Which areas of preventative spending/the preventative agenda would it be most useful for the Health and Sport Committee to investigate?

Sensory impairment or sensory loss has been consistently overlooked by care agencies in the past despite the obvious need for a citizen’s expectation to comply with self-participation within public health.

Specifically, how can an individual adequately commit to their individual public health responsibilities if they are unable to hear what is being imparted to them or see what is required of them. The Optometry Scotland response to this consultation relates specifically to Eye health but the principles could be applied to any aspect of sensory loss.

This consultation provides an opportunity to consider the visual needs of the nation going forward. The challenges facing the care services are considerable with an aging population and increasing general morbidity due to the exponential increase in chronic conditions such as diabetes and obesity.

A new framework for community eyecare was introduced in Scotland in 2006 with the introduction of the new General Ophthalmic Services (GOS) regulations.

This heralded a fundamental change from the testing of sight, to a more patient-led approach with the intention of providing the opportunity for early detection of eye disease and the prevention of visual loss by raising the general standard of care within optometry practices across Scotland. NHS eye examinations became free for everyone, removing an important barrier to care. The emphasis was focussed on managing patients in the community where it was safe to do so, and improving the quality of the referrals that were made to the Hospital Eye Service. Disease prevention and early identification of sight-threatening conditions were also key; improvements were made to develop the case finding/screening for eye disease with the opportunity to recall patients early to reassess or repeat tests or examinations (supplementary examination). Dilating older patients, taking retinal photographs, routinely using binocular indirect ophthalmoscopy, contact (applanation) tonometry and repeating measurements of threshold visual field screening have been key elements to developing the service.

Despite the success of the new GOS over the past ten years there is still a lack of awareness within the population of the importance of eye health and issues around avoidable visual loss persist. It is obvious that despite the considerable benefits associated with the early intervention of eye disease that community optometry remains somewhat isolated within the health and care sector. Not only does the public appear unaware of the importance of eyecare services it would also seem that politicians, senior management, and many other carers could be better informed of the crucial role that optometry can deliver.

This is gradually changing but this consultation provides an opportunity for change across the health and care sector improving the general wellbeing of all service users.

The development and success of GOS in Scotland has been considerable with over 80% of eye problems now being safely managed within the community setting freeing up significant resources in secondary care. But more could be achieved by better collaboration between agencies and service providers by involving optometry more in care networks. For example, this will lead to fewer falls and general morbidity as approximately 70% of people suffering a fall have a visual problem. Similarly,
there is good evidence that involving community optometry within stroke networks has resulted in better care for patients. Despite the level of success, optometry and GOS remain underutilised.

There are several historical reasons behind the ongoing ‘isolation’ of community eyecare services including the following:

- Lack of awareness in the public and other carers of eye health and the optometry services available
- Lack of established national protocols & pathways – post code lottery
- Inconsistent resource allocation
- Poor communication & IT within & across primary & secondary care
- Limited 2-way communication between primary & secondary care

And the potential solutions include:

- Improved IT connectivity for optometrists within primary care and across the primary & secondary care interface
- Improved communication with relevant other health & care professionals
- Collaboration and improved communication across primary care and across the primary / secondary care interface
- The establishment of joint eye-health networks involving all stakeholders
- Adequate resources to support optometry (funding, systems, and equipment)
- An eye-health awareness campaign directed at vulnerable groups

It should be noted that prior to 2005 waiting times for hospital eye appointments such as cataract were around 15 months. This is now down to 4 months due to internal reorganisation and the extended role of community optometry. This is a huge benefit to the patient and their carers, to the HES which can prioritise patients more efficiently and to the SGHD with an overall reduction in waiting times.

A wide range of conditions are now commonly managed by optometrists including:

- dry eye / blepharitis,
- red eye - anterior eye inflammation & infection
- ocular hypertension
- acute vitreo retinal presentations,
- cataract and maculopathy.

In certain areas, an enhanced form of GOS has been introduced to further empower community optometrists to take on a greater role and responsibility for patients.

This enhanced form of GOS has resulted in even more conditions being retained in the community with over 85% of cases being managed safely in primary care. Implementing enhanced GOS in Grampian has also resulted in service re-design within the eye department again freeing up capacity within the HES. Figures for Lanarkshire would indicate a 60% reduction in eye related A&E presentations following the introduction of the Lanarkshire Eye Health Network Service (LENS). Notwithstanding the obvious benefits of such enhanced service development national implementation across Scotland would ensure further equality of care delivery in every community.
lead to reactive spending/ a focus on fulfilling only statutory duties and targets, to initiate and maintain preventative spend?

