NHS Somerset

EYE HEALTH NEEDS ASSESSMENT

30 April 2013
Version 1

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VERSION CONTROL

Document Status	**Final Version**
Version	**1**

DOCUMENT CHANGE HISTORY		
Version	**Date**	**Comments**

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Document Reference:	Eye Health Rapid Needs Assessment

CONFIRMATION OF EQUALITY IMPACT ASSESSMENT FOR NHS SOMERSET EYE HEALTH NEEDS ASSESSMENT

Main aim of the document:

The aim of the Eye Health Needs Assessment (EHNA) is to enable NHS Somerset and its successor organisations to commission high quality ophthalmic services for the population of Somerset. The EHNA will be used to facilitate understanding of the ophthalmic needs of the population and the service requirements to meet those needs.

Outcome of the Equality Impact Assessment Process:

The EHNA will be used to ensure the population of Somerset has good access to quality ophthalmic services, by informing future Service planning.

Groups/individuals engaged with as part of the impact assessment:

- AgeUK
- Compass Disability
- Frome Patient Participation Group
- Guide Dogs for the Blind Association
- Highbridge Patient Participation Group
- Individual Service Users
- Local Optical Committee
- NHS Somerset Eyecare Local Professional Network
- Optima Low Vision Services
- Optometric Practitioners
- Royal National Institute for the Blind
- SeeAbility
- Somerset Older Citizens Alliance
- Somerset Partnership Learning Disabilities Team
- Somerset Sight
- Taunton Macular Disease Group
- Taunton and Somerset NHS Foundation Trust
- Yeovil District Hospital NHS Foundation Trust

Groups/individuals intended to benefit from the Eyecare Needs Assessment:

The population of Somerset

1. INTRODUCTION

Purpose

1.1 A Health Needs Assessment (HNA) is a systematic method for reviewing the current and future health issues facing a population, leading to agreed priorities and resource allocation which will improve health and reduce inequalities.

1.2 The purpose of this Eye Health Needs Assessment (EHNA) and recommended strategy is to identify the main priorities for improving eye health and reducing eye health inequalities in Somerset in the short-term and to outline the direction for the development of NHS eye care services across Somerset, to meet the future needs of the population, over the next five to twenty years.

Background

1.3 NHS Somerset currently commissions eye care services on behalf of the Somerset population. This role will pass to Somerset Clinical Commissioning Group (SCCG) and the NHS Commissioning Board from 1 April 2013.

1.4 In preparation for the transfer, the Somerset Eye Care Local Professional Network agreed to undertaken this 'rapid' assessment of the present and future eye care needs of the Somerset population and to develop a draft strategy for the development of eye care services to meet the identified need.

1.5 This EHNA is described as 'rapid' as it reviews the needs of specific risk groups within eye care and mostly draws on existing data. It focuses on the main causes of sight loss.

1.6 An EHNA of the population of Somerset is also required to enable the Eyecare Local Professional Network, to fulfil the NHS Commissioning Board vision. This includes delivery of best outcomes for patients which reflect local need and the development of strategies for service planning and health improvement.

1.7 The Department of Health's Commissioning Framework for Health and Wellbeing[1] established a duty on upper tier Local Authorities and Primary Care Trusts to produce a Joint Strategic Needs Assessment (JSNA). This is an ongoing process by which Local Authorities, Primary Care Trusts and their successor organisations describe the future health, care and wellbeing needs of the local population, to inform the commissioning of services and the Local Area Agreement.

1.8 The current JSNA makes some reference to the eye health needs of the population but with no specific EHNA available, the JSNA does not

[1] Department of Health, Commissioning Framework for Health and Wellbeing, March 2007

benefit from the contribution that such a needs assessment can provide.

1.9 In July 2010 the Department of Health published its strategy for the NHS Equity and Excellence: Liberating the NHS[2]. The strategy puts patients at the heart of the NHS and empowers professionals and providers, giving them more autonomy in return for being more accountable for the results they achieve.

1.10 The NHS Outcomes Framework 2012/13[3] sets out the high level health outcomes that the NHS should be aiming to improve nationally. The Public Health Outcomes Framework 2012 also specifies outcomes related to preventing sight loss. This EHNA and recommended eye health strategy needs to align with the outcomes identified in the Framework.

1.11 The eye health strategy also needs to align with SCCG's Strategic Plan for Health in Somerset 2011/12 – 2013/14, which sets out its purpose and vision for health and health services in Somerset.

Primary Eye Care Services

1.12 Eye care services have historically been provided within the Hospital Eye Service, with sight testing provided in community optometric practices under Terms of Service.

1.13 The Department of Health's General Ophthalmic Services Review in 2007[4], recommended making greater use of the ophthalmic skills and knowledge which exist in primary care, to support the diagnosis and management of a range of eye conditions.

1.14 In August 2008, the Terms of Service regime, which had underpinned the provision of primary eye care services, was abolished and replaced by the introduction of:

- Mandatory Services, which provides for NHS sight tests and which all Primary Care Trusts (PCTs) are obliged to commission. It is estimated that NHS funded sight tests make up 70% of the total number of sight tests in England, Wales,Scotland and Northern Ireland.[5]

- Additional Services, which provides for other services which PCTs must commission as prescribed in the Primary Ophthalmic Services Regulations 2008, currently NHS sight tests in the domicilliary setting.

[2] Department of Health, Equity and Excellence: Liberating the NHS', (2010)
[3] Department of Health, The NHS Outcomes Framework 2012/13 , (2010)
[4] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_063957.pdf
[5] Optical Federation Optics at a glance 2011 Dec 2011

- Enhanced Services, which PCTs may choose to commission and fund to meet local need.

2 SCOPE

2.1 This needs assessment is decribed as “rapid” as it reviews the needs of specific risk groups within eye care and draws mainly on existing data.

2.2 It focuses on two of the leading causes of sight loss, namely age-related macular degeneration (AMD) and glaucoma and the impact of low vision impairment in conjunction with the impact of changing demographics.

2.3 Eye care services in relation to cataracts and diabetic retinopathy have been reviewed previously and this assessment includes an overview of those reviews.

2.4 The EHNA and strategy recommendations will support the Somerset JSNA and should be reviewed in the light of any new evidence every three years.

2.5 Links to social care support through the local authority and voluntary sector will be included, as sight impairment can impact considerably on independence in daily activities.

3 CONSTRAINTS

3.1 To obtain a complete picture of the eye care needs of the population of Somerset a large and diverse amount of data from various sources is required.

3.2 It is recognised that resources are limited with respect to the availability of staff and time, bearing in mind the current reorganisation of the NHS which will see the demise of Primary Care Trusts (PCTs) on 31 March 2013.

3.3 It is recognised that the EHNA and commissioning strategy need to be sufficiently developed by 31 March 2013 to enable NHS Somerset successor organisations to benefit from its development.

3.4 It was intended that this EHNA would include an assessment of utilisation patterns of NHS sight tests, free to those meeting eligibility criteria. However, the method by which the data is captured does not easily lend itself to such analysis; further information is provided in paragraph 6.9.

3.5 There is some evidence that deprivation is an important factor in the development of glaucoma, AMD and diabetic retinopathy and that uptake of sight tests is affected by whether high street optometric practices are locally available.

3.6 A Second Level Information Sharing Protocol request, for anonymised full postcode data, to enable analysis and mapping by deprivation and of disease data to optometric practices at Lower Super Output Area (LSOA), was declined.

3.7 Analysis has therefore been undertaken at GP practice level, but does not provide the fine detail required to identify optometry service gaps and local areas of unmet need.

3.8 Public engagement is an important element of an HNA. While public and optometrist surveys have been undertaken, the limitations of these, including the lack of a statistically valid sample of public opinion, are recognised.

4. KEY POLICY AND DRIVERS

4.1 Our Health, Our Care, Our Say[6] set out a plan to meet changing health challenges, by enabling and supporting health, independence and well-being together with rapid and convenient access to high-quality, cost-effective services, designed around the patient rather than the needs of the patient being forced to fit around the service already provided.

4.2 The White Paper, Equity and Excellence: Liberating the NHS was published in July 2010 and set out plans for an NHS which keeps the patient at the heart of the system while pushing the NHS further than ever before in being accountable for healthcare delivery while enabling innovation, always ensuring quality whilst increasing value.

4.3 The NHS Outcomes Framework 2013/14[7] sets out the high-level national outcomes that the NHS should be aiming to improve. It includes a duty on the NHS Commissioning Board and Clinical Commissioning Groups to have regard both to the need to reduce inequalities between the people of England and to National Institute of Health and Clinical Excellence (NICE) quality standards.

4.4 Everyone Counts[8] outlines the incentives and levers that will be used to improve services from April 2013, the first year of the new NHS, where improvement is driven by clinical commissioners. Listening to patients, focusing on outcomes, rewarding excellence and improving knowledge and data are the principles behind its approach.

4.5 JSNAs are the responsibility of the newly created local Health & Wellbeing Boards, and identify priorities for health, wellbeing and social care across a health community.

