LOCSU/Optical Confederation response to NICE Commissioning Outcomes Framework consultation

This is a joint response from the Optical Confederation, and the LOC Support Unit. The LOC Support Unit provides quality, practical support to Local and Regional Optical Committees (LOCs/ROCs) in England and Wales to help them to 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/ROCs, facilitating robust lines of communication between the national organisations and the grass roots of the professions.

The Optical Confederation represents the 12,000 optometrists, the 6,000 dispensing opticians, and 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 Ophthalmic and Dispensing Opticians (FODO). As a Confederation, we work with others to improve eye health for the public good.

Our response is primarily related to Outcome 2.71 Age-stratified incidence of certification of visual impairment (at each level of registration) with chronic open angle glaucoma (COAG) as the primary cause.

What are your views on the scope of the COF? Do you think that there is sufficient breadth of topics covered in this consultation, if not, can you suggest other topics that may be appropriate for COF indicator development?

We welcome the focus on glaucoma but recommend the scope of the COF be broadened to reflect the recently published Public Health Outcomes Framework indicator on preventable sight loss ('Healthy Lives, Healthy People: Improving outcomes and supporting transparency' - 4.12: Proportion of Certificate of Visual Impairment (CVI) registrations that are due to age related macular degeneration (AMD), glaucoma and diabetic retinopathy). Apart from the health outcomes and cost savings benefits such priority will bring, it will provide an added incentive for health and wellbeing boards and CCGs to work together to deliver effective eye care pathways that prevent and treat these conditions.

In addition to age-stratification, we recommend that the incidence of certification of visual impairment by ethnicity and deprivation should also be considered to enable CCGs to target services.

Which of the care processes or health outcomes measured by the indicators do you consider have the greatest potential to improve the quality of care in the five domains described in the NHS Outcomes Framework?

Glaucoma is a chronic long term condition which requires prompt diagnosis and effective follow up care. Measuring outcome 2.71 ‘’Age-stratified incidence of certification of visual impairment (at each level of registration) with chronic open angle glaucoma (COAG) as the

primary cause'' will be important in focusing CCGs and health and wellbeing boards to improve the quality of care in domain 2 of the NHS Outcomes Framework ''enhancing quality of life for people with long term conditions''. Moreover broadening the scope of the COF to align with the Public Health Outcomes Indicator (as above 4.12 to include AMD and diabetic retinopathy – also long term chronic conditions) would similarly incentivise the delivery of effective care pathways to prevent and treat these conditions, thereby enhancing quality of life for these individuals.

To what extent do you think the care processes or health outcomes measured by the indicators may be influenced by the actions of clinical commissioning groups (CCGs)[1]?

CCGs have a key role to play in delivery of the indicators and need to recognise the links between indicator specified conditions and other conditions by using an integrated approach rather than looking at conditions in isolation. All the conditions in the eye health indicator glaucoma, AMD and diabetic retinopathy are preventable through early detection and intervention and CCGs will be will be able to work with optometrists, opticians, ophthalmologists and other providers of eyecare services to redesign integrated local pathways to ensure early detection and intervention for patients with these conditions.

The easiest way of achieving this for glaucoma is through implementation of the Local Optical Committee Support Unit (LOCSU) pathways for Repeat Measures (of Intraocular Pressure and Visual Fields) and Monitoring of Ocular Hypertension and Suspect COAG in all areas across England. These evidence-based pathways which have been specifically designed as a resource for the NHS for this purpose and their commissioning across England would be a first step towards meeting NICE Quality Standard for glaucoma.

CCGs should be leading the drive to improve eye care services and reduce sight loss. Minimising sight loss within a population (in line Public Health Indicator 4.12) will make a significant contribution to the wellbeing agenda and impact positively on a number of indicators areas (for example diabetes, depression, glaucoma and stroke) and we would welcome NICE's support to make this a reality. Further to this, commissioning groups will have an incentive to take a closer interest in the performance of the existing diabetic retinopathy screening service if their own assessed performance is linked to the indicator related to diabetic retinopathy.

What, if any, are the barriers to implementing the care processes measured by any of these indicators?
What, if any, are the potential unintended consequences resulting from the implementation of these indicators?

If the indicator is limited to measuring the incidence of certification of visual impairment (at each level of registration) with chronic open angle glaucoma (COAG) as the primary cause in isolation then care for other eye conditions will not receive the combined priority they require to improve eye health and reduce inequalities and costs. By focussing on specific

[1] For example through decisions on which services to commission, the setting of contracts and the monitoring of the quality of services commissioned from providers

indicators there is a risk of failure to take an integrated approach which crosses health and social care.

Do you think there is potential for any of care processes measured by the indicators to impact differently on any particular groups in respect of age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation? If so, please state whether this difference is adverse or positive and for which group.

Yes.

- The risk of depression is over three times greater amongst elderly people with sight loss when compared to their counterparts with normal sight.[2] Reduction of sight loss amongst older people will improve their independence and quality of life as well as reducing demands on community eye health and social services.

- The risk of falls increases significantly with sight loss which has been demonstrated by a number of recent studies, and vision should be checked routinely to as part of falls prevention.[3] Associated to this will be Accident and Emergency costs as well as inpatient costs and potential long-term care costs. In a paper by Scuffham 2003), it was suggested elimination of visual impairment through detection and treatment strategies would save the NHS approximately £128 million annually.[4] More recently, Age UK has estimated that falls cost the NHS up to £4.6 million a day.

- There is a high incidence of eye problems amongst people with learning disabilities for which a specifically designed pathway for people with learning disabilities is shortly to be published.[5]

- There is a potentially positive impact on eye health inequalities experienced by older people, people in poorer socio-economic groups and British Black Caribbean or Black African ethnic groups.

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[2] Bosanquet, N (2010) Liberating the NHS: Eye Care. Making a Reality of Equity and Excellence

[3] Kuang et al (2008) Visual Impairment and Falls in the Elderly: the Shiphai Eye Study, Journal of Chinese Medical Association, 71 (9) pp.467-472; Szabo et al (2008) Older Women with Age Related Macular Degeneration Have a Greater Risk of Falls: A Physiological Profile Assessment Study, Journal of American Geriatric Society 56(5) pp800-807

[4] Scuffham, P (2003) Journal of Epidemiology and Community Health Community Health 2003 (57), pp740-744 Incidence and costs of unintentional falls in older people in the United Kingdom

[5] Emerson E and Robertson J (2011) Estimated prevalence of visual impairment among people with learning disabilities in the UK. Improving Health and Lives: Learning Disabilities Observatory report for RNIB and SeeAbility; Van Splunder J, Stilma J S, Bernsen R M D and Evenhuis H M (2004) 'Prevalence of ocular diagnoses found on screening 1539 adults with intellectual disabilities' Ophthalmology, 111:1457-63; Van Splunder J, Stilma J S, Bernsen R M D and Evenhuis H M (2006) 'Prevalence of visual impairments in adults with intellectual disabilities in the Netherlands: Cross-sectional study'. Eye 20: 1004-1010; Ophthalmology, 111:1457-63; Van Splunder J, Stilma J S, Bernsen R M D and Evenhuis H M (2006) 'Prevalence of visual impairments in adults with intellectual disabilities in the Netherlands: Cross-sectional study'. Eye 20: 1004-1010.