPs mention ophthalmology and the content is often limited to a few sentences, despite the fact that ophthalmology accounts for around 8 per cent of the 90 million hospital outpatient appointments in England, and that most acute trusts are facing significant capacity pressures[xi].

**3. How effective are (a) CCGs at commissioning and (b) STPs at planning eye health services to meet local patient demand? Please explain why.**

See our response to question 6 below.

While commissioning and planning eye health services should be improved at CCG and STP levels, it is also important to tackle the eye health postcode lottery.

As already said, because CCGs have their own commissioning intentions, and their own priorities – eye health is not necessarily a priority. As a result, access to eye health services remains a postcode lottery for patients.

For example, research found variation in cataract operation commissioning rates 4,610 per 100,000 population in the highest commissioning CCGs and 1,595 per 100,000 population in the lowest. Access to cataract operations is impacted by where patients live[xii].

While demography explains some of the variations – the number of elderly patients is an important consideration – the fragmented nature of the NHS in England with local commissioners making their own decisions on what to offer patients has accelerated the trend.

Commissioning eye care at STP level will reduce the inequalities and variations in care that inevitably occur when commissioning at relatively small CCG level. It will also lead to better management of limited NHS resources by reducing duplication and waste.

**4. Do you think the priority of eye health should be raised at the local area to meet existing and/or future patient demand? Yes or no, please explain why?**

Yes.

Ophthalmology accounts for 8 per cent of the 90 million hospital outpatient appointments in England (NHS Digital 2016)[xiii]. Increasing demands on eye health services due to the ageing population and the availability of new treatments are creating acute capacity bottlenecks within the Hospital Eye Service (HES), especially in relation to age-related macular degeneration (AMD), diabetic eye disease and glaucoma[xiv].

It has been predicted that between 2010 and 2020, there will be a 26% increase in patients with AMD, a 20% increase in patients diagnosed with Ocular Hypertension or glaucoma and a 25% increase in people with diabetic eye disease[xv]. We are just over the half way point and a 30% increase in ophthalmology outpatient attendances over the last five years is already being reported and this is set to rise further leading to unmanageable capacity problems in the HES in the near future[xvi] [xvii].

Given the current capacity issues in the hospital eye services in England together with the pressures on general practice, patients are not being seen within clinically appropriate timeframes, which leaves them at risk of avoidable and irreversible sight loss. Also, the wider health and social care system remains under pressure, facing unprecedented demand and severely constrained funding. This only adds to the need for preventing avoidable sight loss, as the ongoing care and management of eye conditions can be a huge drain on resources. We can no longer on the grounds of patient safety ignore the pressure building up in ophthalmic services[xviii].

Optometrists are well placed to provide capacity at a local level, either within a hospital or community setting, thus relieving pressure on hospital eye services, emergency departments and GP practices, allowing these areas of the NHS to concentrate on patients who need their services. Many are already dealing with Minor Eye Conditions and our suite of higher qualifications are available to ensure they are appropriately trained to handle management and monitoring of other conditions. Optometrists also offer patients a flexible and accessible service in terms of locality and availability.

CCGs should raise the importance of eye health in their commissioning intentions as a matter of patient safety. At a time of great challenges and opportunities for the NHS, it is essential to make sure we deliver cost effective quality care to patients in England. Having a more consistent approach to eye care pathways will lead to a more integrated and efficient overall service, with quicker access for those patients who need hospital services and treatment - so important for better outcomes for patients.

**5. Please tell us about examples which are currently meeting demand for eye health services and/or which are enabling them to improve as a result of:**
   **a. commissioning by CCGs and/or**

Research funded by the College of Optometrists has found that introducing an intermediate-tier service (ITS) for eye care services could reduce the volume of patients referred to hospitals by GPs and provide replacement services at lower costs. The research investigated the changes in volume of hospital ophthalmology patients and the related costs, before and after minor eye conditions services (MECS) were introduced in two London boroughs[xix].

The research involved assessing schemes in Lambeth and Lewisham and compared their performance with a neighbouring borough, Southwark, as a control. The scheme was introduced in Lambeth and Lewisham in April 2013 and comparisons in performance were made for September 2011 to April 2013 and April 2013 to October 2014. Estimates on the impact of MECS on hospital ophthalmology attendances showed:

- For Lambeth, first attendances to hospital ophthalmology referred by GPs were differentially reduced by 30.2 per cent at the largest provider, compared with Southwark. Follow up attendances were differentially reduced by 16.7 per cent at a second hospital and by 14.6 per cent at other providers.

