10 questions to ask if you are scrutinising…

Centre for Public Scrutiny

accountability, transparency, involvement

…local eye health services

SUPPORT UNIT

SUPPORT FOR PRIMARY EYE CARE DEVELOPMENT

Optical Confederation

The voice of UK optics

Acknowledgements:

Thanks to the following organisations in the production of this advisory document:

The Centre for Public Scrutiny

The Centre for Public Scrutiny (CfPS) (an independent charity) is the leading national organisation for ideas, thinking and the application and development of policy and practice to promote transparent, inclusive and accountable public services. We support individuals, organisations and communities to put our principles into practice in the design, delivery and monitoring of public services in ways that build knowledge, skills and trust so that effective solutions are identified together by decision-makers, practitioners and service users.

Local Optical Committee Support Unit (LOCSU)

LOCSU provides quality, practical support to Local Optical Committees (LOCs) in England to help them develop, negotiate and implement local objectives in respect of primary ophthalmic services. It is a key interface between the optical representative bodies and the LOCs, facilitating robust lines of communication between the national organisations and the grass roots of the professions.

Optical Confederation

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 Opticians (FODO). The Confederation works with others to improve eye health for the public good.

Why scrutinise eye health?

A hundred people in the UK start to lose their sight every day, yet approximately 50% of cases of the most common eye conditions, such as glaucoma, age-related macular degeneration (AMD) and diabetic retinopathy are avoidable through early case-finding and referral by community optometrists and opticians as part of the regular sight-testing service .

The downstream costs of avoidable sight loss for individuals and society (NHS and social care) are significant. Nationally the costs of sight loss are anticipated to grow from £6.47 billion in 2009 to £7.64 billion this year, unless action is taken at local level.

To address this avoidable public health and cost burden, the Government has already made eye health a priority in England by establishing a preventable sight loss indicator in the Public Health Outcomes Framework, which can be tracked at national, NHS and Local Authority area. This focuses on the three main causes of avoidable sight loss: glaucoma, AMD and diabetic retinopathy. For more details on each condition please refer to Annex 1.

Avoidable sight loss can also be linked to ethnicity and social deprivation (a study by Bhalla and Blakemore (1981) showed high reported rates of sight problems (61% for African-Caribbean and 53% Asian contrasted with 52% for an older white control population). For a list of local eye health responsibilities and roles, please see Annex 2.

Bodies to scrutinise: NHS England Area Team, Local Eye Health Network, Clinical Commissioning Groups (CCGs), Director of Public Health, Health and Wellbeing Board

Witnesses: Local Patient Groups (i.e. Local Healthwatch, Voluntary Sector (e.g. Local Action for Blind People team (part of the RNIB Group) and local Blind Society); Local Optical Committee, Eye Clinic Liaison Officers (ECLOs).

10 questions to ask

1. Has an eye health needs assessment been carried out in your local area?

The first step in commissioning for improved eye health outcomes (i.e. healthy eyes and vision for all and a reduction in avoidable visual impairment and blindness) is an Eye Health Needs Assessment.

Scrutiny questions 1: Has a comprehensive and up-to-date Eye Health Needs Assessment been carried out? Does it form an integral part of the Joint Strategic Needs Assessment (JSNA)? Is eye health included within, and has the Eye Health Needs Assessment influenced, the Joint Health and Well-being Strategy?

Have all relevant parties contributed to the Eye Health Needs Assessment, including patients and advocates for hard-to-reach groups?

Has the Eye Health Needs Assessment (or a prioritised summary) been made available to all the relevant commissioners and the Local Eye Health Network?

2. Starting young – is a children's vision screening service available?

The National Screening Committee has recently confirmed that all children aged 4-5 years should be screened for visual problems by an orthoptic-led service. (N.B. The service can also be delivered by optometrists, opticians, nurses or other health care professionals trained by orthoptists with a care pathway in the Hospital Eye Service.)

Scrutiny questions 2: Is a comprehensive children's vision screening delivered in all primary schools (including independent schools) in the area? If not, why not and what plans are in place to make sure it is and to catch up on those children who have missed out?

Does the screening service cater for all children, including those with special needs?