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[6] Department of Health, Our Health, Our Care, Our Say: a new direction for community services ,(2006)

[7] https://www.wp.dh.gov.uk/publications/files/2012/11/121109-NHS-Outcomes-Framework-2013-14.pdf

[8] NHS Commissioning Board 2013 Everyone Counts:Planning for Patients 2013/14 http://www.commissioningboard.nhs.uk/everyonecounts/

4.6 In response to the Somerset JSNA, the first Health and Wellbeing Strategy, developed by the new Somerset Health and Wellbeing Board in 2012, focuses on three priorities for Somerset, which require a shared vision and joined up action to address them:

- people, families and communities take responsibility for their own health and wellbeing
- families and communities are thriving and resilient
- Somerset people are able to live independently for as long as possible

4.7 Somerset CCG set out its priorities in the Strategic Plan for Health in Somerset 2012/13 – 2014/15 as:

- integrating care closer to home
- ensuring health services reflect the needs of local communities through the development of strong localities
- self management and self care: making sure service users and carers stay in control and that services are joined up around the needs of each individual
- promoting health and wellbeing and
- using our resources wisely

4.8 The World Health Organisation's Vision 2020 programme, to eliminate preventable sight loss by 2020, is supported in the United Kingdom by the UK Vision Strategy[9]. The Department of Health is committed to supporting the strategy aims which in brief are to:

- improve the eye health of the people of the UK
- eliminate avoidable sight loss and deliver excellent support to those with a visual impairment
- enhance the inclusion, participation and independence of blind and partially sighted people

4.9 A consultation to refresh the UK Vision Strategy[10] incorporates the outcomes of the Seeing it My Way[11] initiative, a universal quality and outcomes framework for blind and partially sighted people.

4.10 In 2009, the Department of Health produced guidance to support PCTs to improve the quality of eye care commissioning, as part of its world class commissioning programme[12]. The guidance aims to build

[9] UK Vision Strategy, http://www.vision2020uk.org.uk/ukvisionstrategy/default.asp
[10] UK Vision Strategy Team, Consultation to Refresh the UK Vision Strategy: Setting the direction for eye health and sight loss service (2012)
[11] UK Vision Strategy Team, Seeing it my way, 2011
[12] Department of Health 2009 PrimaryCare & Community Services: improving eye health services

commissioning awareness and capability, with the Commissioning Toolkit[13] specifically referring to glaucoma, AMD and low vision pathways.

4.11 The Royal College of General Practitioners (RCGP) has identifed eye health as one of its four clinical priorities for 2013 to 2016. Working together, the RCGP and the UK Vision Strategy team will develop a framework to support GPs to identify undetected sight loss amongst elderly patients.

4.12 The Department of Health's Quality, Innovation, Prevention and Productivity (QIPP) RightCare[14] programme supports the development of sustainable systems that increase value and improve quality by reducing unwarranted variation and improve population planning.

4.13 In November 2011 the College of Optometrists set out its mission for ophthalmic public health[15], in conjunction with other optometric professional bodies, the RNIB and the UK Vision Strategy. The strategy includes the support of people working in ophthalmic public health and bringing them together with partners in public health and commissioning.

4.14 In 2010, the Local Authority, Somerset County Council (SCC), undertook a review of its services for people with sensory loss, which included services to people with a visual impairment. The review was conducted by independent consultants, commissioned by SCC.

- Work included extensive consultation with service users and stakeholders on a range of social care and health issues, research into policy, legislation and models of good practice, and a gap analysis.

- Recommendations focussed on creating a sensory loss information base, developing rehabilitation services, improving access to information and advocacy services, workforce developments, governance, and improved strategic links with Health.

- Implementation of the review is in progress. Discussions with partner agencies, on the development of an information hub have begun, commissioned services are being reviewed to ensure that they meet rehabilitation needs, and additional training is being offered to staff to develop their skills in rehabilitation.

[13] Department of Health 2009 Commissioning Toolkit for community based eye care services
[14] Department of Health RightCare: Increasing Value – Improving Quality http://www.rightcare.nhs.uk/
[15] The College of Optometrists 2011 An Optical Sector Strategy to Improve Ophthalmic Public Health

- A stakeholder group has been set up to ensure service users and stakeholders are involved in service planning.

National Standards and Indicators

4.15 The recently published Public Health Outcomes Framework for England[16] includes, for the first time, an indicator for eye health and sight loss.

4.16 Inclusion of the indicator, which measures the proportion of Certificates of Visual Impairment (CVI) registrations due to AMD, glaucoma and diabetic retinopathy, will ensure that avoidable sight loss is recognised as a critical and modifiable public health issue.

4.17 The National Institute for Health and Clinical Excellance (NICE) has produced guidance[17] (CG85) and quality standards on the diagnosis and management of chronic open angle glaucoma (COAG) and of ocular hypertension, together with commissioning guidance (CMG44) for services for people at risk of developing glaucoma[18].

4.18 NICE has also been tasked by the Department of Health (DH) with producing guidance on the management of AMD for publication in 2015.

5 THE NATIONAL EYE HEALTH CONTEXT

5.1 Sight loss is a major health issue, affecting about 2 million people in the United Kingdom and by 2020 this number is predicted to increase by 22% and will double to almost 4 million people by 2050.[19]

5.2 The increase can chiefly be attributed to an aging population; over 80% of sight loss occurs in people aged over 60 years.[13]

5.3 New technologies, for example in relation to AMD, have significantly improved the treatment hospital eye services can provide, preserving sight where severe visual impairment was once inevitable.

5.4 The prevention of sight loss is crucial as over 50 per cent of sight loss can be avoided[13]. The challenge is how to implement effective public health prevention of sight loss programmes and making services available where, despite prevention programmes, treatments are required to prevent or limit sight loss.

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[16] Department of Health, HIPD & PHDU Improving Outcomes and Supporting Transparency: Part 1 A Public Health Outcomes Framework for England, 2013/2016 (2012)

[17] NICE CG85 Glaucoma: diagnosis and management of Chronic Open angle Glaucoma and Ocular Hypertension http://www.nice.org.uk/CG85

[18] http://www.nice.org.uk/usingguidance/commissioningguides/glaucoma/glaucoma.jsp

[19] Access Economics 2009. Future Sight Loss UK 1: Economic Impact of Partial Sight and Blindness in the UK adult population RNIB

Direct Healthcosts Associated with Eye Care

5.5 The associated costs and demands on NHS outpatients services are high with ophthalmology having the second highest attendances in 2010-11.[20]

5.6 In England alone, the average spend in 2010/11 on problems of vision was £40,900 per 1,000 head of the population.

5.7 The main direct healthcare costs associated with eye care are:

- Primary care
  - primary ophthalmic services (NHS sight examinations)
  - prescribing and pharmacy - primary care prescribing relating to ophthalmology
  - any local enhanced services
- Secondary care
  - inpatient elective and day cases - all admitted patient care ophthalmology activity which takes place in a hospital setting where the admission is either elective or a day case
  - outpatient - expenditure relating to ophthalmology outpatient attendance or procedures

Relationship Between Sight Loss and Priorities

Age considerations

5.8 The prevalence of sight loss increases with age and the UK population is ageing. One in five people aged 75 and over and one in two people aged 90 and over is living with sight loss in the UK [13]

Socio-economic considerations

5.9 Evidence shows that there is a link between people on low incomes and living in deprivation and people living with sight loss; three out of four blind or partially sighted people are living in poverty or on its margins[21].

Ethnicity

[20] Hospital Episode Statistics: Outpatient, treatment speciality by attendance type: England 2010/11, Health & Social Care Information Centre http://www.hesonline.nhs.uk

[21] RNIB, March 2004. Unseen Neglect, Isolation and household poverty amongst Older People with Sight Loss.

5.10 The chance of developing glaucoma is more common in African and African-Caribbean populations [22]. People from South-East Asia and China are at higher risk of angle-closure glaucoma[23]. Evidence indicates that targeting preventative sight loss amongst people from black and ethnic minority (BME) communities can form part of a cost effective prevention programme[15].

Learning Disabilities

5.11 There is evidence that people with learning disabilities have a higher incidence of eye and vision problems than the general population, yet do not access the required services more frequently than the general population. This gives rise to a health inequality and inequitable distribution of health resources.

5.12 A Cardiff University study in 2000 found that over 60% of individuals had below-normal distance acuity, which in many cases was exacerbated by uncorrected refractive errors. In all, 41% of subjects could have benefited from distance spectacles, and 56% from spectacles for near tasks. The lack of adequate spectacles was particularly high amongst adults with more severe learning disabilities.

5.13 There is also a high prevalence rate of sight loss amongst adults with learning disabilities. An estimated 96,500 adults with learning disabilities in the UK, including 42,000 known to the statutory services, are blind or partially sighted. This means that nearly one in ten adults with learning disabilities is blind or partially sighted. Adults with learning disabilities are 10 times more likely to be blind or partially sighted than the general population[24] .

Health Determinants

5.14 The impact of sight loss, both from uncorrected refractive error and eye conditions, coupled with other health determinants can dramatically increase risk and demand on health and social care services. The links between sight loss and other health determinants include:

Smoking

5.15 The link between smoking and AMD, the UK's leading cause of blindness, is as strong as the link between smoking and lung cancer. Smokers not only double their risk of developing AMD but also tend to develop it earlier than non-smokers. Furthermore, smoking can make diabetes-related sight problems worse, and has been linked to the

[22] Darwin Minassian and Angela Reidy Future. 2009. Sight Loss UK 2: An epidemiological and economic model for sight loss in the decade 2010-2020 EpiVision and RNIB http://www.rnib.org.uk/aboutus/research/reports/prevention/pages/fsluk2.aspx

[23] Progress in Retinal Eye Research. 1999 Jan;18(1):121-32. Predisposing factors for chronic angle-closure glaucoma. Salmon JF. Source Oxford Eye Hospital, Radcliffe Infirmary NHS Trust, UK

[24] Eric Emerson and Janet Robertson, 2011. The Estimated Prevalence of Visual Impairment among People with Learning Disabilities in the UK. RNIB and SeeAbility.

development of cataracts[25] . Research has shown that cessation programmes which link sight loss and smoking provide a motivation for people to reduce or give up smoking[26] .