- For Lewisham, first attendances to hospital ophthalmology referred by GPs were differentially reduced by 75.2 per cent at the largest provider, compared with Southwark, and by 40.3 per cent for follow-up visits.

- Total costs in Lambeth were 2.5 per cent higher in the period analysed after MECS was introduced. Total costs in Lewisham were 13.8 per cent lower because more GP referrals were diverted to MECS. By comparison, costs in the control area of Southwark were 3.1 per cent higher.

- The majority of Lambeth and Lewisham MECS patients presented with minor anterior eye disease and over 80 per cent of these patients were managed by their community optometrist.

Visual issues can exacerbate co-morbidities with other long-term health conditions, such as dementia[xx] and depression[xxi] [xxii]. Sight loss can also cause social isolation[xxiii], increase a person's risk of falling and create a fear of movement, which can then lead to poor muscle growth which in turn increases frailty[xxiv]. To help tackle the increased falls risk, the College of Optometrists has an ongoing project on the link between vision and falls[xxv] with some recommendations for falls services, optometrists, and the public to help reduce risk through a greater emphasis on assessing sight.

Dementia is recognised as a significant burden for the health of the nation[xxvi] and is projected to grow in prevalence over the coming years as the population ages. Vision is also a growing issue alongside the aging population, and many common dementia symptoms directly affect vision. Evidence shows that if a patient with dementia has concurrent impaired vision, their quality of life and cognitive functionality is significantly reduced[xxvii].

The symptoms of visual impairment and dementia can be difficult to separate without regular eye examinations. Diagnosing and correcting visual impairment can improve quality of life and can reduce the related co-morbidities among the dementia

population[xxviii]. To make steps towards addressing this, the Prevalence of Visual Impairment in Dementia project (PrOVIDe)[xxix] was funded by the National Institute for Health Research, and led by the College of Optometrists with a collaborative team involving the Alzheimer's Society, Thomas Pocklington Trust, City University of London, University of Birmingham, University of Newcastle, Trinity College Dublin and University College London.

Nearly one-third of participants in whom vision could be measured were visually impaired (according to an established definition). Almost half of these were no longer visually impaired with up-to-date spectacle prescriptions. Among the remainder, nearly half were visually impaired as a result of cataracts, which could be easily removed. The main aspects of an eye examination were possible in over 80% of participants. Importantly, the prevalence of visual impairment was disproportionately higher in people with dementia living in care homes. Most participants were unaware of the availability and eligibility of home eye examinations[xxx] . These domiciliary eye care services are crucial to the eye health, and subsequent wellbeing of care home residents, especially those with dementia, but awareness of their existence among the public is poor.

In terms of the link between mental health and sight loss, a 2015 study[xxxi] found that the prevalence of depressive and anxiety disorders was significantly higher in visually impaired older adults compared to their normally sighted peers, with agoraphobia and social phobia being the most commonly found. In addition, a 2016 study found that a high incidence of low vision patients with untreated depression[xxxii]. Alarmingly, the prevalence of clinically significant depressive symptoms was found in 43% of those seeking help for sight loss in Britain. This suggests that it is an unrecognised high-risk group. The paper ventures that patients attending low vision services could be screened regularly for depression.

People with a learning disability are 10 times more likely to have serious sight problems than other people, and this is often under-diagnosed and undertreated[xxxiii]. The Local Optical Council Support Unit (LOCSU) created a care pathway for people with learning disabilities[xxxiv] which successfully piloted in London (between 2013 and 2015) with the charity SeeAbility as a key partner[xxxv]. To help meet the challenges of diagnosis, SeeAbility has produced a plethora of resources[xxxvi] on caring for the eye health of this vulnerable group, including guidance for primary care, and carer awareness leaflets. In addition, NHS England has set up a working group to consider making improvements to the provision of NHS sight tests for people, including those with learning difficulties. The working group is expected to report and make recommendations in the autumn[xxxvii].

Other support already in place for people with learning disabilities includes the Royal National Institute for the Blind (RNIB), who offer consultancy services[xxxviii] to practitioners, and the Royal College of Ophthalmologists, who have created guidance on the management of visual problems[xxxix]. Additionally, the optics sector

has called for NHS funded eye examinations for the learning disability population in the past[xl] and we would like to reaffirm this recommendation here.

