Submission to the Primary Eye Care Service Review Group

1. Introduction

We would like to thank the Primary Eye Care Services Review Group for the opportunity to contribute to this review. We welcome the fact that this consultation clearly recognises the role optometrists and opticians in the community play in primary care, and that they have the potential to play a greater role.

The Federation of Ophthalmic and Dispensing Opticians (FODO) Ireland represents opticians in business and individual optometrists in Ireland. FODO's members include both independent and corporate opticians which operate as primary eye care providers, and individual practitioners. Between them, FODO Ireland members deliver 55 per cent of the eye care by volume and some 425,000 eye examinations a year in Ireland. Our mission is to achieve eye health for all, delivered through world-class services, provided by regulated community-based optometrists and dispensing opticians operating in a competitive environment.

Our members are passionate about eye health, eye care, patient safety and accessibility to services and believe that the right care, delivered by the right professional, at the right level, in the right place at the right time makes for the most effective use of public resources.

Further information about FODO is available on our website http://www.fodo.com/ireland.

2. Context

This review of primary eye care, which is taking place in the context of wider reform of health and social care in Ireland, as set out in

- *Future Health – A Strategic Framework for Reform of the Health Service 2012-15*,
- *Report and Recommendations of the Integrated Service Area Review Group* with regard to community health care organisations (October 2014) and
- the Health Service Executive's *National Service Plan 2015*

is both welcome and timely. The Health (Miscellaneous Provisions) Act 2014 will, when it takes effect, bring optometrists and dispensing opticians within the regulatory ambit of CORU and allow them to take on a greater role within the scope of their skills and experience.

It is against this background that FODO Ireland welcomes and supports the key themes of these strategic approaches.

3. Improvements to Current Practice

At present the role of optometrists and dispensing opticians is primarily to carry out sight testing and the provision of spectacles or contact lenses – in short to identify and enable the correction of poor vision in adults.

FODO Ireland suggests the following improvements to help reduce waiting lists, improve patient experience, tackle inequalities, remove unnecessary bureaucracy and free up community ophthalmologist resources to treat patients as opposed to spending time screening:

1. **There is a dangerous lack of consistency in the treatment of children which puts children at risk.** Central Statistics Offices (CSO) figures say that by 2021 there will be 200,000 extra children of primary school age[1]. All children under 12 are entitled to an eye examination and a voucher to cover the costs of glasses. In some counties children can only attend the local health clinic to be seen, thereby causing long waiting lists (up to 3 years in Kildare, Wicklow and Meath). If they attend an optometrist privately no HSE voucher can be issued. In other counties (such as Offaly) they can attend an optometrist privately and a HSE voucher can be issued.

    1.1 The restriction that prohibits the issuing of optical vouchers to parents of children who present a private optician's prescription rather than a public hospital prescription should be removed.

    1.2 All children with a high spectacle prescription should be allowed to access a standard increased voucher value – at present, practice and values differ from region to region.

    1.3 The application system for these vouchers should be centralised and brought in line with modern practice and processed online in a similar fashion to adult optical claims.

2. There is currently a restriction on referring of children from the school screening programme with a suspected refractive error to community optometrists as the first-line intervention. These children should be tested in the community, rather than in a hospital setting where they are subject to waiting lists and other disadvantages. The

[1] http://www.cso.ie/en/newsandevents/pressreleases/2013pressreleases/pressreleasepopulationandlabourforceprojections2016-2046/

small number who do need hospital intervention could still be referred directly to hospital on the basis of a common clinically agreed protocol.

3. The same applies for children with a medical card who are between the ages of 12 and under 16. Once a treated child reaches 12 years of age, they are often relisted under a different waiting list. This separate waiting list can again involve long delays, interrupting continuity of treatment and causing poor service provision. Again, these children and transitioning young adults should be primarily managed in the community with hospital care reserved only for the much smaller group that need it. Transition from children, through young people to adults should be a seamless process in primary care with the same clinicians supporting the young people throughout.

4. The restriction on two year tests should be removed - tests should be based on a frequency recommended by practitioners and service users' perception of their ocular health (subject to advice and guidance from CORU).

5. There should be **more direct referral** pathways for both adults and children by electronic means. At present referral for non-emergency cases is via a GP, thus creating an unnecessary step in the process. Approximately six to eight percent of all adult service users are referred onwards via their GP. To the best of our knowledge 100% of these patients are simply referred based on the optometrists' recommendation.

6. The current system of HSE-funded eye examinations requires a medical card holder to apply for prior authorisation for their sight test from the HSE. Prior authorisation should surely not be required for routine healthcare. Moreover, this paper-based system is outdated, inappropriate and costly. Prior authorisation should be scrapped and replaced with a more efficient centralised database and online system. This would result in a streamlined service, a reduction in costs and the provision of a better service to the end-user.

