

# Implementing the UK Vision Strategy

## A VISION 2020 UK Conference

### Conference Report

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*Supported by the Department of Health*



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## Summary

Vision UK 2009, a Vision 2020 UK conference, hosted by RNIB, and supported by Department of Health, was a one day event that aimed to promote the delivery of the UK Vision Strategy (UKVS). Just one year on since the Strategy's official launch, this conference, chaired by Nick Astbury (Chair, VISION 2020 UK) marked a number of key developments.

There was the launch of Future Sight Loss UK, new RNIB funded research on the prevalence and costs of sight loss. Comprising of two studies, this research provides estimates of the current economic impact of sight loss in the UK adult population. Additionally, and of particular pertinence to the VISION 2020 resolution to eliminate avoidable blindness by 2020, Future Sight Loss UK considers the prevalence and costs of sight loss over the next decade.

Whilst demographics highlight the likely increase in demand for services, commissioners can make an impact on the size and nature of that demand through better and more effective commissioning of services. To this end, a new World Class Commissioning (WCC) guide to improving community based eye health services was announced by Ben Dyson, Department of Health's Director of Primary Care. This guide, which has since been launched, is a significant step forward.

UK Vision Strategy implementation plans for England and Scotland were made available at the conference. These plans outline the work required to deliver tangible improvements, setting priority areas against the three key outcomes, as outlined in the UK Vision Strategy report. The Northern Ireland plan is now also available and work is progressing towards the Welsh implementation plan, which aims to be in place by the end of November. Progress in Scotland includes the development of new referral care pathways, improved patient information and joint training initiatives connecting optometrists and ophthalmologists.

Taken together, the Future Sight Loss UK research, the WCC guide and the UKVS country implementation plans, will provide a powerful framework and resource to drive the delivery of the UK Vision Strategy aims – to bring about transformation in eye health and sight loss services in the UK.

Change, however, is dependant on activity and partnership at local levels. Although this is the next big step, progress is already being made in a number of key areas including Leeds, Cumbria, Leicestershire and Tower Hamlets. Leeds has developed its own local Vision Strategy and at the conference Mick Ward & James Woodhead, NHS Leeds/Leeds City Council Strategic Partnership representatives, spoke about a number of initiatives, including the Leeds Vision Charter, which outlines what should be expected from health and social care services in Leeds.

Of course, the success of the UK Vision Strategy will ultimately be measured by the impact it has on individuals. Peter White, BBC Radio 4's presenter of 'In touch' made this very clear through his accounts of real people and real lives. Anita Lightstone, Programme Director, UK Vision Strategy, also highlighted the crucial role that local communities and individuals can and should play in development of high quality and more personalised services. Working together, across all levels, is clearly fundamental.

In terms of going forward, Anita Lightstone identified two priority actions that cannot wait: 1) Raising awareness of the importance of good eye care and making it accessible to all; 2) Human contact – the importance of a person to talk to during difficult times, to listen to worries and concerns, and a person building bridges to other services.

Further information on the Future Sight Loss UK research, the WCC guide, the implementation plans and the activity in Leeds, is provided below. The conference also included breakout sessions on a number of key topics relevant to the UK Vision Strategy. The main points of these discussions are summarised in Appendix 3.

## **Future Sight Loss UK**

Future Sight Loss UK is a new RNIB funded research study on the prevalence and costs relating to sight loss.

Comprising of two reports, the first undertaken by Access Economics, provides estimates of the current size and economic impact of sight loss in the UK adult population.

The results of this study indicate a total of 1.8 million people with partial sight and blindness in the UK adult population in 2008.

Partial sight and blindness among the adult population imposes significant economic costs on the UK. This was estimated as £6.5 billion in 2008 and includes direct costs such as hospital and social care costs estimated as £2.14 billion, and indirect costs such as informal care costs and costs associated with lower employment, estimated as £4.34 billion.

This study also considered the value in the loss of health associated with disability and premature mortality due to sight loss. This total value was estimated as £15.5 billion.

In addition to estimating the economic cost of partial sight and blindness in the UK adult population, four hypothetical eye care interventions were evaluated in the research to estimate the potential cost effectiveness. The results of the cost-effectiveness analysis suggests that the most cost-effective intervention is expected to be one that targets minority ethnic groups. This is because these groups experience lower access to eye care services than the general population and undetected eye disease is likely to be more severe.

