Whole person care and optometry: Labour policy review

Alice, the typical person who has problems seeing, has a long term eye condition that without treatment will make her blind. Alice has other chronic problems including dementia and diabetes, is at risk from falls and needs social care to remain at home with her husband who suffers similar problems himself. Better integration would increase our chances of saving Alice's sight, greatly improve the quality and safety of her eye care and help Alice to live at home with her husband for as long as she can. We very much welcome the focus on integration set out in *21st Century NHS and social care* and by Andy Burnham over recent months. In this submission we set out our recommendations for integrating eye health into whole person care.

Eye health in England – why integration is so important

Preventing avoidable sight loss is a public health priority. New treatments and better care mean we can now treat more and more of the conditions that until recently caused blindness. Indicator 4.12 of the *Public health outcomes framework*[1] targets a reduction in the number of people registering as visually impaired from three of these treatable chronic diseases: diabetic retinopathy, glaucoma and age-related macular degeneration (AMD). These are all incurable, long term conditions that require lifelong, well integrated care to minimise sight loss.

Diabetic retinopathy is the biggest cause of visual impairment amongst working age people in the UK. It occurs when diabetes affects the blood vessels in the eye. The best diabetic retinopathy services take a whole person approach. Helping someone manage their diabetes is the best way of reducing their risk of retinopathy so eye care teams need to work closely with the person who has diabetes and the other teams helping them manage it. People with diabetes are screened by public health programmes for signs of retinopathy so those teams need to work closely with the hospital eye department that treats retinopathy. However, all too often these services are poorly integrated which impacts upon people's care.

Glaucoma affects around 489,000 people in England, particularly older people. Treatment usually includes taking eye drops for the rest of your life. Glaucoma typically develops slowly and can begin damaging vision before people notice the symptoms. Preventing sight loss relies on well integrated primary and secondary care teams and supporting people to manage their glaucoma effectively. Almost all cases of potential glaucoma are detected by optometrists during routine sight tests. In Scotland and Wales, optometrists are contracted nationally to monitor people at risk of glaucoma, track the development of the disease and help keep people out of hospital until they need to be treated. Despite there being a nationally agreed pathway[2] such services are commissioned at CCG level in England so provision is patchy across the country. Where those services are not commissioned, people are sent to hospital unnecessarily for monitoring which can be inconvenient for them and clogs up already busy eye departments. Better integration will enable patients at risk of glaucoma to have their lifelong monitoring carried out in the community, freeing up hospital resources and potentially saving the NHS money.

AMD is the biggest cause of visual impairment in the country. Over 12% of people over 80 suffer from the disease and there are over 500,000 cases in the UK in total. It can cause rapid sight loss so

[1] DH (2013) Healthy lives, healthy people: Improving outcomes and supporting transparency
[2] http://www.locsu.co.uk/uploads/enhanced_pathways_2013/locsu_glaucoma_repeat_readings_and_oht_monitoring_pathway_rev_nov_2013.pdf

people need to begin treatment urgently and receive the follow up treatments that keep sight loss at bay in time. However, a lack of capacity and problems integrating primary and secondary eye care mean that people are losing their sight to AMD when it could be saved. A survey found eight out of ten eye departments were not able to treat people within recommended waiting times[3]. The ongoing failure to integrate IT systems between primary and secondary care teams means many people can't start treatment quickly enough. A report by RNIB found that services where optometrists have to make urgent AMD referrals using paper or refer people to hospital via a GP rather than directly often delay the start of treatment with worse clinical outcomes[4]. When Mr Burnham visited Queen Margaret hospital in Dunfermline in September he saw firsthand the difference better integrated IT would make to eye care in England if we emulate Scotland's progress[5].

Improving integration – prioritising integration between primary and secondary eye care

We welcome the ambition of better integrating mental, public and physical health services with social care. One of the first steps towards that ambition however must be closing the long-standing fragmentation and gaps between primary and secondary care. These are a major and ongoing barrier to developing whole person care in eye health services.

In many parts of England, a community optometrist cannot send patient information electronically to the hospital eye department. They cannot share test results electronically with an ophthalmologist to save someone a potentially unnecessary trip to hospital or speed up an urgent referral. Nor can they access important information from people's records held by GPs. Potentially invaluable public health data is not collected because optometrists in many parts of the country have to submit payment forms in paper.