   This is already in place for other primary care providers. Pharmacists and GPs for example have an online system in place which allows them to check a person's eligibility for medical card treatment -**www.sspcrs.ie/portal/checker/pub/check** .
   They also have access to an online authorising system in relation to the provision of vaccinations - **www.hse.sspcrs.ie/portal/vaccinations/sec/vacc/Entervacc.** On this system, a patient's medical card details and PPS number are entered and the system will only authorise the service provider to proceed, if the patient is eligible. This system has an "electronic key" so only registered service providers can use it and to ensure patients' personal data are protected.

4. The case for expanding the role of community eye care

We believe that optical practices, which provide high quality eye care in convenient locations across the country, can and should play an important part in helping to deliver the vision set out for the health service, in particular:

- The requirement to deliver better, more integrated and responsive services to people in the most appropriate setting
- That the interests of patients and service users should be put ahead of all other considerations
- People should receive the majority of their services, accessed through primary care, in their local community – at the lowest level of complexity that is safe, timely, efficient and as close to home as possible

We recognise that in order to deliver the desired change some degree of organisational change will be necessary. In particular primary care services will need to be developed and delivered in different ways, and there will need to be a stronger emphasis on prevention, early detection and health promotion.

Why wider changes are needed

To date the scope of practice of optometrists – and to a lesser extent dispensing opticians – has been severely restricted, largely by section 48 of the Opticians Act 1956 which effectively prohibited optometrists from diagnosing or treating any eye health conditions. This restriction will be lifted once the Health (Miscellaneous Provisions) Act 2014 comes into force. This will mean that optometrists and dispensing opticians will be able to take on a greater role in addressing eye health needs, provided of course that they operate within the scope of their training and expertise.

Good healthcare should focus as much on preventing disease, which often results in savings both to healthcare budgets in the future and the prevention of lost income to the economy, as in treating disease. In addition to the correction of poor vision, the sight test also provides major public health benefits in terms of early detection of eye problems and a range of systemic conditions, such as diabetes or high blood pressure, and helps reduce preventable blindness. Approximately 80% of blindness and vision impairment is avoidable if identified and treated early.

Sight loss and visual impairment are insidious in that they are mainly asymptomatic until serious deterioration has occurred and incidence increases steeply with age. There are currently 225,000 people in Ireland living with blindness or vision impairment, and this is forecast to increase to 270,000 by 2020. Ireland also has an ageing population - the CSO estimates that there will be 200,000 extra elderly people by 2021 and that by 2046 there

will be 1.4 million over 65s[2]. The increasing age-related need and advancing technologies which make new sight-saving interventions available (e.g. anti-VEGf drugs to treat age related macular degeneration) mean, that unless skills and capacity are better utilised, hospital eye departments will be over-whelmed and patients will suffer. The only way to cope with this increase in need is to ensure as many patients as possible are

- identified in primary care through early case detection
- referred for rapid assessment, intervention and discharge by the hospital service
- discharged back for routine management and monitoring in primary care.

Effective use of resources

Overall capacity in the hospital sector is limited, whereas capacity in the community optical sector is a great deal more flexible. Optical practices, optometrists and dispensing opticians operate in an open market-driven system. If there is demand, the market will respond. Moreover, the skills of optometrists and opticians are currently under-utilised.

Many patients will consult their GP in the first instance with an eye problem. This not only means that pathologies can be missed (most GPs do not have slit lamps, for example) but also leads to increasing demands on GPs who are already under pressure. Similarly, there are a variety of conditions that are currently identified, treated or managed in hospital that could be managed equally effectively in community optical practices. It would be far better to ensure that pathways are implemented where the optometrist is signposted as the first port of call for patients with routine eye problems.

The obvious solution to the issues of capacity and demand is for optometrists and opticians to provide more care in the community, both within their own skills base and in shared care arrangements with ophthalmologists and other hospital staff. This will meet the Government's health priorities to:

- Improve quality and patient safety, with a focus on service user experience
- Promote health and wellbeing –
    - Reduce the chronic disease burden
    - Enhance and improve service delivery models
    - Deliver population based screening programmes
    - Improve access to primary care and reduce waiting times.

[2] http://www.cso.ie/en/newsandevents/pressreleases/2013pressreleases/pressreleasepopulationandlabourforceprojections2016-2046/

What wider changes are needed?

Ideally we would wish to see greater access to eye care, in particular amongst low income groups, minority and ethnic groups and older people, all of whom are known to be at higher risk of sight threatening conditions. We recognise that in the current financial climate the resources are not available to extend the scope of free sight tests and screening. However, we believe that more can and should be done to make better use of the existing resources available for primary eye care.