Are there clear referral protocols in place for children identified through screening as needing referral to a community optometrist or, in extreme cases, the hospital eye service?

3. What eye health services are currently available?

a) Hospital eye services

Scrutiny questions 3a): How many eye hospitals are there in the area? Between them and national tertiary centres, do they provide a comprehensive secondary care service in the area?

Do the hospitals work together to provide a comprehensive service?

How good are the public transport links (including roads and car parking)? What proportion of patients require NHS patient transport services/volunteer care services and how is it demonstrated they receive it?

What are the waiting times for first outpatient appointments?

What are the ratios of new outpatients to returning outpatients? How could these be improved if necessary?

Do all hospital eye services include the services of an Eye Clinic Liaison Officer (ECLO)? How are these funded? Are they sufficient to ensure support at point of diagnosis and thereafter?

b) Community services

Scrutiny questions 3b): How many optical practices are there in the area? How many of them are commissioned to provide enhanced eye health services in the community (see LOSCU's Atlas of Optical Variation www.locsu.co.uk/atlas). Is this sufficient to meet health need?

Are there agreed local referral pathways/protocols for the major eye conditions (reflected in hospital contracts)?

Are community optical practices able to email referrals to the hospital eye services? Do the hospital eye services provide feedback to optical practices on the quality of their referrals and any refinements necessary?

Do all optical practices refer direct to hospitals (or GPs where a GP intervention is required)?

Have pathways been re-designed, e.g. one stop shop for cataracts, rather than two or three outpatient attendances?

4. What steps have been taken to ensure that excluded groups have access to regular sight testing?

Regular sight testing is the key to early identification of avoidable eye diseases and prevention of deterioration, sight loss and blindness. As most eye diseases are asymptomatic in the early stages, people are usually unaware of deterioration until it is too late unless they have a regular sight test.

Excluded groups include people in poorer socio-economic groups, minority ethnic groups, homeless people, gypsies, travellers, sex workers, etc.

Scrutiny questions 4: Do all people who are unable to leave home unaided because of illness or disability (especially those with dementia in residential or care homes) have access to regular domiciliary sight testing to maintain their eye health like non-disabled people and to prevent poor sight exacerbating their other health conditions or disabilities and reducing their well-being and independence?

Are optical practices set up in the more deprived areas?

Has the Area Team or Local Eye Health Network sought to work with local employers to ensure that all staff, particularly those using VDUs, have access to regular sight tests and advice about safe VDU usage?

Has the Area Team or Local Eye Health Network sought to work with local employers of professional drivers to ensure that all staff have good vision and can drive safely? Has the local police service carried out spot checks of drivers' vision?

5. What work has been carried out to reduce the number of people with cataracts, glaucoma or Age related Macular Degeneration (AMD) in accordance with the Public Health Indicator for preventable sight loss?

a. Cataract

Cataracts are a normal part of the ageing process when the front of the eye becomes cloudy or milky making sight difficult and creating problems with glare. Cataracts can be particularly dangerous for driving and can severely inhibit normal daily functioning.

In most parts of the world, cataract is the second highest cause of avoidable blindness. Fortunately, in the West, cataract replacement operations

are simple, straight-forward, day case procedures and one of the most successful operations provided by the NHS.

In 2012, the Royal College of Ophthalmologists, College of Optometrists, Optical Confederation and UK Vision Strategy, issued joint guidance making clear that when capacity is an issue

- cataract operations should not be rationed on the basis of visual acuity alone – this is not clinically safe. Some patients with poorer visual acuity but sufficient functioning for their daily needs should have a lower priority than others with a higher visual acuity but where the cataract is severely affecting their daily living
- second eye cataract should always be considered at the same time as the first operation. Patients are often likely to need bilateral cataract operations and cannot fully regain their vision and social functioning until both are corrected. There have also been cases of cataracts being rationed to one eye at a time so that when a patient has had the worse eye done, they then go to the back of the queue for the second eye. This again is poor clinical practice.

Scrutiny questions 5a: Have any local criteria been established by CCGs or NHS Trusts to prioritise access to cataract surgery? (If so, these should include functionality as well as simple visual acuity).