Obesity

5.16 Obesity has been linked to several eye conditions including cataracts and AMD. Obesity also has a strong link to diabetes and an exacerbation of sight deterioration in diabetic retinopathy[27].

Stroke and neurological conditions

5.17 Damage resulting from stroke can impact on the visual pathway of the eyes which can result in disruption of eye movement control causing diplopia, nystagmus, blurred vision and loss of depth of perception[28]. In addition there may be inability to read (alexia) or to write (agraphia). Approximately 60 per cent of stroke survivors have some sort of visual dysfunction following stroke. The most common condition is homonymous hemianopia, a loss of half a person's visual field, which occurs in 30 per cent of all stroke survivors[29].

5.18 Cognitive disorders should not be confused with visual impairment and the national Clinical Guidline for Stroke[28] states specialists should be available to provide specific advice for the management of post-stroke visual impairment.

Blood Pressure/Hypertension

5.19 In addition to increasing the risk of stroke, uncontrolled high blood pressure increases the risk of both retinal vein and retinal artery occlusion. Both conditions can cause sudden loss of vision in one eye and can lead to further complications[30].

[25] http://www.rnib.org.uk/eyehealth/lookingafteryoureyes/pages/smoking.aspx
[26] AMD Alliance International campaign report 2005; Awareness of Age-related Macular Degeneration and Associated Risk
[27] http://www.rnib.org.uk/eyehealth/lookingafteryoureyes/pages/obesity.aspx (26 Jan 2013)
[28] Royal College of Physicians National clinical guideline for stroke 2012
[29] http://www.stroke.org.uk/media_centre/press_releases/stroke_survivors.html
[30] Arch Ophthalmol. 1996 May;114(5):545-54. Risk factors for central retinal vein occlusion. The Eye Disease Case-Control Study Group

Dementia

5.20 At least 123,000 people in the UK have both dementia and serious sight loss[13]. Most are aged over 65 and among everyone of that age, normal ageing of the eye will reduce their vision to some extent. As the population ages an increasing number of people will experience both dementia and sight loss[31].

Falls

5.21 A recent review of evidence on the link between falls and sight loss found that almost half (47 per cent) of all falls sustained by blind and partially sighted people were directly attributable to their sight loss[32]. On average, the estimated medical cost of falls nationally is £269 million. Of the total cost of treating all accidental falls in the UK, 21 per cent was spent on the population with visual impairment[25].

5.22 The Projecting Older People Population Information (POPPI) system projects 2540 people over 65 being admitted to hospital as a result of a fall in Somerset per annum. Based on this, approximately 200 of those cases would be in visually impaired people, and 100 due to the visual impairment. However, hospital episode data for Somerset reports far higher numbers of falls in the elderly population. In 2011/12 there were 5035 falls. Applying the formula to these numbers would suggest 405 falls in the visually impaired, with 191 caused by the impairment. Early indications are that fall numbers in 2012/13 are substantially higher than in the previous year.

Depression

5.23 Older people with sight loss are almost three times more likely to experience depression than people with good vision [33]. The Royal College of Psychiatrists estimates that 85 per cent of older people with depression receive no help at all from the NHS [34].

6 THE DEVELOPMENT OF THIS DOCUMENT

Process

6.1 A Project Initiation Document, setting out the framework for this needs assessment and recommended strategy, was produced in May 2012. This document was accepted by the Eyecare Local Professional Network.

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[31] Thomas Pocklington 2007 (Feb), Dementia and Sight Loss
[32] Tammy Boyce 2011 (August). Falls - costs, numbers and links with visual impairment. RNIB
[33] **Evans**, Fletcher and Wormald, 2007 Depression and anxiety in visually impaired older people. Ophthalmology
[34] Age UK, 2012. Later Life in the United Kingdom

6.2 A literature review was conducted to ensure the needs assessment is informed by the scientific and medical evidence base. An existing literature review was used as the basis for the review conducted for this assessment. That review was conducted by the Public Health Action Support Team (PHAST) in 2009, entitled Eyecare in the UK: Epidemiology, Intervention and Ethnicity and produced for Tower Hamlets (London).

6.3 In respect of three conditions only (AMD, Glaucoma and Low Vision), a literature search was undertaken using Pubmed for the period 2009-2012 in order to update the PHAST review to reflect any recent changes in the evidence base. In respect of glaucoma and low vision this resulted in little change. However, in respect to AMD there were substantial differences due to major changes in treatment technologies being introduced in the intervening period and significant research developments. The review findings are reported at paragraphs 8.15-8.35.

6.4 An event was held on 13 November 2012 for members of the public, relevant organisations and healthcare professionals. The purpose of this event was to develop the recommended vision and principles outlined in this needs assessment and strategy. The event was also used to identify and prioritise actions in order to achieve the vision. 22 individuals, representing 18 organisations, attended the event. A summary of the outcome of the group discussions is attached at Appendix 1.

6.5 Undertaking a fully stratified public survey was acknowledged to be challenging, in the available timescale. Consequently, a public 'opinion gathering exercise' was undertaken, to obtain a wider insight into eye care services for this rapid needs assessment.

6.6 200 questionnaires were distributed to all 54 optometric practices and via organisations attending the stakeholder event. 90 were returned, giving a 45% return rate. A summary of the outcomes is provided in paragraph 8.85 and the questionnaire can be viewed at Appendix 2.

6.7 A survey of the Somerset optometric workforce was undertaken with questionnaires distributed to all 66 Somerset optometric practices, including domiciliary providers, with 25 returned. A summary of the outcomes is provided in section 10 and the questionnaire can be viewed at Appendix 3.

6.8 The survey tool was designed to gather information on the skill and qualification levels of optometrists practicing in the county, together with any further planned study, their intentions to provide enhanced services and an indicatation of when they were likely to retire.

6.9 The questionnaire was also designed to gather opinion on the effectiveness of current enhanced services and general aspects of eye

healthcare in the county, how the reputation of optometry services might be enhanced and how to maintain and develop an effective workforce.

6.10 This EHNA and recommended strategy document has been signed off by the Eyecare Local Professional Network and the Sponsoring Director and will be forwarded to the NHS Commissioning Board Area Team, the Local Authority and SCCG, to support future commisioning decisions as part of the JSNA and will also be made available on the SCCG website.

Methodology - Data Collation and Analysis

6.11 A range of data sources and models were accessed and utilised to provide an overview of the number of people living with eye conditions and sight loss. The figures are reported in section 8.

- Hospital Episode Statistics (HES data) is a data warehouse containing details of all admissions to NHS hospitals in England. It includes private patients treated in NHS hospitals, patients who were resident outside of England and care delivered by treatment centres (including those in the independent sector) funded by the NHS. HES also contains details of all NHS outpatient appointments in England.

- General practice data extracted using MIQUEST searches: GPs record data from patient consultations regarding eye conditions, including information derived from secondary care. However, as many eye conditions are detected and treated by optometrists during routine sight tests, GP records may be incomplete records of patient eye health.

- Certificates of Visual Impairment (CVI): This is a dedicated certificate used by ophthalmologists to certify a person as either severely sight impaired or sight impaired. The CVI also enables recording of visual function, the cause of vision impairment and captures epidemiological data. Information is collated nationally.

    * Copies of completed CVIs are held by Local Authorities, which are mandated to maintain a register of the number of severally sight impaired or sight impaired people.

    * The register of severally sight impaired or sight impaired people is voluntary and research indicates the number of people registered in any area is likely to be an under representation of the number of people eligible for registration. The Royal National Institute for the Blind (RNIB) estimates there are 2 million people living with sight loss in the UK of which 360,000 are registered. However, not all those 2 million would be eligible to register, as the

registration criteria would not apply to a significant proportion.

* Registration is a precondition for the receipt of certain financial benefits. However, registration is not a prerequisite for all social care services.

- General Ophthalmic Services (GOS) records (Exeter System): These are the records submitted by optometrists (High Street opticians) for reimbursement of fees for services provided to NHS patients. NHS sight tests are restricted to children, the elderly, people with certain long term conditions and those in receipt of eligible state benefits. There are no central records of sight tests conducted on the remaining adult population, whose sight tests are undertaken on a private basis.

  * The GOS data extracted from the Exeter system was not usable without substantial additional work to clean the records. In addition, GOS forms do not include information about ethnicity, which limits the empirical evidence available to support interventions to reduce health inequalities and for commissioners to understand their communities' attitudes towards their own eye health[35].

- POPPI (Projecting Older People Population Information): Originally developed for the Care Services Efficiency Delivery Programme (CSED), part of the Department of Health, this system provides population data by age band, gender, ethnic group, and various other factors for English local authorities. Prevalence rates from research are used to estimate the impact of visual impairment; www.poppi.org.uk

- PANSI (Projecting Adult Needs and Service Information): This system was developed by the Institute of Public Care (IPC). It is a programme designed to help explore the possible impact that demography and certain conditions, including visual impairment, may have on populations aged 18 to 64; www.pansi.org.uk.

7 VISION FOR EYE CARE IN SOMERSET

7.1 The vision is to improve the eye health of people in Somerset, to reduce inequalities and continually strive to provide the best outcomes for individuals.