Subject to proper underpinning by clinical governance and audit, the default should be that whatever services can safely be delivered in the community should be. By enabling more primary eye care to take place safely in optical practices it will be possible to:

- reduce paediatric waiting lists
- reduce the pressures on busy GP surgeries
- reduce the number of patients with minor or routine conditions who need to be treated in hospital
- reduce unnecessary referrals from primary care to hospitals and
- provide follow up care nearer to home for patients who have received hospital treatment, and
- free-up scarce hospitals resources to cope with the growing pressures from more serious conditions and new interventions.

5. Recommendations for primary care services to be delivered by optometrists and opticians

Given the short timescales for preparing evidence for this review we have not set out any detailed proposals and costings for the delivery of specific services. However FODO Ireland would welcome the opportunity to work with the HSE to develop detailed proposals for the delivery of primary eye care services in the community in all of these areas.

There are certain screening services which we believe could be transferred to community optical services in order to reduce waiting times and provide a more convenient and quicker service to patients. These include in particular school screening and diabetic screening.

Children's Sight Testing and School Screening

The current system of school eye screening is outdated and needs urgent review in the interests of children's health and development. Currently a public nurse visits schools to screen children for a number of ailments. The rudimentary nature of the eye screening is not sufficient to capture children's sight level adequately. It also fails to determine whether

or not there is an underlying problem with the binocular function of that child. Many go undetected, suffer from poorer learning outcomes as a result and go onto adulthood with stigmatising conditions such amblyopia (lazy eye) and strabismus (squint) which are largely correctable up to the age of 7.

In our view all children should be able to benefit from a proper eye examination in their chosen opticians every two years without having to go through the school system. Assessment by a practising optometrist would allow for a more detailed assessment including with dilation where necessary. Delivering this service in primary care will lead to reduced waiting times in the hospital sector.

Diabetic screening programme

The diabetic retinopathy screening programme is an area where community optical practices are already proving their worth. When the existing contact comes up for renewal, changes should be considered to enable both the screening and optometric follow-up to take place in community optical practices to improve access for patients.

Other Services

There is a range of other services which could easily, safely and more cost-effectively and conveniently be delivered in the community utilising the existing core skills of optometrists and opticians. This includes cataract referral refinement, glaucoma repeat readings and referral refinement, management of low vision and management of dry eye.

There is a very strong case for transferring these services to community optical practices as soon as possible, in terms of making more effective use of the health budget, better use of limited and expensive resources in hospitals, and to provide patients with more convenient appointments (in terms of time and location). We provide an example below – glaucoma repeat readings - for illustrative purposes.

Glaucoma Repeat Readings

In the UK, the NICE guidelines on the management of glaucoma (CG85 – April 2009) had the side effect of implying that any pressures above 21mmHg be referred to hospital for investigation in the manner described by NICE. Until then, many optometrists had not referred patients who were slightly above 21mmHg if there were no other indication of glaucoma. The number of referrals soared. Although NICE advised investigation where the pressures were repeatedly high as measured by the gold standard of Goldmann contact tonometry, there was no provision within the NHS to fund optometrists to repeat the pressure readings. Although not related to NICE guidance, a similar situation arises where a visual field defect is noted. It is advisable to ensure this finding is repeated and not a one-off before referral, but there was no funding for seeing patients for further appointments.

Glaucoma repeat readings services fund optometrists to repeat pressures twice by Goldmann tonometry and to only refer when the pressure is above 21mmHg in the same eye on both occasions. This has been extremely effective at reducing unnecessary hospital referrals.

In the longer term, and with further specialist training and appropriate supervision it would be possible for optometrists in the community to deliver cataract post-operative checks and follow up, the monitoring of ocular hypertension and low risk (stable) glaucoma monitoring.

6. Delivering effective eye care

Ensuring safety and consistency

Patient safety must always be paramount. Despite being an area of low clinical risk, optometrists and opticians, like all clinicians, must operate within their level of competence and their scope of practice.

Continuing Professional Development (CPD), which will be overseen by CORU when the regulation of optometrists and opticians transfers across to it, has been normal practice in the optical sector for many years. CPD enables clinicians to both maintain and update core skills, but also to add to their skills to meet new demands.

In the UK the College of Optometrists has a system of higher qualifications at three levels which can enable optometrists to take a more advanced role in the community management of conditions such as glaucoma and medical retina. Additionally the College of Optometrists and the Association of British Dispensing Opticians offer higher qualifications in the management of Low Vision. Higher qualifications are currently available for low vision, medical retina, and glaucoma. Further qualifications in paediatrics and primary care are being considered.

Effective Contracts

If optometrists and opticians are to take on new roles beyond sight testing, new contractual frameworks will need to be agreed and put in place.