This fundamental barrier to integration makes a whole person approach to care impossible. Instead of information following the patient, the patient has no option but to follow the information. People have to wait longer to be treated, they have to keep repeating tests and retelling their story and it increases the chance they have to make an unnecessary trip to the hospital just to be told there is nothing wrong with them. This fragmentation is particularly difficult for people with long term conditions and mobility problems as they are such frequent users of the eye services. Better integrated primary and secondary care services are more patient centred, free up capacity in the hospital and save money.

There are also contractual issues that prevent better integration between primary and secondary care. Around a third of all patients who attend casualty with urgent eye problems don't need to be there. As with the glaucoma monitoring example above, people in Scotland, Wales and some parts of England can get treatment from a community optometrist. But in many CCG areas, people's only option is to attend casualty because urgent community care pathways are not in place. For people who work in one area and live in another, they might find they can get a painful red eye treated at the optometrist next door to their office but if it happens when they are not at work they have to go to their local hospital A&E department. Neither the community optometrist nor hospital eye department will be able to access a shared clinical record.

Much of the additional work optometrists can take on is within their existing ore competence and training is already available for more complicated roles.

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[3] http://www.macularsociety.org/How-we-help/About-us/Newsroom/News-stories/Half-of-eye-clinics-fail-to-meet-guidance-on-waiting-times

[4] RNIB (2013) Don't lose sight! Don't delay! Available from http://www.rnib.org.uk/getinvolved/campaign/yoursight/Documents/Wed_AMD_campaign_FINAL.pdf

[5] http://www.rnib.org.uk/aboutus/contactdetails/scotland/scotlandnews/Pages/andy_burnam.aspx

Improving integration – public health and eye care

Closer working between public health, commissioners and eye care clinicians can prevent sight loss and reduce eye health inequalities.

Many joint strategic needs assessments do not include information on eye health. Public health, patients and eye care clinicians can work together to take this vital first step to planning effective services.

Regular eye examinations are key to preventing avoidable sight loss because most eye conditions are detected through standard sight tests and outcomes are better the quicker treatment begins. People in deprived areas, certain ethnic groups and people with learning disabilities are more likely to have problems with their eyes but less likely to get their eye examined and enter treatment. Better integration with public health can help focus attention on these inequalities and improve prevention.

NICE recognises that people with vision problems are much more likely to falls and injure themselves. Falls are the biggest causes of hospital admissions and death amongst older people and older people are much more likely to have problems seeing. But in many parts of the country optometrists are poorly integrated into falls pathways.

Improving integration – eye health, mental health and social care

People who lose their sight and register as visually impaired qualify for social care support. However, there is worrying variation across the country in the speed at which this support is provided and the extent of this support. With prompt and effective support, people with sight loss can maintain their independence and their employment. This in turn has an impact on mental health outcomes. Over one third of older people with sight loss are also living with depression; helping people stay independent helps tackle the loneliness of sight loss.

Recommendations: eye health and whole person care

Returning to Alice, what can the next Government do to give her whole person care, save her sight and keep her out of hospital so she can live at home? We recommend Labour take the following steps:

- Make a manifesto commitment that the 'preventing avoidable sight loss' indicator will remain in the *Public health outcomes framework* for the duration of the next parliament

- Tackle the long standing IT and contractual barriers between primary and secondary eye care
    - Commit to enabling electronic referral and payment for all community optometrists
    - Commit to a national contract for urgent community eye care services and monitoring of people at risk of glaucoma

- Commit to support and protect Local Eye Health Networks (LEHNs) across England. NHS England is setting up LEHNs across the country. They bring together patients, commissioners, optometrists, ophthalmologists, public health and others to improve the integration and quality of eye health services.

- Guarantee eye health will be included in every joint strategic needs assessment

The policy paper asks for comments on whether to pursue option A or option B to integrate care. We believe that the current NHS and social care architecture offer sufficient scope to make significant steps towards whole person care and that more substantial reform from 2015 might be counterproductive. Whole person care will be impossible without first tackling the fundamental barriers that prevent integration of primary and secondary health care and this priority can be tackled without major structural reform. Therefore, we support option B: "while we do not believe that full

integration of health and social care is appropriate immediately, we will create greater integration between our health and care services, with NHS and local authorities working more closely together on the commissioning and delivery of social care provision alongside primary and secondary healthcare".

About us:

The College of Optometrists is the professional, scientific and examining body for optometry in the UK, working for the public benefit.

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 Opticians (FODO). As a Confederation, we work with others to improve eye health for the public good.