7.2 To meet the eye health needs of the Somerset population the following strategic outcomes should be met:

[35] The College of Optometrists Better Data, Better Care: Ophthalmic public health data report 2013

- promotion of an effective preventative approach to improve eye health

- choice of high quality accessible eye-care services to reduce avoidable sight loss

- effective partnership working to support the independence of people who are sight impaired or severely sight impaired

Underlying Principles

7.1 The following principles should be adopted to ensure achievement of the vision:

- resources will be equitably invested to reduce health inequalities

- eye-care services will be commissioned to reflect the health needs of the community and promote choice

- eye-care services will be of high quality and based on evidence of what works

- commissioning decisions will be informed by the best available professional advice

- the ophthalmic workforce will continue to be utilised and developed to respond to the needs of the community in a cost-effective way

- cost benefit analysis will be a significant factor in determining commissioning plans

- a partnership approach with stakeholders will be encouraged to address eye health inequalities

- individuals will be engaged in a partnership approach so that they become informed patients who share responsibility for their own health

8 THE LOCAL CONTEXT - EYE HEALTH IN SOMERSET

Population Profile

8.1 The majority of the following information is taken directly from the 2011 Somerset Joint Strategic Needs Assessment, as updated in 2012, and aims to provide a demographic overview of Somerset.

8.2 It is estimated that 530,200 people live in Somerset. Outside of Somerset's main towns, the county is characterised by a dispersed pattern of settlement and a relatively low population density.

8.3 Somerset has fewer 20 to 29 years old than would be typical. This is thought to be due to young people leaving the county to attend university or for employment.

8.4 Somerset has a disproportionately older population compared to England. Twenty-one per cent of Somerset's population is aged 65 or over. This figure increases to 30% in West Somerset.

8.5 The elderly population (65+) is expected to increase by 20% by 2020, with much of this growth in the very old.

Population aged 65 and over, projected to 2030				
	2012	**2015**	**2020**	**2025**
People aged 65-69	36,300	39,400	35,400	37,300
People aged 70-74	26,800	30,600	38,000	34,300
People aged 75-79	21,800	23,600	28,200	35,300
People aged 80-84	17,400	17,900	20,200	24,600
People aged 85-89	11,300	12,000	13,500	15,800
People aged 90 and over	6,700	7,800	9,600	12,000
Total population 65 and over	120,300	131,300	144,900	159,300

8.6 Somerset's non-white British population is estimated to have more than doubled in the last nine years from 3% in 2001 to 7% in 2009. This is a much larger increase than seen regionally and nationally. The largest non-White British group is the "White Other" category, associated with an influx of migrant workers and their families, from the A8 states of Eastern Europe after 2004.

8.7 One in four people live in one of Somerset's three largest towns: Taunton (58,200 people, 11% of the population), Yeovil (41,800 people, 8% of the population) and Bridgwater (35,200 people, 7% of the population). At district level population density is highest in Taunton Deane with 238 people per km^2 compared to 48 people per km^2 in West Somerset.

8.8 In January 2011 there were 503 gypsy and traveller caravans in Somerset an increase of 8% since January 2009. 78% of the caravans were on authorised Gypsy and Traveller sites; this is greater than the regional average of 73%.

8.9 Although numbers remain low when compared to the national average of 21.9%, latest data indicates that the proportion of children (under 16) living in poverty in Somerset has increased to 15.6%.

8.10 Further demographic data for Somerset can be found on the INFORM Somerset website: www.sine.org.uk/jsnademographics

Prevalence Overview

8.11 The table below provides an overview of the predicted increase in the number of people developing one of the four leading causes of sight loss and low vision. The projections are based on predicted demographic change only, and do not take into account changes in disease prevalence or possible changes in treatment technologies.

Table 1: Prevalence overview of leading causes of blindness

Condition	Current prevalence 2012	Predicted prevalence 2017	Predicted prevalence 2022
Age-related macular degeneration (AMD)	6387	7364	8623
Wet AMD	3858	4446	5200
Dry AMD	3788	4377	5130
Glaucoma	11113	12433	13848
Low vision	10897	11869 (2015)	13469 (2020)
Diabetic Retinopathy	11260	12949	15150
Cataract	5620	6463	7562

Health Equity and Deprivation

8.12 In addition to the many health determinants which impact on sight loss, as set out in paragraphs 5.8 to 5.23, social determinants, including poverty, also impact.

8.13 Due to the constraints outlined in paragraphs 3.6 and 3.7, analysis and mapping, by deprivation and disease data to optometric practices, could only be undertaken at GP practice level, not at Lower Super Output Area.

8.14 While there were statistically significant differences in the prevalence of eye conditions identified in the GP practice/Federation level data, no obvious reasons were evident from a simple analysis. A full health equity audit, looking at both primary and secondary care data, may identify reasons for these statistical differences in prevalence, as well

as to ascertain whether the inverse care law is evident. The inverse care law describes patterning of health services where activity reflects demand rather than need, with minorities and lower social groups losing out. A health equity audit would include access to eye health care by specific groups including those with learning disabilities, those suffering a stroke and other neurological conditions, looked after children, patients in residential and nursing homes and travellers.

Age-Related Macular Degeneration

Background

8.15 Age-related macular degeneration (AMD), as the term implies, affects older adults and accounts for half of all vision impairment or blind registrations in the developed world. The macula is the central area of the back of the eye, a small and highly sensitive part of the retina responsible for detailed central vision. The macula allows us to appreciate detail and perform tasks that require central vision such as reading. The prevalence of AMD in Somerset is rising with the ageing population.

Pathology

8.16 AMD refers to the breakdown of retinal membranes. Early AMD may be associated with an increased number of fatty deposits of a material called drusen around the macula, a heavily pigmented area of the retina.

8.17 Vision loss due to AMD is more associated with the late forms of AMD of which there are two types. The first is commonly known as dry AMD, more correctly geographic atrophy. This occurs due to the thinning of the macula and results in blurring of vision. This process may be followed by the formation of new blood vessels which are weak and susceptible to haemorrhage. This is neovascular AMD (NVAMD), commonly called wet AMD, and can result in severe loss of central vision.

Epidemiology

8.18 AMD is the most common form of visual impairment in adults over the age of 55 living in developed countries (Coleman et al., 2008). In the UK AMD accounts for 42% of blindness in individuals aged 65-75 (Bunce and Wormald, 2008). This figure increases dramatically with age such that AMD accounts for 75% of blindness in those aged 85 and above (Bunce and Wormald, 2008). Similarly, a large scale Medical Research Council (MRC) study reported AMD to be the most common cause of visual impairment in individuals aged 75 and over (Evans et al., 2004).

8.19 By 2011 one study estimates 250,000 individuals will be living with a visual impairment in the UK due to AMD (Owen et al., 2003). This is in line with projections from a recent RNIB report which estimates 223,000 people will be affected by 2010. This report goes further by estimating a total of 1,493,963 people experiencing either early or late AMD by 2010 (Access Economics, 2009).

8.20 A more recent paper (Owen et al, 2012) has estimated prevalence of late AMD at 2.4% of the over 50 population in the UK, equivalent to 513,000 cases (CI 363,000-699,000), estimated to increase to 679,000 cases by 2020. Prevalence is much higher in older age groups: 4.8% aged 65+, but 12.2% aged 80+. The estimated number of prevalent cases of late AMD were 60% higher in women than men, due to the much higher numbers of older women in the population. There are an estimated 71,000 new cases of late AMD a year.

8.21 The estimated numbers of new cases of NVAMD per year in the UK are 13,400 in men and 26,400 in women (but with wide confidence intervals).

8.22 Local estimates of incidence and prevalence will vary significantly depending on the age profile of the population. The following tables provide data and estimates for Somerset. Estimates and projections have been provided using two methods – the National Eye Health Epidemiological Model(NEHEM) as elsewhere in this document, but also a new projection based on Owen et al 2012, which provides a somewhat higher estimate. Both models suggest an increase of approximately 15% over the next five years, but from different baseline figures. Assuming the general practice data is accurate, that represents an increase of about 750 patients over 5 years. The actual GP figures are within the confidence intervals of the NEHEM model, although those intervals are quite wide, so it cannot be assumed that there is not a degree of underdiagnosis in the community. Such underdiagnosis may arise, for example, if elderly patients and/or their close relatives accept blindness occurring as a natural consequence of aging.