Of particular pertinence to the UK Vision Strategy's 2020 objectives (towards the elimination of avoidable sight loss), the second study, undertaken by Darwin Minassian and Angela Reidy of EpiVision, looked to the future, and considered the impact of demographic change on the prevalence and costs of the 4 main causes of sight loss, during the decade 2010-2020. The results of the study show for example, that in the UK, the numbers of people with sight loss due to AMD will increase by about 31% by 2020. The UK costs for AMD are estimated as approximately £1.7 billion in 2010. The decade costs (2010-2020) are estimated as £16.4 billion.

By modelling different scenarios, the study also considers the impact of improving access to prevention and treatment on the prevalence of sight loss, and its related costs. With AMD, for example, the gain in visual acuity over the decade due to Ranibizumab treatment was considered in terms of numbers who convert from being partially sighted to having adequate vision and from blindness to partial sight. At 50 per cent coverage (to reflect possible limitations in access to treatments or lower uptake), approximately 73,000 people will experience sight gain, over the decade. At 90 per cent coverage, the number increases to 121,453 people. In terms of costs, the total cumulative cost of illness for the

decade increases from £15.9 billion to £16.7 billion, from 50 per cent to 90 per cent treatment coverage. Taken together both studies should provide a powerful resource to guide both policy and practice, in the years to come.

Fuller summaries of the Future Sight Loss UK research presentations are provided in appendix 1. Executive summaries and full reports can be downloaded from:

[www.vision2020uk.org.uk/ukvisionstrategy/future\\_sight\\_loss\\_uk](http://www.vision2020uk.org.uk/ukvisionstrategy/future_sight_loss_uk)

## **World Class Commissioning**

Whilst demographics highlight the likely increase in demand for services, commissioners can make an impact on the size and nature of that demand through more effective commissioning of services.

To this end, a new World Class Commissioning toolkit for improving community based eye health services was announced by Ben Dyson, Department of Health's Director of Primary Care. This guide, which has since been launched, provides a significant step forward. It focuses on improving the quality of commissioning eye health services and provides practical advice on how PCTs can: assess their current performance; identify their vision for the future; and commission services that meet the needs of their local communities.

The guide is intended to build awareness and capability within PCTs:

- section 1 sets the scene for the guide and emphasises the key areas for developing primary eye health services
- section 2 describes the application of world class commissioning to primary care
- section 3 provides key information about eye health services, how they are delivered and describes the distinctive features of commissioning these services
- sections 4 to 6 set out the steps of the commissioning process as they apply to primary eye health services, from establishing the baseline and developing the vision to the levers and tools available to make change happen
- section 7 contains a series of questions that are pertinent for PCT Boards in respect of their commissioning of primary eye health services

- section 8 describes what achievement at level 4 of the world class commissioning competencies might look like.

Used alongside the UK Vision Strategy and the Future Sight Loss UK research, this guide will provide a powerful framework for the transformation of eye health and sight loss services in the UK.

The executive summary is provided in appendix 2. The full document can be downloaded from:

<http://www.pcc.nhs.uk/news/3066>

## **UK Vision Strategy implementation plans**

UK Vision Strategy implementation plans for England and Scotland were made available at the conference. These plans outline the work required to deliver tangible improvements, setting priority areas against the three key outcomes, as outlined in the UK Vision Strategy report. The Northern Ireland plan is also now available.

### **The England plan**

The England Implementation plan also notes the real challenges posed for the health and social care system as people live longer and demands for services increase. In addition it notes that improving commissioning is a key priority for the NHS and social care services and this is the way to deliver improvements for patients. It highlights the need for a joined approach between health and social care in service design, commissioning and delivery.

Some excerpts from the England Implementation plan (Ann Keen, Parliamentary Under-Secretary of State):

"I hope the Implementation Plan can contribute to helping foster improvements in commissioning, to better meet the needs of people. In England, given its size and the diversity of the health needs of different communities, this commissioning needs to be owned and managed locally".

"The plan also highlights that in England, "health and social care services are moving from a system where people have to accept what is on offer, to one where they have greater control over identifying the type of support or help they want and more choice about and influence over the services they receive. We want to see improvements in the life chances of disabled people, including

people with visual impairments, by promoting their inclusion and participation in their communities and enabling them to have more control over their lives".

