THE COLLEGE OF OPTOMETRISTS

London Assembly Health Committee review into eye health and preventing sight loss in London – response from the College of Optometrists

31st July 2017

The College is the professional body for optometry. 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 address each of your questions below. We hope you find the comments useful.

1. Why should eye health be a priority for London?

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[i].

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[ii]. 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[iii] [iv]. This UK-wide picture is also reflected in London, and the trends are the same[v].

Given the current capacity issues in the hospital eye services in London 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.

2. What are the key factors that affect eye health? Which groups are particularly affected?

Ageing, smoking, genetic dispositions, and socio-economic status can all affect eye health. These are often exacerbated by lack of public awareness and understanding of the role that optometrists play in maintaining eye health and detecting eye disease, and also by the fragmented way in which eye services are organised.

There is good evidence of a causal relationship between smoking, sight loss and blindness[vi]. Smoking accelerates the likelihood of age-related macular degeneration[vii] (AMD) and cataract. Optometrists are well placed to offer advice on smoking cessation to groups who could benefit most. This is due to a significant amount of contact with patients with established AMD and those at high risk of developing the disease[viii]. Optometrists can be instrumental in delivering this important public health message to a large proportion of the population who are generally in good health and therefore, not in regular contact with other healthcare professionals[ix].

There is significant evidence of the higher prevalence of eye disease in the Black, Asian and other minority ethnic groups. Cataract is higher in people of South Asian ethnicity compared to white populations[x] [xi]. The prevalence of primary open-angle glaucoma is higher in people of African/Caribbean/Black British ethnicity[xii] [xiii] [xiv] [xv] [xvi] [xvii] who are also more likely to present late with more advanced field loss[xviii] and to be sight-impaired as a result[xix] [xx].

African/Caribbean/Black British[xxi] [xxii] [xxiii] [xxiv] [xxv] and South Asian[xxvi] populations have a higher prevalence of diabetic eye disease and are more at risk of being sight-impaired as a result[xxvii] [xxviii] [xxix]. People of Chinese heritage have a higher prevalence of lens opacities and cataracts[xxx].

Minority ethnic communities are at higher risk of eye disease, yet are generally less aware of the conditions, the symptoms or their increased risk of contracting them[xxxi]. This means that they are a group who potentially benefit the most from health education around the increased risk of poor eye health.

Deprived populations can also be particularly affected due to the perceived cost implications of spectacles, a lack of eye health awareness, and access issues – General Ophthalmic Services (GOS) fees in England for a basic eye examination are below cost, so this can mean that certain areas will have a dearth of optometric businesses due to sustainability issues[xxxii] [xxxiii]. A 2009 study of optometric practices in Tower Hamlets found this to be true[xxxiv], and these types of data were instrumental for persuading the Welsh Government in formalising the Wales Eye Care Service[xxxv] scheme across the country.

The NHS sight test under the GOS contract is a core delivery service and the responsibility of NHS England. The GOS contract funds a single appointment, and,

in some CCG areas, there are local primary eye care schemes to support the refinement of referrals. Due to the size and complexity of London, variation is inevitable. However, patients can choose to attend **any** optical practice including a practice not within their CCG area. This can result in the patient not receiving the service they are entitled to, if the CCG only commissions within its own area. Local primary eye care schemes need to be commissioned and extend much further than the CCG area to reduce this inequality and post code lottery.

3. How aware are people of the importance of maintaining eye health? What are the main barriers to raising awareness?

Qualitative studies suggest that public awareness is poor and the barriers, complex[xxxvi] [xxxvii]. These barriers include a general lack of trust of optometrists and opticians as clinicians, fear of having to spend large amounts of money with every visit, and a lack of public awareness around NHS optical vouchers. It is clear that there is some national awareness-raising work needed if any effective change in perceptions is to be realised, especially when interventions to encourage people to have a sight test have previously failed to change behaviour, even where they successfully raised awareness of the need for sight tests[xxxviii].

A core shift in patient perspective is sorely needed. The main barrier to this being achieved is lack of investment in a major, fully funded, public health campaign to have eye examinations recognised as a standard health intervention that is undertaken regularly.

To make steps towards this goal, the College of Optometrists already run regular public campaigns help to raise awareness of the importance of good eye health care, regular eye examinations, and the role of the optometrist in maintaining good vision. These campaigns focus on a broad range of topics - from the ageing eye to the benefits of wearing sunglasses. We also created a dedicated website for members of the public - lookafteryoureyes.org. It includes extensive information about the eye examination, the main eye conditions and how to take care of our eyes. It is recommended that the messages of these campaigns are picked up by the Mayor and integrated into a funded public drive for eye health awareness, especially to the most vulnerable groups as described in our response to Question 2.

4. How can eye health be integrated with other public health and social care activity at local or London-wide levels?

An excellent example of optometry integrating with public health and social care can be found in Dudley, with their successful Healthy Living Opticians scheme[xxxix] [xl]. In partnership with Public Health Dudley, the optometry practices who participate can offer the following services:

- Alcohol Screening
- NHS Health Checks such as glucose testing and cholesterol
- Weight Management
- Smoking Cessation Services

Initial results have proved to have a positive effect in deprived communities[xli], and the service is slowly growing, with eight Healthy Living Opticians now operating across the area. The fact that optometrists can be well-placed to provide smoking cessation services[xlii] [xliii] [xliv] was also recently recognised in Wales and such a service was implemented though the nationally commissioned Welsh Eye Care Scheme (WECS) [xlv]. It is hoped to show positive results when the data is made available[xlvi].