Table 2: Number of patients on general practice registers with Age-related Macular Degeneration (AMD) diagnoses (2012)

Search Code	Description	Number	%
F425	Degeneration of macular and posterior pole	1,689	31
F4250	Unspecified age-related macular degeneration	743	14
F4251	Age-related Dry macular degeneration	791	14
F4252	Age-related Wet macular degeneration	686	13
F4253	Cystoid macular degeneration	33	1
F4254	Degeneration of macular due to cyst, hole or pseudo hole	491	9
F4255	Toxic maculopathy	11	0
F4256	Macular puckering	18	0
F4257	Drusen	464	8
F4258	Epiretinal membrane	454	8
F4259	Maculopathy	6	0
F425z	Degeneration of macular or posterior pole NOS	77	1
	Total	**5,463**	**100**

Chart 1: Percentage of patients on general practice registers with Age-related Macular Degeneration (AMD) diagnoses (2012)

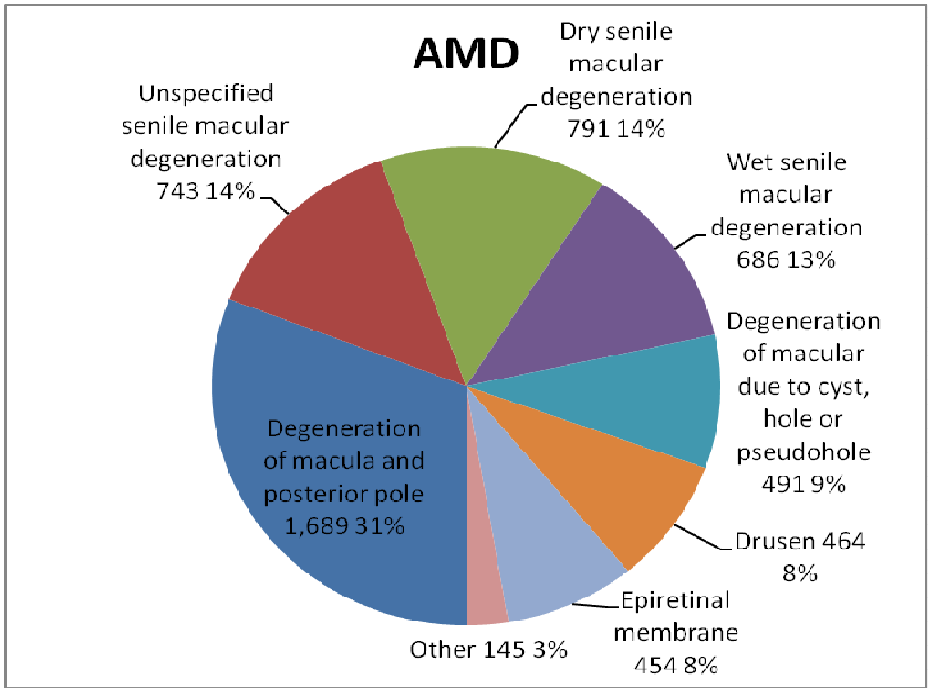


Table 3: Percentage of patients on general practice registers with Age-related Macular Degeneration (AMD) diagnoses (2012)

Condition	MIQUEST - Somerset registered population with condition	Estimated number in Somerset resident population - using ONS 2010-based population projections and MIQUEST 2012 rates			Estimated percentage increase over 2012 number		
	2012	2012	2017	2022	2012	2017	2022
AMD Prevalence	5,463	5,550	6,307	7,267	0%	14%	31%
AMD Incidence	643	652	736	841	0%	13%	29%

Table 4: Modelled estimates for numbers of Age-related Macular Degeneration (AMD) cases by type and district

	AMD			
	AMD Cases	NV-AMD Cases	Geographic Atrophy Cases	Drusen Cases
Mendip	1,147	809	402	5,128
Sedgemoor	1,245	879	435	5,612
South Somerset	1,854	1,311	649	8,171
Taunton Deane	1,235	872	436	5,325
West Somerset	574	406	202	2,407
SOMERSET PCT*	6,057	4,277	2,124	26,649

Source: National Eye Health Epidemiological Model

Table 5:Estimated projected prevalence of Age-related Macular Degeneration (AMD)

late AMD			GAMD			NVAMD		
2012	**2017**	**2022**	**2012**	**2017**	**2022**	**2012**	**2017**	**2022**
6,387	7,364	8,623	3,788	4,377	5,130	3,858	4,446	5,200
0%	15%	35%	0%	16%	35%	0%	15%	35%

(Derived from Owen et al 2012)

Table 6: Estimated projected incidence of Age-related Macular Degeneration (AMD)

late AMD			GAMD			NVAMD		
2012	**2017**	**2022**	**2012**	**2017**	**2022**	**2012**	**2017**	**2022**
896	1,030	1,202	555	640	749	498	572	667
0%	15%	34%	0%	15%	35%	0%	15%	34%

(Derived from Owen et al 2012)

Detection and Treatment

8.23 As the disease processes are gradual and generally painless early detection can be difficult. Regular comprehensive eye examinations are recommended for adults aged over 55. Diagnosis of early AMD is often an incidental finding of regular eye examinations. NVAMD has a more acute onset with the patient complaining of central distortion and blurring in the affected eye. Patients who describe a sudden change in vision of this nature should be referred for urgent ophthalmic evaluation.

8.24 AMD is an incurable condition. There are currently no effective treatments for geographic atrophy (Dry AMD). Treatments for NVAMD focus on preservation of the retina by targeting new blood vessel formation. However, treatment of NVAMD has changed radically in recent years with the introduction of injections into the eye of anti-vascular endothelial growth factor (anti VEGF) medication. This is now the standard treatment. However, a fifth of those treated do not respond to this treatment and a further quarter may lose the initial gains in visual acuity over time. At the time of writing there is much debate about the use of an alternative much lower cost anti VEGF medication which is not licensed for this use, but is widely used in the USA.

8.25 Research in this field is developing rapidly, with clinical trials underway looking at dietary factors (AREDS2) and numerous potential treatments based on genetic factors (Gehrs et al 2010).

8.26 Individuals suffering from AMD are good candidates for low vision services to best utilise residual vision. AMD is a very serious condition, but even if it is very advanced, the person affected will not become totally blind; peripheral vision is unaffected, and a good degree of independence can be maintained with training and use of specialist equipment, issued by social services. This consists of training and education together with the provision of aids to maximise an individual's residual vision (see Low Vision Services at paragraph 9.23).

8.27 Finally the psychological impact of an AMD diagnosis should not be overlooked. Mitchell and Bradley (2006) report a two-fold increased incidence of depression in AMD patients relative to other community

dwelling adults (Mitchell and Bradley, 2006). Depression is common in people diagnosed with AMD. Training of eye health professionals in recognition and referral is important (Rees et al 2009).

Risk factors

8.28 Age, current smoking, cataract surgery and family history are strongly and consistently associated with late AMD (Chakravarthy et al, 2010). Cardiovascular risk factors are also associated with AMD, but less strongly.

8.29 Recently it has been recognised that genetic factors account for a large part (75%) of the attributable risk of AMD. Screening to identify genetically susceptible individuals in the pre-clinical stage is a realistic prospect and would enable external risk factors to be modified to prevent or delay onset of clinical AMD (Gehrs et al 2010). Importantly in their study of AMD patients and their families Klaver and colleagues demonstrated a 5-fold increased risk of AMD in 1st degree relatives (Klaver et al., 1998). Such findings could be used to inform policy by adopting a 'family-centred' approach to interventions.

8.30 Age is a major risk factor for developing AMD. The prevalence of AMD increases markedly with age (Coleman et al., 2008).

8.31 Ethnicity may be an important factor in development of AMD. White populations appear to be at higher risk.

8.32 A number of modifiable risk factors are also associated with AMD. There is strong and consistent evidence that current tobacco smoking is the principal known preventable exposure associated with any form of AMD (Smith et al, 2001).

8.33 Diet may also be a determinant of eye health:

- Diets rich in antioxidants have been found to be protective against developing AMD (van Leeuwen et al., 2005). In their large population study of over 5,000 individuals above average consumption of 4 nutrients (beta carotene, vitamin C, vitamin E, and zinc) was associated with a 35% reduced risk of AMD. This result remained significant when supplement users were excluded suggesting normal dietary intake is important. A similar finding was reported by the Age Related Eye Disease Study (AREDS) which found antioxidant supplementation reduced the incidence of AMD by 25% over a 5 year study period (AREDS, 2001).

- At the present time, there is insufficient evidence in the literature to recommend routine nutritional supplementation for primary prevention of AMD. However, patients with intermediate risk of AMD or advanced AMD in one eye are recommended to take AREDS-type supplements, as this formulation has been proven to

reduce the risk of progression to advanced AMD by 25% over 5 years.

- Many observational studies have also suggested benefit from increased dietary intake of additional nutrients such as carotenoids and omega-3 fatty acids. These supplements are currently being evaluated in the AREDS2 trial, a randomized controlled clinical trial testing the effects of lutein and omega-3 fatty acids on rates of the progression to advanced AMD. Although vitamin B supplementation appeared to have potential benefit in the treatment of AMD in a randomized trial, no recommendations can be made until further studies are conducted.

- The cost-effectiveness of prevention with oral supplements has been demonstrated in the AREDS study. The results of AREDS2 and other studies may provide further insight into the prevention of AMD (Nupura et al, 2011).

8.34 Supplementation with beta carotene is contraindicated in smokers where a link has been established with the development of lung cancer (Evans, 2006).

8.35 There have been conflicting reports of an association between AMD and traditional cardiovascular risk factors (reviewed by Coleman, 2006). Most consistently AMD has been linked to hypertension, while a protective effect of HDL (good) Cholesterol on AMD development has been reported in 2 studies (Hyman et al., 2000, Tomany et al., 2004).

8.36 Inflammatory markers have been implicated in the development and progression of AMD. C-reactive protein (CRP) is an inflammatory marker known to be associated with cardiovascular disease, and a link between AMD and CRP has been suggested. A meta-analysis of evidence from eleven studies shows that high serum levels (>3 mg/L) of CRP are associated with a two-fold likelihood of late onset AMD, compared to low levels (<1mg/L). (Hong et al, 2011)

8.37 There is some evidence that alcohol intake is also associated with the development of AMD. In their systematic review Chong and Colleagues (2008) report heavy drinking (3 or more standard drinks per day) is associated with developing early AMD. Despite a large sample size the data did not permit the relationship between moderate drinking and AMD to be explored (Chong et al., 2008). The association between heavy drinking and late AMD was less strong but in three out of the four studies reviewed the association was positive. The authors suggest that heavy alcohol intake may reduce the levels of antioxidants which may promote the development of AMD.

