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

There is a vast skill base in the community that is massively under-utilised. Making use of these available resources will, with the correct organisation, reduce costs paid in professional services and also those paid to support patients in using them.

Skills are often shared by professional groups, some groups may find an interesting and exciting challenge in using their more advanced core competencies when doing a task that other groups find an irritating day to day chore. An approach should be taken to obtain excellent professional care at the most reasonable cost whilst maintaining an appropriate professional fee structure for those performing on behalf of the NHS. The use of alternative professional services should always be considered. Value could even be found in investment in upskilling professionals leading to long term professional fee savings.

Organisationally, value can be achieved by doing work once. Currently each local area is approaching eye care slightly differently and it is impossible that this has not led to work duplication and staff time wasted. National bodies exist and have lately been guiding development of local eye care schemes. LOCSU provide standard clinical and business frameworks and WOPEC provide education for optometrists to ensure that they meet the required professional standards to provide community services. Much work has already been done and a 'cross England' approach would ensure that optometrists across the country have a comparable skill set, that patients are not subject to a 'post code lottery' regarding available community services, and that future work is done only once, nationally, rather than many times at a local CCG or LAT level.

Provision of services close to home will also reduce costs in other areas such as hospital patient transport for access to out patient appointments.

In our area we have introduced five community pathways over the last three years. More than sixty percent of optometry practices across the county provide these services so patients are able to access these services on their doorstep from providers who they know through their regular sight tests.

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

Education. Some eye conditions are not apparent to patients until the advanced stages, largely patients are not aware of these dangers. Involvement of eye care in television programmes and public heath campaigns, particularly campaigns aimed at specifically targeted groups such as those patients who are becoming 'at risk' of age related conditions. Previously these patients tended to attend optometric practice as they developed problems with reading, the need for reading glasses, though this has declined after the introduction of 'ready readers' and these patients now only attend when their vision worsens, sometimes irreparably.

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

As in encouraging a preventative approach, education regarding the 'silent' conditions that patients only notice themselves when it is too late is key. This could be achieved through public health campaigns using hard hitting 'scare tactics'. A legislative approach, for example requiring a regular sight test to maintain a driving licence or motor insurance, would certainly achieve the goal of increasing uptake of regular eye care.

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?

All health care workers undergo education and training before they begin to work with people. Structured qualifications such as NVQs offer an ideal opportunity to educate health and social care workers through a module in eye health and how ocular conditions can affect people, not only through visual difficulties but also in social interaction, mental health, mobility and fall risk.

Education could be standardised if eye care pathways are structured in the same way across the country. This would lead to better understanding for other health professionals and practitioners and hence more frequent and appropriate referral or promotion to patients. Should standard services be provided health professionals and practitioners would be able to relocate without having to learn new pathways for their local area.

A greater use of community eye care professionals will raise the profile of eye care in general through word of mouth amongst patients and through communication between health professionals and practitioners, this will likely increase uptake of services in itself.

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?

It is important to raise awareness of the long list of systemic conditions that can have ocular involvement and effects. Education can be provided to other health professionals including doctors, practice nurses, pharmacists, etc., not only regarding the ocular involvement of systemic conditions, but also informing them of appropriate referral pathways and the skills of optometrists in their community. Addressing potential eye problems could be as simple as proper advice to seek an eye examination with an appropriate professional or could be a referral via letter. Patients who do not qualify to receive a GOS sight test will then be faced with a choice. GP and hospital appointments are free, a trip to the optometrist will come at a cost. Even though the community optometrist may be the most appropriate place for the eye condition to be assessed and maybe even managed, the fee to the patient will be off-putting and hospital time may be wasted through referral to the free service. Provision of an NHS sight test for anyone referred by another health professional would remove this pitfall.

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?

The first step to making best use of the skill mix is to be aware of the skill mix available and the crossovers, those skills that are available in both hospital and community practice. Local Eye Health Networks bring together all the stakeholders in eye health care and hence will be able to ascertain the skill sets available, their location and scope. Practitioners often enjoy working at the more advanced end of their skills. Those professional groups who share a skill, and hence would provide the same quality of care can then be identified and patients signposted to the most appropriate care provider. In deciding the most appropriate provider, consideration must be given to patient access, quality of care and finances.

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?

Yes. Many areas now provide a PEARS service in the community. Patients benefit from an urgent eye care service close to home and only the more challenging cases present to accident and emergency when this is the more appropriate route, normally having been assessed by an optometrist first. Optometrists manage chronic disease in practice every day, be it dry eye, cataracts, or any number of other minor but longstanding problems. Integration of

optometrists into the continued care of those with other chronic conditions would provide similar benefits to the acute 'PEARS' schemes – easier access for patients as the service is close to home and reduced burden for hospital services whose capacity could then be used for more urgent or complex cases. Accepted referral pathways have been with us for decades, so should a condition worsen referral for treatment introduction or change would be second nature.