**b. Planning by STPs.**

Many STPs are still a work in progress rather than a finished plan: few have published the detailed financial appendices, workforce plans and implementation plans that are required to make any useful assessment of how realistic and viable the proposals may be.

**6. How do you think the commissioning, planning and delivery of eye care services can be improved at?**

**a. the local level, and**

Eye health and sigh loss services should be co-ordinated and commissioned across STPs, as this has significant potential to improve care and prevention, and enable commissioners and providers to transform eye health and sight loss services at greater scale.

Across NHS eye health services, there has been a tendency to try to fix problems at the symptom level rather than to address the underlying issues; and to preserve boundaries rather than develop shared solutions boundaries. By making the effort to work at a greater scale with clear responsibilities and objectives, there are opportunities for greater efficiencies in commissioning, procurement and delivery of similar service specifications by reducing the duplication of effort and the waste of resources.

The most urgent issue to address is the lack of capacity in the Hospital Eye Service (HES).

As already said in our response to question 4 above, optometrists are well placed to provide capacity at a local level, either within a hospital or community setting, thus relieving pressure on hospital eye services, emergency departments and GP practices, allowing these areas of the NHS to concentrate on patients who need their services. Many are already dealing with Minor Eye Conditions and our suite of higher qualifications are available to ensure they are appropriately trained to handle management and monitoring of other conditions. Optometrists also offer patients a flexible and accessible service in terms of locality and availability.

Innovative models of eye care need to be implemented at greater scale to have maximum impact. However, any redesign should not be done in isolation as it will have implications across the entire service. We recommend that commissioning practices for eye health should be at STP level, as this has the potential to vastly improve care and prevention, and transform services across the entire region[xli].

To facilitate this, the Clinical Council for Eye Health Commissioning has brought together groups of experienced clinical leaders and patient advocates to design commissioning frameworks for community ophthalmology, primary eye care and low vision, habilitation and rehabilitation for adults and children[xlii]. The frameworks are underpinned by RightCare principles[xliii] i.e. that patients should be managed in the most appropriate service according to clinical risk stratification of their condition, and the skills of the practitioner.

The main objective of the Community ophthalmology framework[xliv] is to release capacity in the HES by enabling management and monitoring of low risk and stable eye conditions within the community. The objective of the Primary eye care framework[xlv] is to manage minor eye conditions in the community, as well as to undertake pre-operative cataract assessments and repeat measures for suspect glaucoma to deliver improved appropriateness of referral to ophthalmology.

The Low vision, habilitation and rehabilitation framework for adults and children [xlvi] calls for more joined up commissioning to ensure better access and consistency of services, supported by the provision of appropriate equipment and expertise to improve quality of life. With increased demand, waiting times for low vision appointments/assessments vary greatly.

Sitting alongside these frameworks, the Royal College of Ophthalmologists have published a *Three step plan*[xlvii] and a set of options to help meet demand and capacity issues in the *The Way forward*[xlviii]. These documents clearly map the underlying issues around ophthalmology capacity and suggest solutions.

We encourage CCGs and local authorities to implement these frameworks at STP level.

Another area for improvement is better sharing of data and information for direct patient care. Good communication and secure sharing of relevant information between health and care professionals, and their patients, at each stage of the patient's pathway, facilitated by electronic patient records and underpinned by community optometric connection to the NHS e-Referral system via the Health and Social Care Network and NHS mail. This will make a positive impact on joined up care. Optometrists are responsible for about 90% of new ophthalmology referrals and there were 1.82 million first outpatient ophthalmology appointments in 2015/16 in England. There must be greater efficiencies than using the current paper based referral route mostly via the GP. An NHS e-Referral solution would release significant GP practice resource and time and could allow for freer flow of patient data. It would also allow optometrists to send data that would be useful to the ophthalmologist and allow ophthalmologists to give feedback to the referring optometrist, all of which could free up considerable ophthalmologist time by improving referrals and allowing more to be managed in the community.