Another aspect where eye health can integrate with social care can be found in the delivery of low vision services. In some areas, services do not exist and the population need has not been assessed. With increased demand, waiting times for low vision appointments/assessments vary greatly. To address this, the Clinical Council for Eye Health Commissioning (CCEHC) has produced a low vision, habilitation and rehabilitation framework for adults and children [xlvii] which 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.

5. What impact do poor eye health and sight loss have on wider health and wellbeing?

Visual issues can exacerbate co-morbidities with other long-term health conditions, such as dementia[xlviii] and depression[xlix] [l]. Sight loss can also cause social isolation[li], 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[lii]. To help tackle the increased falls risk, the College of Optometrists has an ongoing project on the link between vision and falls[liii] with some recommendations for falls services, optometrists, and the public to help reduce risk through a greater emphasis on assessing sight. The Mayor's office may find these useful.

Dementia is recognised as a significant burden for the health of the nation[liv] 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[lv].

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[lvi]. To make steps towards addressing this, the Prevalence of Visual

Impairment in Dementia project (PrOVIDe)[lvii] 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[lviii] . 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[lix] found that the prevalence of depressive and anxiety disorders were 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 have been found to have untreated depression[lx]. 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.

6. What are the main challenges around improving screening and eye test uptake, in both adults and children?

The Clinical Council for Eye Health Commissioning issued a Freedom of Information request in February 2016 to Local Authorities across England to see how effectively they were commissioning the 4–5 years old vision screening and onward care. Evidence of an inconsistent approach was suggested by the data collected. This is consistent with the 2013 review by the National Screening Committee[lxi], where variation was found in the delivery of screening programmes across the UK. The review stressed the need for a more standardised approach, which we would like to echo here.

Convincing the public to visit their optometrist regularly, regardless of symptoms remains a challenge. Public awareness campaigns are needed to have this embedded in the public's collective mind. For issues around eye-test uptake[lxii], please see the response to question 2.

7. What impact is the rising prevalence of eye health problems having on the health care system in London?

London ophthalmology outpatient attendances account for nearly 17% per cent of the England total. With an increase of up to 30% in HES attendances over the last five years, we can no longer ignore the pressure building up in ophthalmic services on the grounds of patient safety. The increase in demand is leading to the occurrence of delayed follow-up appointments and hospital initiated cancellations[lxiii]. Research evidence now highlights that patients with chronic eye conditions are suffering preventable harm due to delayed follow-up or review[lxiv lxv].

8. What impact does treatment delay have on patient outcomes and the wider health and care system?

The lack of capacity in HES is exacerbated by the 18-week Referral to Treatment (RTT)[lxvi] protocols, which can serve as a perverse incentive to prioritise new patients over the essential management of conditions already diagnosed. There is compelling evidence[lxvii] 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[lxviii]. 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.

9. What additional challenges are there in supporting people who are homeless, in prison or have learning disabilities to maintain good eye health?

A Homeless eye clinic was piloted in East London[lxix] and identified a high proportion of uncorrected refractive error among the sample audited. This suggests that there is large unmet need for regular eye examinations and provision of refractive correction for homeless people.

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[lxx]. The Local Optical Council Support Unit (LOCSU) created a care pathway for people with learning disabilities[lxxi] which successfully piloted in London (between 2013 and 2015) with the charity SeeAbility as a key partner[lxxii]. To help meet the challenges of diagnosis, SeeAbility has produced a plethora of resources[lxxiii] on caring for the eye health of this vulnerable group, including guidance for primary care, and carer awareness leaflets. In addition, we have just learned that 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[lxxiv].

Other support already in place for people with learning disabilities includes the Royal National Institute for the Blind (RNIB), who offer consultancy services[lxxv] to practitioners, and the Royal College of Ophthalmologists, who have created guidance on the management of visual problems[lxxvi]. Additionally, the optics sector has called for free eye examinations for the learning disability population in the past[lxxvii] and we would like to reaffirm this recommendation here.

10. How could the Mayor and the GLA further support better prevention, detection and treatment of eye health issues in London?

As already stated in our previous responses, across the UK, Hospital Eye Services are struggling to manage the rising demand due to an ageing population and more advanced ophthalmic treatments. In England, ophthalmology accounts for 8 per cent of the 90 million hospital outpatient appointments[lxxviii], and London ophthalmology outpatient attendances account for nearly 17 % of this England total[lxxix]. Given these capacity issues and the growing pressures on general practice, the status quo is not sustainable.

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 Sustainability and Transformation Partnerships (STP) level, as this has the potential to vastly improve care and prevention, and transform services across the entire region[lxxx].

To facilitate this, the CCEHC has brought together groups of experienced clinical leaders and patient advocates to design commissioning frameworks for community ophthalmology and primary eye care[lxxxi]. The frameworks are underpinned by RightCare principles[lxxxii] 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 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[lxxxiii] is to manage minor eye conditions in the community, as well as to undertake pre-operative cataract assessments and repeat measures for glaucoma to deliver improved appropriateness of referral to ophthalmology. Sitting alongside these frameworks, the Royal College of Ophthalmologists have published a Three step plan[lxxxiv] and a set of options to help meet demand and capacity issues in the *The Way forward*[lxxxv]. These documents clearly map the underlying issues around

capacity and suggest solutions. We recommend the Mayor encourage London's CCGs and local authorities to implement these frameworks at STP level.

We also urge the Mayor to promote the implementation of an electronic referral system, as 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.

Finally, we would like to stress further the importance of targeted public eye health campaigns to raise awareness of the importance of eye health, especially among the more vulnerable communities, and to support optometrists in becoming partners in delivering public health services (as in the Dudley Healthy Living Opticians described in our response to question 4).

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