### **The Scotland plan**

Some excerpts from the introduction to the Scotland implementation plan (John Legg, Director RNIB Scotland; Gillian Syme, Chairwoman Optometry Scotland; Paul Baines, Chairman Eyecare Scotland):

"The Scottish Vision Strategy is nothing if not ambitious. It points to a society where we are truly integrated and centered on the needs of individuals. It calls for everyone to have access to a straightforward process for maintaining their eye health, and for people with sight impairments to receive timely and appropriate services. For service providers, the strategy calls for speedy referrals, clear care pathways, and more rational and cost effective methods of operating.

In this implementation plan, we have tried to translate these aspirations into realistic and achievable milestones with clear objectives that can be monitored to ensure that progress is maintained.

Implemented effectively, the Scottish Vision Strategy will improve the eye health of Scots and improve the lives of those who have lost some or all of their sight. This implementation plan points the way to a Scotland that has grasped this real opportunity to secure world class services over the next few years".

### **The Northern Ireland plan**

Some excerpts from the introduction to the Northern Ireland implementation plan (Naomi Long, Chair – All Party Assembly Group on Visual Impairment):

"We are encouraged to see the development of a unified approach towards eye health and sight loss in Northern Ireland.

The framework of the Vision Strategy gives us all the opportunity to play our part in ensuring that sight loss is avoided and blind and partially sighted people receive excellent support and are included fully in our society.

The All Party Assembly Group on Visual Impairment is in full support of the Vision Strategy and looks forward to seeing its

delivery through the work of the Vision Strategy Implementation Group.

We commend the engagement of the Executive Ministers, Senior Civil Servants, Eye Health professionals and service users in joining with us as a force for radical change and improvement in tackling visual impairment in Northern Ireland".

Copies of the England, Scottish and Northern Ireland vision strategy implementation plans can be downloaded from:

<http://www.vision2020uk.org.uk/ukvisionstrategy/page.asp?section=72&sectionTitle=All+Implemenation+Plans>

## **Making the Strategy Happen**

The City of Leeds has already developed and commenced implementation of a local Vision Strategy with some key developments. NHS Leeds/ Leeds City Council Strategic Partnership representatives, Mick Ward & James Woodhead, presented The Leeds Vision Charter, which outlines what you should expect from health and social care services, if you live in Leeds. It includes:

- Information on sight loss prevention and how to contact prevention and support services
- Access to high quality eye care services in your community and in hospital
- Emotional and practical support to aid independent living - available to both patients and their carers
- Rapid access to low vision aid and support services - whether or not you are registered as sight impaired
- Barrier-free access to education, employment, leisure, transport services etc
- Care and support available to individuals in all communities, whichever language you speak
- To be treated with dignity and respect

The work in Leeds also includes: targeting 'at risk' groups such as the African-Caribbean population; employing eye care liaison officers (ECLO); and offering training for assistant occupational therapists and social workers in how to better support and rehabilitate people with sight loss.

# **Appendix 1: Future Sight Loss UK presentations**

## **Future Sight Loss UK (1): The economic impact of partial sight and blindness in the UK adult population (Access Economics)**

### **Introduction**

Access economics was commissioned by RNIB to provide estimates of the (current) economic impact of partial sight and blindness in the UK adult population. This comprised the direct and indirect costs of partial sight and blindness, and the burden of partial sight and blindness on health.

In addition to estimating the economic cost of partial sight and blindness in the UK adult population, four hypothetical eye care interventions were evaluated in the research to estimate the potential cost effectiveness. These focused on four current policy areas, including:

- prevention of eye injuries;
- improving access to integrated low vision and rehabilitation services;
- increasing regular eye tests for the older population, over 60 years of age;
- and improving access to eye care services for minority ethnic groups.

### **Approach**

- The study used an 'all cases' approach, with prevalence split by the 6 causes of partial sight and blindness: AMD; Cataract; Diabetic retinopathy; Glaucoma; Refractive error (RE) and 'Other'.
- Total prevalence was the starting point, applied to Office for National Statistics population data by age, sex, ethnicity and region (9\*England, Scotland, Wales and NI). UK Medical Research Council (MRC) and National Diet and Nutrition Survey (NDNS) were primary sources for epidemiology. For future prevalence estimates, Government Actuary Department projections were used with ethnic share changes derived from Rees and Parsons.

- Disease type, severity and ethnicity splits were modeled using peer reviewed sources: different studies for ages – ‘mosaic’; estimated 24 sets of prevalence rates by age, sex and severity (i.e. 6 conditions \* 4 ethnicities).