If local protocols are not in line with national guidelines, what are the plans to change them so that people who need cataract surgery get it within a reasonable timescale?

b. Glaucoma

Glaucoma is an eye disease which occurs when the optic nerve, which carries images from the eye to the brain, is damaged. This is usually caused by increased pressure in the eye ball. A person may not know they have glaucoma until they have lost a considerable part of their vision. Once lost, that vision cannot be regained. If it is detected early enough, in the main, it can be treated (by drops to reduce the pressure in the eye) and sight loss prevented.

The risk of developing the condition increases with age and affects about two per cent of people over the age of 40. It is estimated that more than 600,000 people in the UK have glaucoma and that only half have been diagnosed. The remaining 300,000 are, until detected, needlessly going blind.

Scrutiny questions 5b: What proportion of Referrals of Visual Impairment (RVIs) result from glaucoma?

What is the estimate of undetected glaucoma in the local population and what are the plans to address it?

Is stable glaucoma management available in the community to free up hospital capacity for new cases?

c. AMD

Wet AMD – which causes central vision loss and blindness – can now be treated through injections into the eye thanks to new treatments developed in the past ten years. These should be available on the NHS. Urgency is absolutely critical as treatment needs to start rapidly as well as follow up appointments.

In the past few years, some areas have implemented unacceptable rationing schemes whereby only the better of the patient's two eyes is treated to save their sight. This is unacceptable in equality and human rights terms and the Local Authority should check that no such restrictions are in place.

Dry AMD – cannot currently be treated. However, in some cases, dry AMD can rapidly turn to wet AMD (which can be treated) without the patient noticing.

Scrutiny questions 5c: Are referral pathways in place to ensure that patients are diagnosed and treated promptly?

What advice leaflets are available locally for community optometrists and hospitals to routinely issue to patients with dry AMD telling them what to watch out for and to return to their community optometrist if they spot any signs?

6. Is a diabetic retinopathy screening programme currently in place?

All patients who are diagnosed with diabetes should be part of a regular diabetic retinopathy screening programme.

Scrutiny questions 6: How do CCGs in your area perform against standards on Diabetic Retinopathy Screening?

Is there an improving trend in outcomes for Diabetic Retinal Disease? If not, why not? And what can be done to remedy this?

7. Is there a local eye health network in your area?

NHS England has provided funding for each Area Team to establish a Local Eye Health Network. The key to success is engaging all parties: NHS England, CCGs, the Local Optical Committee, hospital eye service colleagues, the local voluntary sector (both as the voice of patients and providers), Public Health England, re-ablement services and social services.

Scrutiny questions 7: Has the Local Eye Health Network for your Area Team been set up? Who is the Clinical Chair and what progress has been made?

The Local Authority may wish to scrutinise the composition, work programme and achievements of the Local Eye Health Network (including that it is inclusive and wide ranging).

Are Local Voluntary Sector Organisations and Blind Societies fully engaged in the work of the Network?

Does the work of the Network cover the issues identified in questions 1-6 above?

Given that resources are extremely tight, what methods are being adopted by the Local Eye Health Network to ensure all relevant partners are engaged (e.g. email communications, occasional open meetings, etc).

How much public health support has been made available to the Local Eye Health Network?

Are local optical practices and hospital eye colleagues fully engaged, as well as commissioners?

8. Clinical Council for Eye Health Commissioning

The ophthalmic, optical and voluntary sector together with Public Health England have established a Clinical Council for Eye Health Commissioning in England to advise NHS England, the Department of Health, Local Eye Health Networks, patients and the public (as well as professionals) about eye health issues.

Scrutiny questions 8: Are the Local Authority, Local Eye Health Network, Area Team and CCGs aware of the Clinical Council?

Are there any local issues which have national implications and have these been raised with the Clinical Council?

