THE ROYAL COLLEGE OF OPHTHALMOLOGISTS'

Improving eye health and reducing sight loss – A 'Call to Action' Response from the College's Lay Advisory Group – August 2014

Introduction

Summary of Key Points identified by the Lay Group of the Royal College of Ophthalmologists

1. Patients want and need to be seen in efficiently run clinics by a named ophthalmologist responsible for their care and highly skilled in making sound diagnoses and prognoses. While we do not question the skill and dedication of eye doctors the pressure of patient numbers gives them insufficient time for each consultation with the result that patients leave the clinic unsure of their diagnosis and follow up regime. Patients frequently do not have time to ask questions and leave the clinic confused and uninformed about what they could do to help themselves where that is possible.

   Conclusion:
   - More ophthalmologists and allied healthcare professionals are needed to ensure that clinics can be run more effectively with patient outcomes, medical and mental, at the forefront
   - Patient mental clarity about their treatment journey, follow up and access to low vision services, social services and information on registration could be greatly improved by funding of ECLO posts in eye clinics

2. We support the concept of the intelligent "pyramid team working", using to the full ECLOs, ophthalmic nurses and optometrists and rehabilitation workers. Optometrists[1] need to be incorporated into the diagnosis, referral and follow up pathway. However so long as optometrists are trained towards working as commercial profit makers there will always be distrust

[1] We commend reference to the Vision 2020UK Adult Sight Loss Pathway http://www.vision2020uk.org.uk/core_files/UKVS_sightloss_pathway(1).pdf

by ophthalmologists, patients and the general public over their knowledge and skill base and hence their involvement in the process. Optometrists' involvement can only be partially effective so long as they are not able to use IT within the NHS to transmit referrals and photographs of patients' eyes electronically. The concept of having to say "I will write a letter to the hospital" or GP is archaic.

Conclusion:

- Optometrists should be used as a valuable resource in the diagnosis, referral and follow up pathway but their inclusion should be as part of a network of NHS funded community optometrists under the medical leadership of ophthalmologists. These could either be in GP clinics or could be designated high street optometry practices.

- To be effective, efficient and improve referral times community optometrists must be fully integrated in local NHS IT systems

3. There continues to be a dysfunctional system for assessment and provision of low vision services which are a vital part of keeping visually impaired patients active and capable. The savings to the NHS and social services by reducing falls, improving independence and also helping people to stay in work are considerable and yet funding for low vision services is uneven nationally and is randomly split between hospitals, social services and voluntary societies

   Conclusion:

   - Low vision services should be recognised as a mainstream part of the medical treatment and follow up pathway for patients. Funding should be provided as part of an integrated health and social care budget.

   - In the same way as optometrists could be better used and integrated in eye health services, dispensing opticians many of whom are trained in the specialist discipline of low vision services could also be used as part of community eye health services in clinics or as designated providers based in high street practices.

Questions

Q 2– how can we secure the best value for the financial investment that the NHS makes in eye health services?

The term "Best Value" needs to be seen in a broad way – looking across the whole system rather than a single budget- and should include costs to the patient and social services. For example, the value of a speedy return to work for

someone who needs a cataract operation or has had an accident and the effect of halting wet ARMD in maintaining independence in old people should also be taken into account.
The following need to be taken account of to secure best value:

- Increase the number of ophthalmologists in order to reduce waiting times, relieve capacity problems, improve outcomes and improve patients experience in and after clinic attendance
- Reduce the social care burden by including all services in eye health planning including rehabilitation, assessment and provision of low vision services and funding ECLO posts in eye clinics
- Fully integrate all available expertise into the eye health services chain using optometrists under medical leadership of ophthalmologists, dispensing opticians in low vision services and improved education of GPs on eye conditions, referral and treatments
- Optometrists to be able to access NHS IT systems in order to be able to refer patients and transmit notes electronically
- Improve system for return visits and monitoring so that patients can be seen in their community rather than making time consuming and expensive visits to hospital clogging up clinics and causing capacity problems
- The Royal College of Ophthalmologists, along with other medical royal colleges in their own sphere, is the engine room for ensuring that ophthalmology services in primary, secondary and specialist clinics are provided to the highest possible standards of safety and skill. The NHS must recognize the essential role played by College members and must allow them adequate paid time away from their Trusts and clinics to perform the essential work they must do to ensure through the College that training, examinations, medical education, technical skills etc are maintained and developed for the national good and that ophthalmic services nationally are developed consistently using good evidence bases. Without this recognition financial investment in eye health services will be wasted.