Direct costs were determined using a top-down and bottom-up approach to estimating costs. Reference cost data from the Department of Health was the starting point. Indirect costs were estimated using a bottom-up approach based on peer reviewed literature and Access Economics prevalence estimates.

### **Definitions**

- As per Reidy & Minassian
- Blindness is defined as best corrected visual acuity of <6/60 in the better seeing eye
- Partial sight = best corrected visual acuity of <6/12 to 6/60 in the better seeing eye
- Mild <6/12 to 6/18
- Moderate <6/18 to 6/60

### **Key findings**

- The results of the study indicate that there were a total of 1.8 million (2.9%) people with partial sight and blindness in the UK adult population in 2008. This estimate includes a total of 218,000 blind people.
- 53.5 per cent of this total was due to refractive error; 16.7 per cent, AMD; 13.7 per cent, cataract; 5.3 per cent, glaucoma; 3.5 per cent, diabetic retinopathy; and 7.4 per cent to other eye diseases. The major causes of blindness were AMD (50.5%) and glaucoma (17%).
- The prevalence of sight loss increases by age from 0.2% in 0-39 year age group to 53% in 90+ group. It is numerically highest in 85-89 group (18% of total). Nearly 2/3 blind and partially sighted people are female.
- 96% of people with partial sight and blindness are White. These groups are over-represented because they live longer and, for the main diseases, being Black or Asian is considered a protective factor. Black ethnic groups have reduced risk of refractive error and Asian groups have reduced risk for AMD.

Together RE and AMD are >70% of UK partial sight and blindness.

- The research also predicts that by 2050 the numbers of people with partial sight and blindness in the UK will more than double (115 per cent increase over 2010), to nearly 4 million people.
- Partial sight and blindness among the adult population imposes significant economic costs on the UK. This was estimated as £6.5 billion in 2008.
- The total direct costs, such as hospital and social care costs were estimated as £2.14 billion. These were grouped as follows:-
  - Hospital recurrent expenditure = £593 million
  - Non-admitted expenditure = £508 million
  - Public prescribing expenditure = £158 million
  - General ophthalmic services = £484 million
  - Expenditure on injurious falls = £25 million
  - Research and development = £14 million
  - Residential and community care = £305 million
  - Capital and administration = £58 million
- The total indirect costs, such as costs informal care costs and costs associated with lower employment were estimated as £4.34 billion. These were grouped as follows:
  - Lower employment = £1.6 billion
  - Absenteeism = £80 million
  - Premature mortality = £2.0 million
  - Informal care costs = £2.0 billion
  - Devices and modifications = £337 million
  - Deadweight loss = £269 million
- This study estimated the value in the loss of health associated with disability and premature mortality by using World Health Organization's Global Burden of Disease methodology.
- Loss in health measured in DALYs
- Mild = 0.02, Moderate = 0.17, Blind = 0.43
- Value of a statistical life year derived from UK Dept of Transport (£76,866)
- Around 60% of the burden is due to AMD and Refractive Error. The burden from AMD is derived mostly from blindness. The value in the loss of health due to disability and to premature

mortality, were estimated as £14.5 billion and £978 million, respectively. The total value of the burden of disease was estimated as £15.5 billion.

### **Key findings – case studies**

- The results of the cost-effectiveness analysis suggests that the most cost-effective intervention is expected to be one that targets minority ethnic groups. This is because these groups experience lower access to eye care services than the general population and undetected eye disease is likely to be more severe.
- Cost effectiveness ratio = £1,230 per DALY avoided. 90% CI of £1,032 to £1,559 per DALY avoided.

## **Future Sight Loss UK (2) An epidemiological and economic model for sight loss in the decade 2010-2020 (Darwin Minassian and Angela Reidy of EpiVision)**

### **Introduction**

EpiVision were commissioned by RNIB to provide estimates of the future prevalence and costs relating to sight loss over the decade 2010- 2020. Each of the four main eye conditions (age-related macular degeneration (AMD,) glaucoma, cataract), were modelled individually to assess the impact of demographic change and estimate the related prevalence and costs, for the UK and by country. This study has also investigated the impact of expected future improvements in prevention and treatment on both prevalence and cost.

Crucial to the development and implementation of the UK Vision strategy, this work should provide a powerful resource towards of informing future planning, policy and practice.

Though the study modelled the 4 main eye disorders, these findings focus on **Age-related Macular Degeneration**

- the **Wet** form, which is treatable; and,
- the **Dry** form, not yet treatable.