### b. the national level

The lack of capacity in HES is exacerbated by the 18-week Referral to Treatment (RTT)[xlix] protocols, which can serve as a perverse incentive to prioritise new patients over the essential management of conditions already diagnosed. There is compelling evidence[l] that hundreds of patients have suffered irreversible loss of vision due to delay in ophthalmology outpatient follow up attendances from 2003 onwards, with ongoing evidence of about 200 such cases still occurring annually in the UK[li]. This unnecessary loss of vision will have severe implications for the patient's life and the lives of those people surrounding them, and significant follow on cost implications for the social care system.

A recent study[lii] explored the frequency of patients suffering harm due to delay in ophthalmic care – this identified that up to 22 patients per month in the UK are irreversibly losing vision due to delays in review or treatment. These findings have prompted further research into new ways of working and models of care that can alleviate the pressures on the demand for hospital eye services - The Way Forward[liii] and the development of guidance for commissioners, managers and clinicians[liv],[lv].

This has been further heightened by the 2017-2019 proposed out-patient tariffs, which have significantly higher payments for new patients. We agree that setting a two-year tariff will give greater certainty against which to plan and make investment decisions and will reduce the burden on both commissioners and providers that comes from annual contract rounds.

However, we have serious concerns about the detrimental impact on patient care that will result from the proposed 30 per cent transfer of follow-up costs into first attendances for ophthalmology at the expense of ophthalmology outpatient follow-up appointments.

This changes to ophthalmology tariffs without the necessary support for service redesign will result in unintended consequences for patient safety as the introduction of financial incentives for providers to undertake more first attendances at the expense of follow-ups will exacerbate the current capacity pressures in the hospital eye service[lvi]. This in turn, will increase the risk of sight loss due to delayed follow-ups in patients with long-term and high-risk disease. These patients may have no prospect of a cure and many will have serious sight-threatening conditions which mean that ongoing management is essential.

There is also a risk that CCGs may seek to drop the challenges on NHS Trusts via block contracts which can only be delivered by jeopardising follow-up requirements and patient safety.

In the interests of patient safety, we recommend that the balance between ophthalmology tariff for new and follow up is restored.

7. **What effect would raising the priority of eye health at a national/ strategic level (such as the NHS Mandate) have on improving commissioning across England and at the local level, and planning and delivery by STPs, to help meet current and future demand for services?**

A national eye health strategy for England would give eye health the profile it has long-since deserved. Having a national strategy – and the commitment of Government leadership behind it – would deliver a much needed re-design of the system, better coordinated services, more consistency across the country, and more effective use of scarce resources.

There are equivalent national strategies for hearing loss and dementia as well as eye health strategies in Scotland, Wales and Northern Ireland.

8. **The Public Health Outcomes Framework (PHOF) includes an indicator to highlight the rate of preventable sight loss in the population. The PHOF Data Tool shows significant variation in the rate of preventable sight loss for each local authority.**
    a. **At the national, CCG and STP-levels, how can the scrutiny of commissioning and planning of eye health services and eye health outcomes be improved?**

Commissioners need to be aware of any local HES capacity issues and providers need to monitor follow-up waits for their moderate to high risk patients. This allows for appropriate capacity planning and resource allocation.

The VISION 2020 UK developed a portfolio of eye health indicators that has been endorsed by the Clinical Council for Eye Health Commissioning. These indicators are designed to review and monitor population eye health and wellbeing at a national and CCG level. The portfolio contains broad population and eye specific indicators designed to review and monitor population eye health and wellbeing at a national and CCG level[lvii]. It has been developed to ensure a better use of existing sources by avoiding duplication and additional burden for data collection.

The Broad Population Indicators will demonstrate overall change at population level in areas relevant to prevention of sight loss, eye health improvement and living with sight impairment.

Eye Specific Indicators cover the main causes of sight impairment in the UK, all age groups, and include prevention, accessibility, availability, safety & effectiveness of services.

We believe the portfolio of eye health indicators will facilitate the monitoring of access & availability of services, encourages scrutiny of data and its quality, and ensure whole pathways are considered in service specifications.

**9. Please provide any other information that you feel the APPG should be made aware of in support of your response. Links to relevant reports or research can also be included or you can email them along with your response to the inquiry.**

You will find the following Clinical Council for Eye Health Commissioning frameworks attached:

- Community ophthalmology framework
- Primary eye care framework for first contact care
- Low vision, habilitation and rehabilitation framework for adults and children

**10. Please indicate in your written response to this Call for Evidence whether you, or a representative, are willing to give oral evidence to the Inquiry.**

Yes.

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