Safe and consistent practice should be a requirement of, and be managed through contract specifications. This should include agreed pathways for care, and processes for monitoring and collecting data. This is addressed in more detail in section 7 below.

It will be essential that all contracts are proportionate to the risks involved. In the case of primary eye care, these risks are recognised to be low. Optical practices comprise a mix of large, small and independent providers. The majority of optometrists and dispensing

opticians are employed under limited company models and it should be these companies that would hold the contracts.

Meeting the Costs

We recognise that any service must operate within the total available resource limits. However at present a number of eye care services are delivered in ways that are not cost effective. Too many routine primary care services and screening functions are being carried out using expensive hospital resources.

It will important that the review of primary eye care takes account of how resources are currently delivered and how they could in some cases be better deployed to achieve service transformation.

7. Standards and pathways for care

We support the principle that standardised models and pathways of care should be developed for specific care groups within primary care.

Services must be safe, subscribe to a clear set of quality standards, relevant to the needs of the patient and the patient must be empowered to interact with the service delivery system. Different approaches have been adopted in the UK which maximise the use of optometrists and opticians to meet needs and keep public expenditure under control. The training and skills required of optometrists and opticians in the UK are comparable to those in Ireland, and therefore are appropriate models to demonstrate how such services can be delivered safely and effectively.

Enhanced services in England

The current review is not dissimilar from the recent *Call to Action on eye health and reducing visual impairment* in England. There the call has been for the commissioning of community enhanced services (which include cataract referral refinement, cataract post operative checks, ocular hypertension monitoring, glaucoma repeat readings, and glaucoma monitoring), which is currently fragmented, to be delivered via a standard national service specification, which includes pathways, accreditation and clinical governance frameworks. Standardised electronic data collection, reporting, clinical audit, performance monitoring and evaluation of outcomes are integral to the process.

A number of eye care pathways, based on best practice, have been developed to enable the core skills of optometrists and opticians to be utilised to reduce unnecessary referrals to secondary care. This includes services for minor eye conditions, glaucoma repeat readings, and cataract referral refinement. Cataract post-operative checks and the monitoring of ocular hypertension both utilise the core skills of optometrists, whereas other services such

as monitoring of patients with low risk glaucoma require optometrists with higher qualifications and/or arrangements for supervision by an ophthalmologist.

The English Local Optical Committee Support Unit (LOCSU) has developed clinical training packages and implementation tools to assist with the commissioning and governance of services based on these pathways,[3] and has produced a map of community eye health services in place across England[4].

Primary care service in Scotland

In Scotland the system includes:

- a national eye examination (with defined tests that are age and disease targeted)
- a national referral refinement and disease/condition monitoring service with a supplementary examination.

More significantly, patients with all eye problems go to an optometrist first for evaluation, triage and referral, via a hotline phone within 24 hours if it is considered urgent. This means that GPs no longer see patients who have problems related to their eyes and walk-in eye casualty centres in secondary care have been shut.

Referrals are direct to secondary care, and the patient sees the appropriate specialist on their first visit. Electronic referral will be introduced in the near future.

All of these activities are within the core competencies of optometrists. This system has reduced the number of referrals to hospitals and the savings to secondary care have been calculated conservatively at £55m per year.

The scope of practice of optometrists in Scotland will extend further in the coming years. 25% of optometrists are qualified or currently in training to undertake independent prescribing. And Scotland will shortly move to the discharge of patients with stable glaucoma, diabetic retinopathy and macular degeneration for monitoring by optometrists in the community.

Primary care service in Wales

In Wales, National Schemes such as the Welsh Eye Care Service (WECS) and its predecessor Primary Eye Care Assessment and Referral Service (PEARS) have seen a steady decline in the number of referrals being made into secondary care despite the ageing population. The chief pathway for achieving this has been in primary care assessment and management of acute eye conditions and referrals from other professionals such as GPs and Pharmacists**.**

[3] http://www.locsu.co.uk/community-services-pathways/
http://www.qualityinoptometry.co.uk/
www.locsu.co.uk/training-and-development/enhanced-services-training
[4] www.locsu.co.uk/community-services-pathways/community-services-map

More recently, the Welsh Government has encouraged each of the Health Boards in Wales to bid for additional funding to assist in the delivery of services in primary care. There are well established pathways for referral refinement in cataract and glaucoma alongside a general referral triage service which involves an optometrist working alongside consultants to grade all incoming referrals to secondary care and return many to the community where they can be managed by WECS accredited optometrists.

In addition, a well established community based low vision service exists throughout Wales using optometrists to assess, manage and counsel patients who have lost their vision.

Accreditation and audit of all these schemes and pathways is rigorous with much published data. The bulk of the work has been undertaken by WOPEC (Welsh Optometric Postgraduate Education Centre), Cardiff University and the Health Boards.

FODO Ireland
12 December 2014