The treatment at issue is the new therapy with Ranibizumab (Lucentis), as per the NICE guidance August 2008

### **Approach**

- Find, extract, and derive historic prevalence and incidence figures;
- Obtain data on treatment or prevention efficacy;
- Define stages of the eye disorders;
- Bring together data on population size by age & gender; and,
- Demographic trends, including mortality.

For the economics basis of this project, we reviewed the sources to find the most reliable cost data, which suited the epidemiological approach to the diseases. This was patient-based stage of disease resource use from cohort studies, and social care cost data from government sources.

These epidemiological and economic data were fed into- and integrated in- our **Decade Model**.

- The Model was constructed to simulate the occurrence of the disease in the population, and the flow of patients through the health and social care systems. It records the changing pools of affected persons, as new cases are allowed to flow in according to incidence rates, and existing cases flow out through mortality or 'cure', over the 10-year simulation period.

### **Demographic change in the population at risk**

The number of persons in the 70+ age group in the UK is expected to increase by about 28 per cent rising from 7.37m in 2008 to 9.42m by 2020. In the 85+ age group the number is expected to increase by 34%, from 1.40 - 1.87m.

### **Key findings**

- The prevalence of AMD in the UK adult population will increase significantly over the decade. Early AMD will rise by 22 per cent from 1.5m - 1.8m. Wet and Dry AMD will increase by approximately 25 per cent from 400 000 - 500 000 and 190 000 - 240 000 people, respectively.
- These prevalence estimates do not depend on levels of treatment, since treatment does not affect the incidence rate of AMD. The following estimates of sight loss and costs do depend on levels of treatment coverage.
- The numbers of people experiencing partial sight and blindness from (both wet and dry) AMD in the UK will increase by about 29 and 34 per cent respectively, by 2020. Partial sight will increase from 133,000 - 171,000 and blindness from 90,000 -120,000, over the decade. This is assuming that Ranibizumab treatment coverage for wet AMD is 75 per cent for those eligible.
- Costs of illness for AMD in the UK in 2010 are estimated to be approximately £1.7 billion. Estimated costs for the decade 2010 to 2020 are £16.4 billion
- The gain in visual acuity over the decade due to Ranibizumab treatment was considered in terms of numbers who convert from being partially sighted to having adequate vision and from blindness to partial sight.

- At 50 per cent coverage (to reflect possible limitations in access to treatments or lower uptake), approximately 73,000 people will experience sight gain, over the decade.
- At 90 per cent coverage, the number increases to 121,453 people.
- In terms of costs, the total cumulative cost of illness for the decade increases from £15.9 billion to £16.7 billion, from 50 per cent to 90 per cent treatment coverage.
- However, even with 90 per cent treatment coverage, the prevalence of sight loss due to wet AMD is expected to increase over the decade, resulting in 44,000 more people with sight loss in the year 2020 compared to 2010. This is because the beneficial effect of the treatment is overwhelmed by the demographic 'ageing' trend over the 10-year period.

### **Ways Forward in Research**

- We need continuing research to find more effective **therapeutics** ...
- and **treatment strategies** that maximise patient acceptance (uptake of treatment), and the coverage rate.

### **Need studies to monitor & assess:**

- How the NICE guidance is interpreted and implemented in practice.
- Treatment coverage achieved, how it varies across the country, and the outcomes, including adverse events.
- Patients' perspective: treatment uptake, & barriers to access.
- Longevity of the treatment benefit.
- Issues of clinical capacity.

### **Finally, a reminder**

- Of the importance of continuing research in **primary prevention**, to reduce the **incidence** of AMD.

## **Appendix 2: World Class Commissioning Guide for Improving Community Based Eye Health Services**

### **Executive summary**

The provision of high quality, patient-centred care is a key priority for the NHS. Developing primary eye health services and building on the strengths of the NHS sight testing system forms an important part of the overall strategy to ensure safe, effective, fairer and more personalised patient care.

Primary eye health services have much more to offer than testing of sight and dispensing of corrective lenses. There is scope to expand provision of clinical services in primary care settings using a mix of skills and developing integrated services and for this to become a persuasive force in improving health and wellbeing.

Although the document focuses on the commissioning of primary and community eye health services, this has implications across the primary, secondary and community care sectors, and the voluntary sector. The needs of people with vision problems, and the potential development of those problems, mean that commissioners should aim to achieve integrated eye health services, across sectoral boundaries. This ensures that patients do not fall between organisational structures, and do receive increasingly high quality, personalised care.

