

8 September 2014

The Call to Action (CTA) is a major opportunity for eye health and care in England. LOCSU issued guidance for LOCs on how to respond to the CTA in June 2014. This second document contains further information on the key points LOCs may want to include in their submission to NHS England.

Routes to respond to the CTA

LOCs have various options for responding to the CTA:

1. Complete the online questionnaire, answering the questions posed by NHS England in the CTA www.england.nhs.uk/2014/06/12/eye-cta/
2. Feed your views to LOCSU to inform the national response
3. Participate local engagement event(s) hosted by your Area Team (AT)
4. Send a joint response to your AT with neighbouring LOCs

If possible, we suggest that LOCs feed in via all routes. We would be grateful if LOCs could forward a copy of your response to info@locsu.co.uk.

Suggested key points to include in CTA responses

Question 1

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

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. These services have already been commissioned by a number of individual CCGs 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.

Better utilisation of the primary care workforce - 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 in ophthalmology, working in the community, are better utilised to introduce much needed capacity to meet the rising demand for eye health services. This already happens with cataract post-operative care and Ocular Hypertension (OHT) monitoring in some areas.

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

Commissioning - Commissioning services at a national level will also 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.

Local commissioning, supported by Local Eye Health Networks (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.

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.

Integration of services and IT - the current lack of infrastructure and connectivity between primary, secondary and social care means that community eye health services operate in technological isolation from the rest of the NHS and care system. This is a major barrier to efficiency and improving outcomes and needs to be overcome to reduce duplication and inefficiency in the system at all points.

Everyone who needs vision correction must be able to access it to improve their health well-being and social inclusion

Reducing avoidable sight loss - Earlier detection and intervention of eye conditions is required 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.

Support for people with sight loss - People with sight loss must be properly supported so that barriers to care and social inclusion are overcome, minimising downstream costs to the health and social care systems.

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 as proxies for need, for service development and to inform commissioning decisions.

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.

Innovation and better use of new technologies - Increased use of telehealth is needed to bring 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. This approach could be used to both minimise unnecessary referrals and support community management services.

Question 2

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

- ensure there is equitable access to General Ophthalmic Services (GOS) for the whole of the eligible population including seldom heard groups
- address capacity issues in hospital eye clinics to ensure equitable access to surgery and other sight preserving treatments for those that would benefit
- ensure that systematic population-based screening is implemented as recommended by the UK National Screening Committee (NSC)
- implement eye health awareness campaigns targeted at high risk groups, particularly groups known to have a low uptake of sight tests
- increase the understanding of eye health issues and the impact of sight loss among health and social care practitioners.
- promote optical practices as the first port of call for people with eye health problems.

Question 3

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

- provide high quality eye care and ensuring that those services are easy to access
- deliver education about eye health and care from an early age
- change the public's perception that the purpose of a sight test is only to correct refractive error and increase awareness that it is important in detecting causes of preventable sight loss
- promote optical practices as part of primary care and as the first port of call for eye health problems
- provide information on eye health and eye conditions in a range of accessible formats
- ensure people with sight loss have access to an Eye Clinic Liaison Officer (ECLO) service.

Question 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?

LEHNs have a key role to play with other Local Professional Networks. National initiatives such as the Royal College of General Practitioners Eye Health Priority are also important.

- Health and social care practitioners need to be made aware that dementia, diabetes, smoking, and falls in the elderly can have serious implications and co-morbidities with eye health.
- General Practitioners need to understand the signs and symptoms, and treatments and referral pathways for eye conditions, particularly the leading causes of blindness.
- General Practitioners need to understand what eye health services are available in their local area and how to signpost patients to them.
- Community pharmacists need to be aware 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.

Question 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?

LEHNs must 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.

Question 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?

NHS England should look at the success of services that have already been commissioned by many CCGs in England to better utilise community optometrists and opticians. They should also learn from the successful 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.

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. 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.

Question 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?

- Integration of IT systems between primary and secondary care is required so that data can be exchanged securely and efficiently between primary and secondary care.
- Incentives for primary and secondary care providers (and in some cases the voluntary sector) to collaborate to deliver integrated care are required.
- Support is needed for clinicians to develop skills beyond core competencies and to undertake higher qualifications where necessary.
- Standardised robust clinical governance and quality assurance arrangements need to be implemented across all services.
- Perverse incentives, such as follow up tariff paid for patients being monitored in hospital, where it could be done in primary care, need to be removed.

Clinicians must be encouraged to develop a culture of working as an integrated whole looking after the care of the patient

When commissioning widescale management of chronic or acute disease in the community, commissioners need to consider the implications for local hospital eye services, including the financial viability of the remaining hospital service and training of junior doctors.