Are there any messages that the Local Area would wish to send to the Clinical Council? If so, this would normally be through the College of Optometrists. The College of Optometrists, 42 Craven Street, London WC2N 5NG. Telephone: +44 (0)20 7839 6000 or visit: www.college-optometrists.org

9. How does local work on ophthalmic public health link with national strategies?

Vision 20/20 is the WHO Global Initiative to eliminate avoidable visual impairment and blindness. The UK is a signatory and a supporter and the strategy is implemented in the UK via the UK Vision Strategy (The latest version of the Strategy can be found via the following link: http://www.vision2020uk.org.uk/ukvisionstrategy/landing_page.asp?section=274&sectionTitle=Strategy+2013-2018

Vision 2020 UK has a specific Public Health Committee which is supported by the Ophthalmic Public Health Network. For more details, please visit: http://www.networks.nhs.uk/nhs-networks/ophthalmic-public-health-network

Scrutiny questions 9: Are the Local Authority, Local Eye Health Network and Health & Wellbeing Board aware of the existence and work of the Vision 2020 UK Ophthalmic Public Health Committee and is the Local Authority a member of the Ophthalmic Public Health Network?

How are they using these tools and "enablers" to help improve Eye Health in the Local Authority area?

10. When will eye health services next be scrutinised?

Scrutiny questions 10: What is the proposed target date for the next scrutiny of eye health services?

Has an action plan been agreed that the scrutiny committee will review in the interim?

Annex 1

Glaucoma

Glaucoma is an important cause of blindness. Glaucoma damages the nerve fibre layer in the retina, leading to a gradual loss of the field of vision, which is irreversible, and if untreated, can cause total loss of sight. It can progress to an advanced stage without being noticed by the individual as it is usually without symptoms of pain or noticeable loss in vision. Early diagnosis is the key to improving outcomes, as intervention can be very successful in slowing its progression. The relative risk of glaucoma is much higher for the black population compared to the white population (Friedman et al 2004a; Wormald et al 1994).

Cataract

Cataracts affect sight by causing an opacification (or frosting) of the lens in the eye. This causes a person's sight to become blurred or misty with a gradual loss of the ability to see contrast and detail. Cataracts are generally uncovered during a sight test, although referrals must be sent via the GP. Fortunately, cataracts are generally easily treatable by surgical intervention, and can be regarded a major success story within secondary eye care. Over the past fifteen years, substantial progress has been made in improving detection of and reducing waiting times for cataract surgery. One key UK source for ethnicity data was Das et al (1994, 1990), who examined 377 people and found that Asians had a significantly higher prevalence of cataract compared to people of European descent (30% compared to 3% in people aged under 60 years and 78% compared to 54% in those aged 60 years and over). Asians have a greater risk of developing cataracts compared to the black population and white population (Kempen et al 2004; Das et al 1994).

Uncorrected refractive error

Uncorrected refractive error simply means blurring in vision that could be remedied by sight correction such as glasses or contact lenses. A surprising number of people in the UK have uncorrected refractive error, especially among the older population. "In the older population, of England and Wales, (aged 65 and over), a total of 735,000 have impaired vision (<6/12) in one or both eyes due to refractive error. Some 395,000 have impaired vision in both eyes and need spectacles to bring their visual acuity up to the level required for driving" (RCOphth 2002). The white population has the greater risk in developing refractive error compared to the black population (Kempen et al 2004a).

Uncorrected refractive error affects quality of life as it impacts on distance or near vision, or both, which makes it increasingly difficult for an individual to perform day to day tasks. Uncorrected refractive error is often overlooked as a cause of sight loss. Fortunately it is one of the easiest to remedy with an updated visual correction. Primary eye care services are available across the country to resolve this, although the individual must first attend for a sight test.

Diabetes

The ever increasing prevalence of diabetes in the UK population is by now well understood. The latest data from the National Diabetes Audit (2009) show that there were 2.3 million people with diabetes in 2009 compared with 1.3 million in 2003. For type 1 diabetes there is no association with social deprivation or age. By contrast type 2 diabetes is strongly associated with ethnicity, social deprivation and age. The prevalence of all types of diabetes, rises steadily from 0.05 per cent in the 16-25 year age group to 13.5 per cent in the 70-84 year age group (National Diabetes Audit 2009). A more recent report by Epivision (2009) put the overall number of persons in the UK with diabetes at 2.66 million (p.44 Epivision 2009).

Less well known is the impact that diabetes can have on visual impairment. Diabetes can affect vision in several ways, but the most serious impact is generally on the blood supply to and within the retina. Most sight loss due to diabetes can be prevented, the crucially important thing is that it is diagnosed early and treated promptly. Among the 2.66 million estimated to have diabetes by Epivision (2009), an expected 748,000 will have background diabetic retinopathy which needs to be monitored carefully as this can develop into irreversible sight loss.