Demographics are likely to influence the development of community based eye health services and mean that increased attention will need to be given to this area. The population is ageing and this will lead to an increase in the burden of eye disease, particularly as eye disease is more prevalent amongst older people and frequently chronic in nature. Therefore the patients enter the service require lifelong follow up. Trends in public health, such as the rise in obesity, will also affect the prevalence of visual ill-health because there is a link between obesity and development of eye disease, such as diabetic retinopathy. Similarly, there are links between smoking and macular degeneration.

Whilst demographics highlight the likely increase in demand for services, commissioners can make an impact on the size and nature of that demand. Investment in identifying sight problems at

early stages, and treating where possible, provides a means to reduce future demand for more complex and costly interventions from the health and social care system. In turn this can improve the independence and quality of life of people with vision problems. Therefore, commissioning primary eye health services effectively is as important as the PCT's role in commissioning other primary care services. However, this area of commissioning is complex, with a number of distinctive features that are unique. World class commissioners will need to develop and strengthen their commissioning of these services if they are to maximise the opportunities for contributing to their population's health.

This guide is intended to build awareness and capability within PCTs:

- section 1 sets the scene for the guide and emphasises the key areas for developing
- primary eye health services
- section 2 describes the application of world class commissioning to primary care
- section 3 provides key information about eye health services, how they are delivered and
- describes the distinctive features of commissioning these services
- sections 4 to 6 set out the steps of the commissioning process as they apply to
- primary eye health services, from establishing the baseline and developing the vision to
- the levers and tools available to make change happen
- section 7 contains a series of questions that are pertinent for PCT Boards in respect of
- their commissioning of primary eye health services
- section 8 describes what achievement at level 4 of the world class commissioning competencies might look.

Eye care and public health professionals need to have a clear voice in key commissioning decisions and a local Eye Care Forum can make a valuable contribution in determining eye care needs in relation to the broader joint strategic needs assessment (JSNA).

To be world class commissioners PCTs need to have a system in place for commissioning primary eye health services based on a comprehensive, well researched and up to date targeted local needs assessment, and focus decisions on local priorities. World class commissioners need to be assured that the commissioning of

eye health services is appropriately supported by public health and commissioning functions, to prevent this being disconnected from other commissioning decisions e.g. in respect of the hospital eye service and social care.

To support world class commissioning, PCTs need to make sure there is appropriate eye care input at Board level whenever decisions about commissioning primary eye health services are taken. In addition, PCTs should have a named Board member with responsibility for primary eye health services. This guide may be used alongside the stakeholder-led *UK Vision Strategy*<sup>1</sup>.

*1 UK Vision Strategy*

*<http://www.vision2020uk.org.uk/ukvisionstrategy>*

## **Appendix 3: Breakout sessions**

### **Session 1: Together we are stronger: Implementing the UK Vision Strategy through partnership in Leicester, Leicestershire and Rutland**

- Partnership requires a commitment to joint working and respect for each other's contributions
- A champion is needed to drive the agenda forward
- Link the UK Vision Strategy to other priorities and agenda (show what's in it for them)
- Have targets/ objectives which are simple and measurable
- Look in different places for funding diversity - equality teams may be willing to link in
- Examples need to be shared so others can learn/adapt them to meet their needs. If you have a problem, ask the question via the UK Vision Strategy newsletter, someone will be able to help

### **Session 2: Using research as a tool for change**

- In looking at clinical interventions in areas such as glaucoma there is often very little evidence to show the effectiveness of such interventions compared with alternative interventions. This lack of evidence impacts on and limits NICE recommendations
- Research is needed into how blind and partially sighted people operate today within their own homes and to identify unmet needs, including those for children and those with multiple disabilities
- Research is needed on socio-economic costs of failing to fully address preventable causes of blindness
- In considering sight loss care it is important to look at not only direct costs but also indirect costs
- Much more emphasis needs to be placed on funding research that addresses the socio-economic questions associated with the services we are, and should be, providing to the blind and partially sighted people
- Research must produce uncontroversial evidence for the need for change from the status quo. Current research agenda is too biased towards topics that just interest researchers or have a direct commercial payback