Q3 – how can we encourage a more preventative approach to eye disease to reduce the burden of blindness and vision impairment?

Much of eye disease is not preventable in the same way as say - cardio vascular problems . Eye disease is frequently genetic or a result of aging and is significantly more in evidence in areas of social deprivation. Regular eye tests will lead to early identification of eye conditions with a greater likelihood of success in reducing instances and severity of sight loss.

Smoking cessation programmes, encouragement to eat a wide diet of fruit and vegetables and tackling obesity are good public health policies particularly amongst hard to reach and socially deprived groups. Better contact lens hygiene

is also important but successful public health campaigns will not empty eye clinics.

Note the following points:

- Patients with eye conditions need to be informed about how to take responsibility for ensuring maximum vision and so must be treated as partners in the process of tackling the condition, rather than passive recipients of the NHS services. This means more ophthalmologist time has to be spent on each patient so that at the end of the appointment the patient is very clear about what their 'problem' is and has had time to ask questions on what is to happen next and how they could help themselves
- Children – ensure universal preschool vision screening is introduced. It is available in some places but is generally a post code lottery. Schools used to have routine eye checks. Lay group members would welcome universal provision.[2]
- The knowledge of GPs and physicians about eye disease can be low, and the Lay Group is concerned that this lack of knowledge may not be conducive to prevention of eye disease.
- Cosmetic surgery – the general public is unaware of how it can go wrong and severely affect eye sight and a public awareness campaign can only help to spread this information. The public should be made more aware of procedures such as laser refractive surgery, cosmetic eyelid surgery and cosmetic fillers; and when these are and are not appropriate and the risks involved. The same is certainly true for more dubious practices such as eye tattooing and conjunctival jewelry

Q4 How do we encourage individuals to develop personal responsibility for their eye health and sight?

- This has to be part of public health campaigns to stop smoking, reduce obesity, improve diet and have regular eye checks. Obesity causes diabetes and diabetes has severe risks to eye health. Smoking increases the risk of age related macular degeneration and other serious eye diseases.
- A recurring theme of this report is the need for more time to be available in clinic for eye doctors to talk to their patients about self help and personal responsibility
- ECLOs and ophthalmic nurses can be trained to provide information to patients on personal responsibility
- RCOphth and voluntary organisations such as RNIB, IGA (International Glaucoma Association) and the Macular Society

[2] We commend reference to Vision 2020UK Children and Young Peoples Guidelines and Children and Young Peoples Pathway
http://www.vision2020uk.org.uk/library.asp?libraryID=5205&section=000100050005

produce excellent leaflets at their own expense. The NHS should give funding for public health information produced by voluntary organisations and should encourage their display in eye clinics

- High street optometry practices could have an important role in public health information about eye health.
- Optometry practices can encourage their clients to check their own eyes regularly using an Amsler grid
- Encouragement of the use of good quality sunglasses can help reduce a risk of macular degeneration
- Contact lens providers must give clear instruction about the need for hygiene and the risks when this fails.

Q5 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?

GPs and other healthcare professionals do not know enough about eye care. They need to know more about eye conditions, including how to identify eye problems at an early stage, how to help people to stay well and healthy and avoid the onset of eye conditions.

- Junior doctors and GPs training must include more about common eye conditions, their treatment and about the best referral pathway to ensure that patients reach the most capable and suitable eye clinic in the shortest possible time
- Similarly social care practitioners , particularly those frequently seeing elderly patients must be trained in the common conditions, treatments and pathways
- The voluntary sector also has an important role to play in providing information to recently diagnosed patients

Q6 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?