8.38 An interesting association has been observed between the progression of AMD and cataract surgery. A number of studies suggest the successful treatment of cataracts can increase the risk of developing

AMD (Bockelbrink et al., 2008). While cataract surgery is now seen as routine practice, treatments for AMD are often more lengthy, requiring multiple treatments and follow ups. This association may underscore the importance of preventative strategies for AMD to ensure the gains made by cataract surgery uptake are not lost to increased prevalence of AMD.

Glaucoma

Background

8.39 Glaucoma is a term that describes a group of eye conditions that affect vision. Glaucoma often affects both eyes, usually in varying degrees. One eye may develop glaucoma quicker than the other. Incidences of glaucoma increase with age and mainly affect the over 50s.

8.40 If left untreated, glaucoma can cause blindness. About 10% of all UK blindness registrations are due to glaucoma. If it is diagnosed and treated early enough, further damage to vision can be prevented

Pathology

8.41 Glaucoma occurs when the drainage tubes within the eye become slightly blocked. This prevents eye fluid (aqueous humour) from draining properly.

8.42 When the fluid cannot drain properly, pressure builds up. This is called intraocular pressure (IOP). This can damage the optic nerve, which connects the eye to the brain, and the nerve fibres from the retina (the light-sensitive nerve tissue that lines the back of the eye).

8.43 There are two main types of glaucoma:

- primary open angle glaucoma (POAG): this is by far the most common type of glaucoma and develops very slowly
- primary closed angle glaucoma (PCAG): this is rare and can occur slowly (chronic) or may develop rapidly (acute) with a sudden, painful build-up of pressure in the eye

8.44 POAG is usually asymptomatic until advanced and many people will be unaware there is a problem with their eyes until severe visual damage has occurred. Ocular hypertension (a higher-than-normal internal pressure in the eye) is a major risk factor for developing POAG, although POAG can occur with or without raised eye pressure. Approximately 10% of UK blindness registrations are attributed to glaucoma.

8.45 There are over a million glaucoma-related out-patient visits in the hospital eye service annually.

Epidemiology

8.46 In England, about 480,000 people have chronic open-angle glaucoma. Among white Europeans, about 1 in 50 people above 40 years old and 1 in 10 people above 75 years old has POAG. It may be more common among people of black-African or black-Caribbean origins.

8.47 The other types of glaucoma are much less common. Among white people, acute PCAG may affect about 1 in 1,000 people. It is more common among people of Asian origin, affecting approximately 1 in 100.

8.48 The prevalence may be higher in people who have a family history of glaucoma. People who are diabetic or very short- sighted are also more prone to glaucoma. With changes in population demographics the number of individuals affected is expected to rise.

8.49 Local estimates of incidence and prevalence will vary significantly depending on the age profile of the population. The following tables and charts provide estimates for Somerset. Note that the terms borderline and suspects are interchangeable.

Table 7: Number and proportion of patients recorded in Somerset General Practices (2012)

Search Code	Description	Number	%
F45	Glaucoma	4,821	43
F450	Borderline glaucoma (mostly OHT)	3,964	36
F451	Open-angle glaucoma	1,755	16
F452	Primary angle-closure glaucoma	279	3
F453	Steroid-induced glaucoma	4	0
F454	Glaucoma due to disease EC	9	0
F455	Glaucoma associated with disorders of the lens	48	0
F456	Glaucoma associated with other ocular disorders	71	1
F45y	Other specified forms of glaucoma	70	1
F45z	Glaucoma NOS	71	1
P3200	Congenital glaucoma	21	0
	Total	**11,113**	**100**

Chart 2:Proportion of patients recorded in Somerset General Practices with glaucoma (2012)

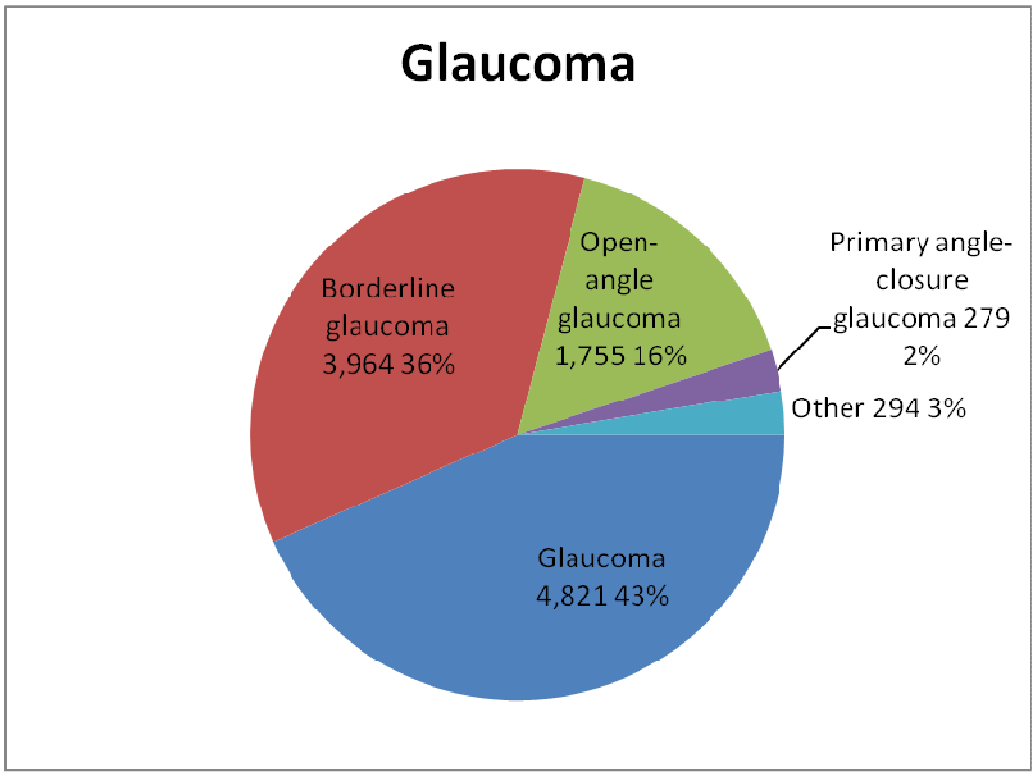


Table 8: Estimates numbers of glaucoma cases in 2012 using the ONS 2010-based RESIDENT population projection for 2012

	Mean	Upper CI	Lower CI	Suspects Under 60	Suspects 60+	Total Suspects	OHT
Mendip	1,095	1,539	666	2,175	2,135	4,310	2,368
Sedgemoor	1,203	1,707	737	2,210	2,338	4,548	2,483
South Somerset	1,738	2,470	1,071	3,005	3,444	6,449	3,498
Taunton Deane	1,167	1,652	719	2,120	2,170	4,290	2,349
West Somerset	498	710	312	585	1,015	1,600	838
SOMERSET PCT*	**5,708**	8,073	3,511	**10,094**	**11,103**	**21,198**	**11,536**

Source: National Eye Health Epidemiological Model

8.50 The actual numbers from practice data are somewhat higher than those predicted by the model, but within the confidence intervals. The number of suspects predicted by the model is five times higher than the borderline cases shown in practice data, suggesting that there are approximately 17,000 people with early signs of glaucoma that has not yet been recognised.

Table 9: Current and projected numbers of patients with glaucoma in Somerset

Condition	MIQUEST – Somerset Registered population with condition	Estimated number in Somerset resident population – using ONS 2010-based population projections and MIQUEST 2012 rates			Estimated percentage increase over 2012 number		
	2012	2012	2017	2022	2012	2017	2022
Glaucoma Prevalence	11,113	11,197	12,433	13,848	0	11	24
Glaucoma Incidence in the last year	814	817	899	984	0	10	20
Prevalence of Risk of Glaucoma	3,919	3,837	3,958	4,088	0	3	7

8.51 Glaucoma prevalence is predicted to rise by 11% over the next five years in Somerset, some 1200+ people, and by a further 1400+ in the following five years.

Detection and Treatment

8.52 Glaucoma can take a long time to develop before a person realises that there is a problem with their eyesight. This is because glaucoma usually damages the outer edge of the eye and works slowly inwards. The individual may not notice a problem until the glaucoma is near the centre of the eye. It is therefore very important to have regular sight tests so that any problems can be detected and treated as early as possible.

8.53 An eye test at least every two years is recommended. An optometrist may recommend more frequent tests, for example, if a patient has a close blood relative with glaucoma, such as a parent, brother or sister. There are several glaucoma tests that an optometrist can perform. If he suspects glaucoma then the patient will be referred to an ophthalmologist for further tests. There are over a million glaucoma-related out-patient visits annually in the hospital eye service nationally.

8.54 Once diagnosed, people with POAG need treatment and lifelong monitoring so that any progression of visual damage can be detected. Once lost, sight cannot be restored, and controlling the condition, together with prevention, or at least minimisation of ongoing damage, is crucial to maintaining a sighted lifetime.

8.55 The National Institute for Health and Clinical Excellence has issued clinical guidelines on the diagnosis and management of primary open angle glaucoma and ocular hypertension. This guidance covers testing, treatment, monitoring and information for patients. NICE has

also issued a commissioning guide and quality standards to assist with implementation of this guidance.