### **Session 3: Preventing sight loss**

- Useful messages within campaigns should be pushed through local committees and they need to act collaboratively with the voluntary sector to get the message across
- The whole sector should focus on just one single generic Eye Health Day/Week - the current many days approach is confusing and weakens the message
- People get much information on health issues such as obesity, strokes, diabetes and coronary problems but not about eye health. Wherever possible, it would be useful to link eye health with some of these other campaigns, as it is often linked to these conditions
- Local PCT's are more likely to take more notice of local professionals and specialists
- PCT's will be carrying out World Class Commissioning at local level and a key point is that the voluntary sector groups are built into these strategies
- It would also be useful when people have blood tests or health checks that they were asked if they had had a recent eye check as one of the routine questions asked and encouraged to do so if they had not done
- GP's have a role to play in disseminating information and advising people to participate in regular eye checks. 99% of the public is registered with a GP, 40% of them visit the GP first when they have an eye problem
- In the past we have tended to use shock tactic type campaigns e.g. 'Don't go blind' which gives a negative/tragic/end of the world feel about blindness which is very upsetting for people going blind. We need to see whether we could get a more positive message e.g. no-one wants to go blind so avoid it if you can, but it is not the end of the world and blind and partially sighted people live very fulfilled lives

### **Session 4: Taking the eye health message to the seldom heard groups**

- Make more use of 'social marketing' tailored to specific groups e.g. a message for young people (not particularly hard to reach!) re smoking is that it makes your breath smell and you are therefore not going to get the girl/boy, rather than you are at more risk of AMD

- Be opportunistic in placing messages where hard to reach groups go, e.g. the local shop, the library
- No substitute for good old-fashioned social work in the field - get behind the closed doors
- Use peer volunteers from the same social group/culture
- With a will and some money, local authorities/PCTs can make a difference, e.g. the Tower Hamlets initiative with people with learning disabilities.

### **Session 5: Optometry/Ophthalmology: working towards effective eye care services**

- A strong appetite from a number of optometrists (in particular) to have a PEARS (Primary Eyecare Acute Referral Scheme) -type scheme for England
- The huge amount that can be achieved simply if hospital ophthalmologists, optometrists and other key stakeholders in eye health/eye care actually get together to agree how to improve patient pathways
- The risks of PCTs trying to develop schemes that do not have support and active engagement from hospital ophthalmologists
- The importance of engaging service users in designing new pathways
- The importance of embedding messages about prevention into all stages of these pathways
- No need for enhanced services in optometry settings in order to improve quality and timeliness of AMD referrals

### **Session 6: Meeting emotional need at the time of sight loss**

- Need to recognise that everyone working with customers /patients/clients are at some level impacting upon emotions
- Need for proper training and accountability for services providing emotional support and counselling
- Reluctance to ask for support/denial may mean services need to be taken to the clients- more openness about such services is needed
- VINCE as a vehicle for communication
- Must not forget children and young people
- Any work ongoing is possible under the radar of the UK Vision Strategy- need to link to other priorities where work is happening

## **Session 7: Low vision and rehabilitation: are we offering the right service?**

- There may be a bias towards health, perhaps there needs to be a shift towards social care, which would require joint working and improved commissioning
- A holistic view is needed with integration between health and rehabilitation
- Increase awareness and make more use of individual budgets and personalisation
- Improve usage and knowledge of ECLOs
- Different models work for different areas
- Services must be audited and evaluated
- Delegate responsibilities to appropriate areas e.g. voluntary sector
- Commissioners must be made aware of options

## **Session 8: Getting it right from the start (children's issues)**

- Insufficient emphasis on paediatric patients
- Insufficient reference to education

## **Session 9: Employment: out of sight, out of work**

- Need to change perceptions. Recent survey says 90% of employers think it would be too difficult to employ someone with sight loss.
- Big barrier to employment is lack of incentive to move away from benefits system. Need to discuss how to overcome this.
- Jobcentre plus and DoE need to do a lot more but it is not about blame – we need to encourage them where they are doing well
- Need to train the trainers better to deal with those with sight loss. Also need to look at provision of specialised courses
- Call for more Eye Clinic Liaison Officers who often give sound advice

## **Session 10: Leisure: change for life**

- There is a need to teach leisure and recreational skills to visually impaired children in schools
- How do we develop a help system for blind people to access sport and other activities? Could a database of 'buddies' be

developed so people could find someone to support them in taking up an activity?

- There needs to be more 'buy in' from planners and politicians to ensure facilities were made available
- A 'Gold Standard' for audio description of plays, cinema and the theatre needs to be developed