Diabetic eye disease and eye care

All diabetics should be screened appropriately for diabetic retinopathy. As the numbers with diabetes continue to grow, this places an ever-increasing burden on eye care services. In addition to screening programmes, a growing proportion of diabetics require intensive treatment and follow up. Figures from the National Diabetic Audit indicate that currently about 3 per cent of type 1 diabetics and 1 per cent of type 2 diabetes require Diabetic Retinopathy treatments (National Diabetes Audit 2009). Black and Asian populations have a greater risk of developing diabetic eye disease compared to the white population (Kempen et al 2004; Das et al 1994).

Much has already been done to meet this challenge, but there is much more to do to meet the expected rise in numbers over the next ten years. England now has the world's first screening programme for diabetic retinopathy which should assist greatly in detecting and referring diabetic eye disease for appropriate clinical management.

Macular eye disease

Age-related macular degeneration (AMD) is a chronic disease that results in progressive damage to the macula, with loss of central vision and the ability to see details. The numbers of individuals suffering from AMD in its various forms are increasing rapidly. In 2002, almost 700,000 aged 65 and over have sight-impairing macular degeneration (RCOphth 2002). By 2009, an estimated 1.49 million individuals had some form of AMD (p.19 Epivision 2009). The black population has a greater risk of developing AMD compared

to the white population in younger age groups, whereas the white population has a greater risk of developing AMD in the latter years of life; Asians are at lower risk than whites of AMD (Friedman et al 2004; Das et al 1994).

AMD mainly affects the population over 50, with increasing incidence with age. AMD can be classified as dry or wet. Dry AMD is the more common form and is characterised by progressive and permanent loss of central vision that causes blurring and loss of perception of colour and detail. There is currently no medical treatment for this type, although many of these patients would benefit from an improved low vision service. Wet AMD results from bleeding of new and leaking blood vessels at the back of the eye. Wet AMD can respond well to treatment in its early stages. If untreated, wet AMD can cause sudden and permanent loss of central vision.

Wet AMD and the challenge for secondary eye care

Wet AMD accounts for about 10 per cent of patients with AMD. It is estimated that there are about 26,000 new cases of wet AMD in the UK each year. The condition usually affects people over 50, and the risk significantly increases with age (NICE 2008). It is crucially important that wet AMD be detected and referred for appropriate treatment in as short a time as possible after symptoms develop. Treatments for AMD are expensive and require an intensive programme of follow up appointments and further treatment.

Annex 2

Commissioning responsibilities for eye health

In your local area eye health responsibilities are as follows:

- commissioning NHS sight testing services for all against the national contract on a demand-led basis – NHS England Area Team.
- commissioning hospital services for referrals from community optometrists, GPs and self-referral through A & E – Clinical Commissioning Groups (CCGs)
- children's reception (Year 1) vision screening – Local Authorities
- ophthalmic public health and health needs assessments – Health and Well-being Boards
- commissioning co-ordination – Local Eye Health Network (LEHN). There should be a LEHN covering every NHS England Area Team and funding for management, public health and a LEHN clinical chair has been made available by NHS England in every Area Team's budget.

Eye health professionals

There are a number of different professionals working in eye health in the local area.

In primary care, Optometrists test sight, prescribe and dispense glasses and contact lenses as well as delivering many enhanced eyecare pathways. Dispensing Opticians dispense, fit and supply glasses and, if they have undergone further training, fit contact lenses. Optometrists can also be based in hospitals alongside Ophthalmologists.

Ophthalmic medical practitioners are doctors who specialise in eye care. There are also GPs with a Special Interest (GpwSIs), which can include eye care.

Orthoptists diagnose and manage disorders of vision and binocular vision problems and lead primary vision screening.

In the secondary care setting, Ophthalmologists are medically trained doctors who have undertaken further specialist training into eye diseases and are based in hospital eye clinics.

All of these professions have a key role to play in prevention, early diagnosis, prompt referral and ongoing community management of serious eye conditions.

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CfPS is a registered charity no 1136243

September 2013