- This is particularly applicable to diabetes and advice with regard to this condition and other long term conditions affecting eye health is best provided by clinicians
- Certificates of Vision Impairment are a key resource for medical and social services the funding of electronic CVI's and better data capture would increase understanding and enable more efficient resourcing of services.

Q7 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?

- This has already been partly covered in our introduction and in the answer to question 2. Commissioning must be built around the needs of the patient reducing hospital visits and increasing community eye health centres
- A good example is the “Local Community Eye Care Pathway “ for Adults with Learning difficulties, so they receive a good service (and more time) from Community Optometrists rather than having unnecessary (and more time- restricted) hospital appointments.[3]
- It is essential that a named ophthalmologist consultant stays in charge of determining a patient’s care. In the same way that the new NHS initiative aims to have ‘a name above the bed’ for hospital patients it is essential that eye patients are given the name of the consultant who will be in charge of their entire treatment pathway. They should know whose team is looking after them even if they do not always see the named consultant particularly if they are being managed under a pooled list.
- It is time to examine work force planning for ophthalmologists

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Q8 Can we develop more widely the integrated role of eye health professionals in primary care in the identification and management of chronic or acute disease?

- Yes by educating GPs
- By making better use of optometrists in ophthalmology led teams
- By reorganizing the funding of work done by optometrists so that those practising in a community role are remunerated correctly by the NHS for their work. Currently many optometry practices having invested in new expensive diagnostic equipment offer their clients a ‘super thorough eye exam to detect disease’ but they make a considerable charge to the patient for doing this. Patients should be entitled to thorough investigation and diagnosis without extra charges.

Q9 What can we do to relieve pressures in ophthalmology departments because of difficulties in discharging patients back into the community?

- This comes back to the establishment of multi disciplinary community eye care teams who are capable of monitoring patient progress after initial diagnosis and treatment.
- These teams would also be able to provide low vision services, advice on registration, rehabilitation and access to social services[4]

Q10 How can we appropriately increase access & uptake of timely routine sight tests for the general population, including for people at higher risk?

[3] See Adult and Childrens sight loss pathways mentioned in footnotes 1 and 2
[4] See Adult and Childrens sight loss pathways mentioned in footnotes 1 and 2

- Public health information campaigns have an important role in this and in reassuring patients that they will not be sold unnecessary glasses
- GPs have an important role in prompting patients to have their eyes tested
- Schools have a role in recommending to parents that their children have regular eye tests.
- The major chains of optometrists could be encouraged to include the need for eye tests in their advertising. For example Specsavers run massive advertising campaigns for stylish glasses. They could include encouragement to have an eye test in their advertising.
- Access to testing in a community setting must be increased to provide for vulnerable and socially deprived people who are those particularly requiring eye health attention and can't access a high street optometrist or will not do so as they are intimidated by the commercial nature of the shop.

Q11. How can we improve timely access to eye health treatments & sight loss services for vulnerable or seldom heard groups?

- GPs need to know much more about eye conditions, including how to identify eye problems at an early stage, how to help people to stay well and healthy and avoid the onset of eye conditions.
- Social care practitioners must be adequately educated in eye health matters through local forums led by ophthalmologists
- Eye hospitals should routinely convene "Best Interest Meetings "to ensure the best outcomes for patients who lack the capacity to make decisions.
- All eye departments should undertake visual awareness training for their staff to ensure they are responsive to the accessibility, communication and information needs of patients whose sight is threatened or failing. Visionary (formerly NALSVI) member organizations could help with this.

Q 12 How do we best involve service users & their carers in the development, design & delivery of NHS services for eye health?

- Starting with the Lay Advisory Group of the RCOphth there are many lay and patient groups whose interest is to obtain the best services possible for patients, including and especially for vulnerable and seldom heard groups.
- Hold forums or focus groups with lay and patient groups such as
  - Macular Society
  - Retinitis Pigmentosa Society
  - Diabetes UK
  - RNIB
  - Action for Blind People

    - Visionary members formerly NALSVI (National Association of Societies for Visual Impairment)
    - SeeAbility
    - Vision 2020 UK
- International Glaucoma Association (IGA)
- When involving service users avoid unnecessary jargon and acronyms