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

Although optometrists have long been used to referring patients to ophthalmologists, the opposite has not been the norm. Hence, ophthalmologists will need reassurances that referring out to optometrists does not compromise patient care. The development of nationally accepted protocols for management and re-referral when required will increase ophthalmologists' confidence that optometrists have the clinical skill to manage patients appropriately.

Although difficulties in discharge are apparent, reduced referral into ophthalmology departments through optometric triage will also aid pressure relief. Optometrists with special interests or skills are often a more appropriate first step of referral for referral refinement, this should be encouraged. Referral to other optometrists will likely inspire optometrists to pursue further education and specialisation themselves to prevent loss of patients to competitors, this will lead to improved patient choice and higher levels of competency and skill amongst professionals.

Current financial incentives may lead hospitals to keep their patients, with CCGs paying hospital trusts per patient visit. Discharge into the community is, in essence, discouraged. This could be combated should ophthalmology departments be financially rewarded for appropriate discharge rather than for repeat visits.

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

The is no issue of access to routine sight tests, there is more capacity than is required and provision is available in many towns and villages, as well as in large cities, up to seven days per week. There is only the option to increase uptake, this may be largely restricted by financial pressure. For a large part of the population there will be a fee attached to a sight test, a professional service which can be ignored whilst there are no appreciable problems. Extended provision of the NHS sight test to all would remove this cost implication to the patient and increase uptake – this may in fact reduce hospital costs in the long term as patients are managed in optometric practice and will not attend an emergency department with a chronic problem, or are referred at an early stage of a condition making treatment more effective and take less ophthalmology time.

The optometric profession has an image problem. Many patients feel that the only time they need to visit an optometrist is when they feel that they need glasses, or an updated prescription. Further education aimed at patients, explaining the healthcare role of their local optometrist may help to ease this. Patients also feel that a trip to the optometrist is going to cost a lot, with the required purchase of spectacles as well as the cost of the test itself. Whilst spectacle sales are currently a necessary part of the optometric business models this will be difficult to change, though in the most part optometrists recommend appropriately. Patient perception could be improved by removing this image of a sales driven business culture and replacing it with an image of a healthcare professional who is responsible for looking after ocular health but who is also able to help by provision of spectacles. ***Patient perception of the value of an optometrist, and hence their importance in healthcare, may also be***

adversely affected by advertising and promotion through reduced professional fees, sometimes even free professional time. These marketing techniques further emphasise the sales led business model to our patients, thus compounding the notion that an optometrist is a salesman rather than a health professional. First steps in changing the image of optometry may be to curb advertising that tries to bring patients into optometry practices by focussing on financial benefits such as special offers, cheap spectacles ***and reduced price sight tests***.

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

Specific services can be commissioned for vulnerable groups, and these can be advertised to patients, their carers, and to other healthcare professionals who can signpost the patient towards the most appropriate service. Costs are a significant barrier to access to eye care, the NHS should do it's utmost to remove this barrier.

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

Nationally there are many very large patient representative groups that would be delighted to be involved in new developments in their eye care services. Meetings about the development of new services could be held where several options of service or pathway design could be presented for opinions to ensure that the most patient friendly option is considered.

Not all patients are involved in patient groups, but all patients attend a health care provider. Short questionnaires provided to all service users would give insight into how well a service is functioning from a patient's perspective, but balance does need to be sought between amount of information collected and likelihood of return of the questionnaire. All patients are presented with a copy of their prescription at the end of a sight test – this could be used as an opportunity to present them with a short questionnaire on the same form for return to the NHS by freepost.

12. In stimulating debate about the potential for transferring more elements of eye care from hospitals into 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?**

LOCSU can provide significant banks of audit data in support of many different community care pathways, showing their effect on patient care and NHS expenditure. As these pathways are used across the country further audit data will become available.

b) **What are the workforce implications (development / restructuring / training) to ensure safe an effective services for patients, and how would these be delivered?**

There are already training institutions in place that can provide additional and more effective learning opportunities for professionals. Improvement in the clinical knowledge of optometrists at graduation from universities and at qualification with the College of Optometrists and General Optical Council would be a solid base. WOPEC provide further education and have accreditation criteria, teaching and exams for specific schemes and pathways. Providing national schemes would allow optometrists to work across different areas without having to retrain, improving the efficiency of service for patients. Learning from experience is still key, and feedback from

hospital ophthalmology departments regarding appropriateness of referrals can allow future refinement.

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

Free flow of information between all practitioners involved in patient care will be vital. Secure connections and NHS.net email accounts will aid speed and convenience of referrals as well as allowing discussion of specific cases between parties before deciding if a referral is appropriate.

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

Information should be shared between ALL practitioners involved in patient care. Often community optometry is often not considered for the forwarding of letters regarding the condition of shared patients.

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

Those cases that require out of hours service are likely to be too serious or urgent to be dealt with by a community optometrist. On call and A&E doctors with appropriate ophthalmology knowledge will still be required for the more severe urgent cases.