Risk factors

8.56 There is strong and consistent evidence of a significant association between four risk factors and most types of glaucoma (Worley and Grimmer-Somers, 2011)

- Elevated intraocular pressure (IOP)
- Advancing age
- Non-Caucasian ethnicity
- Family history of glaucoma

Elevated IOP

8.57 High IOP is a significant risk factor for all forms of glaucoma, with 21mmHg commonly cited as the upper limit for normal IOP. Each 1mmHg increase in IOP is associated with a 10% increased risk of progression from ocular hypertension to glaucoma and in progressive glaucomatous damage.

Age

8.58 Advancing age is a significant risk factor for the development of POAG, so POAG is much more common in older age groups.

Ethnicity

8.59 The prevalence of POAG is approximately a threefold increase in populations of African descent compared to white populations. Similarly the prevalence of PCAG is raised threefold in Asian populations.

Family history

8.60 In close relatives of individuals with POAG, the prevalence of the disease is 3-6 times that of the general population, with the strongest association being between siblings. There is a 22% lifetime risk of glaucoma found in close relatives of patients with glaucoma, almost 10 times that of controls.

Other risk factors

Socio-economic status

8.61 Of those with glaucoma in the United Kingdom, it is estimated that only one-third are currently detected. It has been shown that deprivation at both area and individual level is a risk factor for late presentation and resultant blindness from glaucoma. Glaucoma thus forms both a cause and a consequence of health inequalities in the United Kingdom. (Day et al, 2010)

8.62 There are several other risk factors which have been suggested where the evidence is less strong or equivocal. Of these, myopia, eye injury, diabetes and long term use of corticosteroids present low to moderate risk for developing glaucoma. On their own these risk factors are relatively insignificant compared to the major risk factors outlined above.

Low Vision

Background

8.63 Low vision is an impairment of visual function where full remediation is not possible by conventional spectacles, contact lenses or medical intervention, which causes restriction in that person's everyday life but which can often be improved with low vision aids and adaptations. The majority of patients suffering from low vision tend to be elderly. Patients suffering low vision are offered the option of registering as visually impaired. Although registering offers a number of benefits it is estimated that at least 50% of patients eligible to register have not done so, either as a result of not wishing to be registered or as a result of not being identified as sight impaired.

8.64 Three quarters of those registered sight impaired and severely sight impaired are aged over 70. Most people with low vision retain some sight – 95% are able to see light through a window; 75% are able to read newspaper headlines. Their vision can be maximised to enable them to live as independently as possible if appropriate low vision services are in place. Low vision is increasingly more prevalent due to an aging population. In England, there are approximately 306,500 people who are registered blind or partially sighted (ONS 2000). However there are estimated to be at least the same number of people eligible to be on the register who are not currently registered due to various reasons. It is estimated the number of people in England with vision poor enough to cause them problems with doing everyday tasks is about one million.

8.65 There is a strong association between low vision and impaired quality of life, which may express itself as depression. There is also a correlation between falls and low vision. The care of people with low vision should

include accurate clinical assessment of the cause of low vision (to ensure that any treatable aspects of the visual problem are treated adequately), appropriate optical correction, the prescription of optical aids such as magnifiers or additional illumination where appropriate, social and psychological support as necessary.

8.66 Patients not registered are mainly elderly patients, aged 80 and over who are in care, and patients with multiple disabilities. In addition a further third can be added to these numbers for people with low vision who are not eligible to register.

8.67 Somerset County Council commissioned a comprehensive review of services for sensory loss, including vision, in 2010. This report estimated that there are 19,622 people in the county with sight loss.

Epidemiology

8.68 Local estimates of incidence and prevalence will vary significantly depending on the age profile of the population. The following tables and charts provide data and estimates for Somerset.

Table 10: Estimated numbers in 2012 using the ONS 2010-based RESIDENT population projection for 2012 and, for Somerset only, the REGISTERED population in April 2012

	Low Vision		
	Impaired Vision Binocular vision <6/18	Low Vision Binocular vision <6/18-3/60	Severe Sight Impairment Binocular vision <3/60
Mendip	1,897	1,613	283
Sedgemoor	2,065	1,759	306
South Somerset	3,060	2,609	458
Taunton Deane	2,029	1,725	304
West Somerset	945	800	143
SOMERSET PCT*	9,998	8,504	1,494
Somerset	**9,846**	**8,375**	**1,471**

Source: Based on National Eye Health Epidemiological Model

8.69 According to GP records about 2000 people in the county are blind or have low vision, a similar number also recorded as being on the CVI register. However, these numbers are much lower than the official CVI register, which has 1410 people registered blind, and a further 1830 registered partially sighted (2011).

Table 11: Future estimated prevalence of visual impairment

	2011	2012	2013	2014	2015	2020	2025	2030	Increase between 2011 and 2015	Increase per year between 2011 and 2015	Increase between 2011 and 2030	Increase per year between 2011 and 2030
Somerset: People aged 18-24 predicted to have a serious visual impairment	24	24	24	23	23	21	21	23	-4%	-1.1%	-4%	-0.2%
Somerset: People aged 25-34 predicted to have a serious visual impairment	33	33	34	35	35	37	36	34	6%	1.5%	3%	0.2%
Somerset: People aged 35-44 predicted to have a serious visual impairment	44	43	41	40	40	39	43	45	-9%	-2.4%	2%	0.1%
Somerset: People aged 45-54 predicted to have a serious visual impairment	50	51	52	53	53	50	44	44	6%	1.5%	-12%	-0.7%
Somerset: People aged 55-64 predicted to have a serious visual impairment	49	48	47	47	48	53	57	54	-2%	-0.5%	10%	0.5%
Somerset: People aged 18-64 predicted to have a serious visual impairment	**200**	**199**	**198**	**198**	**199**	**200**	**201**	**200**	**-1%**	**-0.1%**	**0%**	**0.0%**
Somerset: People aged 65-74 predicted to have a moderate or severe visual impairment	3,354	3,556	3,735	3,870	3,970	4,217	4,161	4,642	18%	4.3%	38%	1.7%
Somerset: People aged 75 and over predicted to have a moderate or severe visual impairment	6,969	7,142	7,316	7,490	7,700	9,052	11,210	12,648	10%	2.5%	81%	3.2%
Somerset: People aged 65 and over predicted to have a moderate or serious visual impairment	**10,323**	**10,698**	**11,051**	**11,360**	**11,670**	**13,269**	**15,371**	**17,290**	**13%**	**3.1%**	**67%**	**2.8%**
Somerset: People aged 75 and over predicted to have registrable eye conditions	3,597	3,686	3,776	3,866	3,974	4,672	5,786	6,528	10%	2.5%	81%	3.2%

Based on POPPI and PANSI modelling

Table 12: Blind on register 2011

	Total	0 to 4	5 to 17	18 to 49	50 to 64	65 to 74	75 or over	Unknown age
Somerset	1,410	5	25	125	135	105	1,015	0

Table 13: Partially sighted on register 2011

	Total	0 to 4	5 to 17	18 to 49	50 to 64	65 to 74	75 or over	Unknown age
Somerset	1,830	5	40	125	135	155	1,370	0

Table 14: Blind new cases registered during 2010/11

	Total	0 to 4	5 to 17	18 to 49	50 to 64	65 to 74	75 or over	Unknown age
Somerset	120	0	0	10	10	10	90	0

Table 15: Partially sighted new cases registered during 2010/11

	Total	0 to 4	5 to 17	18 to 49	50 to 64	65 to 74	75 or over	Unknown age
Somerset	210	0	5	10	15	15	160	0

Table 16: Blind on register with an additional disability 2011

	Total	Mental health problems	Learning disability	Physical disability	Deaf with speech	Deaf without speech	Hard of hearing
Somerset	235	10	40	70	5	5	105

Table 17: Partially sighted on register with an additional disability 2011

	Total	Mental health problems	Learning disability	Physical disability	Deaf with speech	Deaf without speech	Hard of hearing
Somerset	310	10	25	130	5	5	135

Table 18: Blind on register, with additional disability by age 2011

	All ages	0 to 4	5 to 17	18 to 64	65 or over
Somerset	235	0	5	60	170

Table 19: Partially sighted on register, with additional disability by age 2011

	All ages	0 to 4	5 to 17	18 to 64	65 or over
Somerset	310	0	15	45	250

From NHS Information Centre as at 21 May 2012
www.ic.nhs.uk/pubs/blindpartiallysighted11

8.70 NHS Information Centre data suggests a large fall, between 2008 and 2011, in the number of people on the register with additional disabilities. Local data does not reflect this and further work would be required to understand the difference in the data.

Diabetic Retinopathy

Background

8.71 As noted in paragraph 2.3, eye care services in relation to diabetic retinopathy are reviewed separately and this EHNA includes a summary of key elements of the 2012 review document[36], rather than a full assessment of need. The report presents information about the Somerset Diabetic Eye Screening Service offered to residents registered with a General Practitioner across the Somerset Primary Care Trust area (excluding East Mendip currently covered by the Bristol Community Health programme) for the period 2011/2012.

8.72 Diabetic retinopathy is a complication of diabetes affecting blood vessels of the retina, leading to major haemorrhage and retinal detachment if untreated and significant sight loss. It is the biggest single cause of blindness and visual impairment amongst working age people in the country.