Question 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 into the community is essential to relieve pressures in ophthalmology departments as overall capacity in the hospital sector is limited whereas there is capacity available within the community optical sector which can be harnessed for the benefit of the NHS.

Developing integrated IT, incentivising collaboration between primary and secondary care providers, and developing robust governance frameworks are all achievable with national investment and support from NHS England.

Question 9

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

Access

High quality eye care must be easily accessible to all; in ways, locations and at times that suit the patient. The majority of optical practices are open Monday to Saturday, with many open evenings and/or weekends, and they are generally well located for public transport links and have access to parking. Research is required to understand the links between deprivation, access and how these can best be overcome.

Work needs to be done to ensure GOS is universally accessible to groups who have particular needs. These include:

- A national service, based on the LOCSU pathway for Adults and Young People with Learning Disabilities as developed with the charity SeeAbility, should be commissioned to ensure people with learning disabilities have universal access to GOS.
- A national service should also be commissioned 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 is required to improve access to GOS for homeless people, gypsies and travellers, vulnerable migrants and sex workers.
- 'At risk' groups, such as people of African, Caribbean and South East Asian descent, should be targeted.

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. As older people, among whom eye conditions are more prevalent, make up the majority of this patient group, it is essential that they receive regular eye care as early detection can lead to the prevention of sight loss.

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 current pre-notification system should be abolished.

Uptake

The uptake of timely routine sight tests can be increased by:

- changing the public's perception that 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 the first port of call in primary care for people with eye health problems
- implementing eye health awareness campaigns targeted at high risk groups, particularly groups known to have a low uptake of sight tests
- increasing awareness of the NHS funded sight test and vouchers for spectacles among eligible groups, to remove any anxiety about the cost
- increasing the understanding of eye health issues and the impact of sight loss among health and social care practitioners, so that they recommend regular sight tests to people at higher risk.

NHS England should also work with patient groups and the public to better understand their views on how individuals can be encouraged to have regular sight tests.

It is suggested that the retail aspect of optical services could inhibit some patients, especially those on low incomes, from accessing the service. Without significant public investment, the current subsidising of the NHS sight testing service by the sale of spectacles, contact lenses and other optical products is likely to remain for the foreseeable future. Therefore NHS England should ask the LEHNs to consider the impact of these issues and to work with the Local Optical Committees to see how these issues could be addressed in their area.

Question 10

[How can we improve timely access to eye health treatments and sight loss services for vulnerable or seldom heard groups?](#)

Homeless people - Only an estimated 15% of homeless people receive state benefits, therefore 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. A more systematic, commissioned solution is needed to improve access to primary eye care for homeless people.

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.

A nationally agreed eye health and sight loss pathway for homeless people is needed and LEHNs should play a key role work in implementing the pathway. The pathway should also be made available to sex workers, gypsies and travelers, vulnerable migrants and minority ethnic groups.

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.

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.

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 should be commissioned to ensure people with learning 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. Access to GOS for this group could be simplified by designating schools for children with special needs as "day centres".

Question 11

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

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

Information must be presented in an accessible format.

Question 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?

The Local Optical Committee has gathered and submitted 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:

http://www.locsu.co.uk/uploads/communications/community_services_summary_september_2014_2.xlsx

They have also submitted evidence to support Ocular Hypertension (OHT) monitoring, a community low vision service and a pathway for people with learning disabilities.

A number of different models of shared care for monitoring glaucoma 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.

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.

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.

- 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 supply in the community is far more flexible than in the hospital sector and can be expanded rapidly outside centralised NHS controls.

Many of the services that can be provided in primary care utilise core skills of optometrists and

opticians. National peer reviewed accreditation modules 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.

Ophthalmology oversight and training for optometrists and opticians beyond core skills are required for more specialist services that can be provided in primary care. Support for clinicians to develop skills beyond core competencies and higher qualifications should be provided. 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 conditions such as glaucoma and medical retina.

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

The key to making greater and more effective use of community eye care providers 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.

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.

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.

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

- access to NHS numbers for community optical practices
- development of an evidence base
- update the National Eye Health Epidemiological Model
- improve certificate of visual impairment data.

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

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

LOCSU Call to Action guidance for LOCs

Part 2

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.

For information on the Call to Action including details of NHS England's local engagement events see www.locsu.co.uk/communications/calltoaction.

To submit a response to the Call to Action, go to www.england.nhs.uk/2014/06/12/eye-cta/.

To feed your views to inform the national response or if you have any questions, please email info@locsu.co.uk.