There is now evidence that there is comprehensive provision of optometry practices in every community in the country regardless of deprivation category. Despite this, anecdotal evidence would suggest that people living in challenging circumstances present late with eye disease, a problem for people with anterior eye disorders, cataract, glaucoma, maculopathy, and diabetic eye disease. In addition, childhood problems such as strabismus, amblyopia and myopia can remain undetected. The Scottish Government introduced the ‘new’ GOS arrangements in 2006 with a pledge to support this with an eye health awareness campaign, but this did not materialise.

OS calls for new & novel eye health campaigns targeting our most vulnerable communities such as: SIMD 1 / 2, ethnic minority communities and those living with disability.

How could spend that is deemed to be preventative be identified and tracked more effectively? What is required in terms of data, evidence, and evaluation to test interventions for producing ‘best value for money’?

At present PSD monitor spend and activity within GOS. Optometrists record data such as clinical conditions and some aspects of the patient journey and this is collated and published by PSD. The average cost of an eye examination within GOS is around £37 and the average cost of an outpatient visit is £120 – there are considerable cost savings to be made by doing more in the community and discharging patients into optometry for ongoing management. OS produced a document in 2011 that demonstrated this saving:


SIGN also published guidance on glaucoma in 2015 (SIGN 144) that made recommendations for improved care by community optometrists and for the safe discharge of patients into the community for ongoing management by optometrists.

SIGN 144 is an evidence based guideline, but to date there has been varied uptake of the key recommendations across Scotland. One key recommendation relates to the risk factors associated with glaucoma and this presents an opportunity to include this message within an eye health awareness campaign. The benefits of implementing the SIGN guideline are many and considerable. Introducing the key recommendations on referral alone would reduce inappropriate referrals by 33%. This will instantly increase capacity within the HES as glaucoma cases take up 20-30% of the total out-patient load in most hospital eye clinics. Right now, patients are at risk; return appointments for glaucoma in the HES are beginning to slip. By retaining more patients in the community capacity increases significantly. The optometry resource is flexible and provides a care system that can meet the demands of a changing and ageing demographic landscape. Not only will this ‘future proof’ provision but there will also be the ability to match patient expectations of access to care. Patients will clearly benefit from having a service closer to home with easy access and convenient, timeous appointment systems. The SIGN guideline empowers optometrists to take additional responsibilities for managing patients by better understanding the principal risk factors for glaucoma and applying the relevant key recommendations. There is also an opportunity further develop services for patients by discharging stable glaucoma patients as defined in the guideline - creating more capacity in secondary care. SIGN 144 provides a management template that could benefit other aspects of the service such as cataract discharge.
How can the shift of spending from reactive/acute services to primary/preventative services be speeded up and/or incentivised?

If the benefits to the overall service can be identified it should be possible to ‘ring fence’ a portion of the total budget to be allocated to community eyecare. Within eyecare this would mean assessing the general budget and allocating sums for specific areas of concern such as glaucoma. The ‘Community Eyecare Services Review’ (CESR) will publish their recommendations in April 2017 providing an opportunity to implement key recommendations around joined up provision of care across the primary and secondary care interface. This can be facilitated by adequate resource allocation to support community optometry services such as the implementation of technological advances.

Impact Summary

The above suggestions should result in significant gains across the eyecare sector with a positive impact on early intervention / prevention and shifting the balance of care. It is difficult to quantify precisely what this might look like but the following does give some perspective on this:-

✔ Thousands to benefit from early diagnosis of eye disorders due to a targeted national eye health campaign
✔ Ensuring standardised, uniform high quality care through enhanced GOS across Scotland
✔ 80-90% reduction in acute eye presentations to eye casualty and A&E
✔ Thousands of appointments released in secondary care by transferring chronic cases to the community
✔ 5-10% appointments released in GP surgeries by directing patients to community optometrists
✔ Around 80,000 HES appointments released by fully implementing SIGN 144
✔ Over 5,000 HES appointments released by establishing low vision networks in the community
✔ 40% efficiency savings in drug budgets by transferring all red eye and dry eye care to optometry
✔ Potential capital budgetary savings by service delivery savings by utilising community optometry within the Diabetic Retinopathy Screening service
✔ Further efficiency savings within secondary care by utilising optometrists to deal with technical failure and Level 2 & 3 grading within the Diabetic Retinopathy Screening service

All of this fits well with current NHS policy and these measures could have huge implications in the future planning of emergency care, in the design of hospital eye departments and going some way to fulfil the need for robust service development planning to meet the ever-increasing demographic changes and clinical developments in the future.