8.73 Diabetic retinopathy begins without any noticeable changes in vision although there are often extensive changes in the retina visible to a ophthalmologist, or optometrist. Screening has the potential to improve quality of life through early diagnosis and treatment while laser therapy can prevent the progression of the disease and save sight for many years in most patients. Screening is therefore offered, at least annually, to patients who have either type 1 or type 2 diabetes, to detect this sight threatening condition before symptoms appear.

8.74 Having a Diabetic Retinopathy Screening Programme in place locally is a government and Department of Health requirement, for all people with diabetes, aged 12 and over, eligible for diabetic eye screening using digital photography

The Local Eligible Population and Service

8.75 The Somerset Diabetic Retinopathy Screening service screens an eligible population of over 19,600 patients per year. This represents an increase of 6.1% over the previous year's eligible screening population which may be due to the significant increase in registrations of new patients aged between 65 to 74 (nearly 3,000 people versus 1,300 for the previous year) as well as notable

[36] Somerset Diabetic Screening Service Annual Report 2011/2012

increased registrations in people aged 75 to 84 as well as those aged 85 plus.

8.76 As set out previously in Table 1, prevalence is expected to rise by approximately 14% by 2017 and 34% by 2022.

Diabetic Macular Oedema

8.77 NICE has recently issued treatment guidance on the use of ranibizumab in patients with Diabetic Macular Oedema (DMO). There are approximately 450 patients with visual impairment due to DMO in Somerset, with a further 56 new cases each year. Of these new cases, 15 patients are amenable to this new treatment, with 5 requiring treatment on both eyes. NICE estimates a 75% take up of the treatment. The estimated cost of this new treatment is £193,000 per annum for Somerset. However, of the 450 existing cases, some 117 are eligible for this treatment (41 in both eyes), to be applied over the next 3 years.

Table 20: Estimated costs over the next 4 years, assuming a 75% uptake of the treatment

Costs-over-time profile	Year 1	Year 2	Year 3	Year 4 onwards
Recurrent costs (incident population)	£193,110	£193,110	£193,110	£193,110
Non-recurrent costs (prevalent population)	£857,599	£502,655	£372,582	£0
	£1,050,709	**£695,765**	**£565,691**	**£193,110**

Reference: http://guidance.nice.org.uk/TA274

Cataract

8.78 As noted in paragraph 2.3, cataract eye care services have been reviewed separately and this EHNA includes a summary, rather that a full assessment of need for cataract services.

8.79 Cataracts are a commom problem, and as with AMD, age is a major risk factor. Worldwide, cataract problems are the leading cause of visual impairment.[37]

8.80 Cataracts are cloudy formations which occur in the lens of the eye. They develop slowly and are painless but vision becomes blurred or dim, because light cannot pass through the clouded lens. If left untreated cataracts can result in sight loss.

[37] World Health Organisation 2005 cited in Public Health Action Support team (PHAST) 2009 Eyecare in the UK: Epidemiology, Intervention and Ethnicity.

8.81 Given current understanding of the condition, cataract prevention is not an option. Identifying the most clinically and cost effective surgical technique, together with improving access and uptake appear the most realistic therapeutic options currently.

8.82 Treatment options include surgical intervention to remove the affected lens and replace with a substitute lens. The cost/benefit of this procedure is described as one of the most effective interventions in healthcare (Riaz et al., 2006).

8.83 As set out previously in Table 1, prevalence is expected to rise by 15% by 2017 and 35% by 2022.

8.84 Cataract services were reviewed in 2011 by the Ophthalmic Pathways Development Group following publication of The NHS Atlas of Variation in Healthcare[38]; the group included clinical representation at consultant ophthalmologist level.

8.85 Subsequently, agreed referral criteria for surgery have been introduced, which combine objective criteria, with the application of clinical judgement, considering the effect of the cataracts on the individual's life.

8.86 An audit of referrals has been performed since the application of these criteria, which demonstrated that the criteria were being met and appropriate judgement was being consistently applied by referrers into Somerset's largest Foundation Trust, in the majority of cases.

Stakeholder Feedback

8.87 In addition to recommendations on the Vision for improving the eye health of people in Somerset, stakeholders identified a number of issues. A summary of the feedback is included at Appendix 1 and 2 with key issues outlined below.

Fair and equitable access:

- and a lack of understanding of the specific needs of people with learning disabilities among health care professionals
- and the need for a focus on all 'at-risk' groups
- for those living in deprived and rural locations
- to public premises generally including those providing eye care, where the physical environment is challenging

[38] Right Care: The NHS Atlas of Variation in Healthcare – Reducing unwanted variation to increase value and improve quality (2010)

Public education:

- on the causes of eye conditions, particularly the effect of smoking and obesity, with a focus on 'at-risk' groups
- on the benefits of having regular sight tests to enable early detection of disease, not only eye disease but other conditions, for example diabetes and brain tumours; tests are not only identifying sight problems which can be addressed by wearing spectacles
- on available services, including the Acute Community Eyecare Service, with just 35% (23/66) of people responding to the opinion gathering exercise reporting an awareness of the service

Public expectation of providers performing NHS sight tests

- professional well trained staff who share experience and expertise with colleagues
- personal service to meet individual needs against minimum standard sight examination component tests
- clear communication in relation to diagnosis, clinical signposting and referral

Improvement to optometric services in Somerset

- by fair reimbursement for the provision of General Ophthalmic Services
- by further integrated working between primary and secondary care, social services and low vision services

8.88 Further feedback informs section 10, Developing and Maintaining an Effective Workforce.

9 CURRENT SERVICE PROVISION AND ACTIVITY

9.1 This section provides an overview of eye health services available to, and used by, Somerset residents.

Primary Care General Ophthalmic Services – NHS Sight Tests

Overview

9.2 NHS provision of primary eye care in England is known as General Ophthalmic Services (GOS). This service, the provision of NHS sight examinations, aims to provide, preventative and corrective eyecare for

children, people aged 60 years and over, people on low incomes and those suffering from or predisposed to eye disease.

9.3 NHS sight testing is provided under the General Ophthalmic Services Regulations and contract of 2008. The sight test has two purposes:

- to provide a prescription for spectacles or contact lenses to correct sight and defective vision and
- to check the internal and external health of the eye.

Service Provision and Challenges

9.4 This demand led service is mainly delivered by optometrists although can also be provided by Ophthalmic Medical Practitioners. It should be noted that provision of contracts is not needs led, but is subject to providers (whether professionally qualified or lay) meeting certain criteria, regarding premises, equipment and good character.

9.5 The vast majority of work is undertaken in community practices under Mandatory Services Contracts, with a much smaller proportion of work carried out in patients' own homes, care homes and day centres, under Additional Services Contracts.

Table 21: Type and number of NHS Sight Tests undertaken January to December 2012

Type of NHS Sight Test Provision	Number	%
High Street Practice (Mandatory Services)	136478	97
Domiciliary (Additional Services)	4630	3

9.6 Contracts are currently held with Primary Care Trusts and will transfer to the NHS Commissioning Board from 1 April 2013. As at 31 March 2013, 56 practices provide Mandatory Services in Somerset and 9 contractors provide Additional Services. 7 contractors provide both Mandatory and Additional Services (Appendix 6).

9.7 The number of NHS funded sight tests undertaken within Somerset is based on the number of claims received for payment from providers based within the geographical area covered by NHS Somerset. Consequently, this number will include non-Somerset GP registered patients who are living outside Somerset but have accessed a sight test with an NHS Somerset based provider. Conversely, any figure will exclude Somerset GP registered patients accessing sight tests outside of Somerset.

9.8 As noted in paragraph 3.4, the NHS sight test information captured by the Open Exeter payments system, does not easily lend itself to analysis. The ability to analyse NHS sight test utilisation patterns is essential in understanding health equity issues.

Enhanced Services - Acute Community Eyecare Service

9.9 The Acute Community Eyecare Service (ACES) has been successfully operating since July 2009 and provides patients experiencing recently occurring medical eye conditions, with appropriate treatment closer to home.

9.10 The service is provided by local optometrists accredited to undertake this work at a locally approved high street optometric practice.

9.11 The service manages many acute conditions within primary care, such as red eye unresponsive to treatment, the removal of foreign bodies and investigations into flashes and floaters. ACES supports GP's who typically have limited equipment and expertise to differentially diagnose between acute eye conditions.

9.12 The service manages approximately 6,000 patient episodes per annum and is currently provided at 33 optometric practices across the county (Appendix 7).

9.13 The service routinely manages the majority of referred patients within primary care with approximately 30% requiring onward referral to hospital eye services.

Enhanced Services - Intra-Ocular Pressure Referral Refinement Service

9.14 The Intra-Ocular Pressure Referral Refinement Service (IOPRRS) was introduced in May 2010, in response to NICE Guidance CG85: "Glaucoma: diagnosis and management of chronic open angle glaucoma and ocular hypertension, which recommended all patients with an Intra-Ocular pressure above 21mmHg should be reviewed by an ophthalmologist.

9.15 The Guidance led to a significant increase of referrals into the hospital eye service. The introduction of the IOPRRS reduced the number of false-positive referrals, by measuring intra-ocular pressures using the more accurate Goldmann Applanation Tonometry technique.

9.16 The service is provided by local optometrists accredited to undertake this work at a locally approved high street optometric practice.

Service Provision

9.17 The service continues to manage approximately 1,000 patient episodes per annum and is currently provided by 38 high street optometric practices across Somerset (Appendix 7).

9.18 Since implementation, the service has discharged an average of 72% of patients, significantly reducing the level of referrals into the hospital eye service, from that seen during 2009/10.

Enhanced Services - Ocular Hypertension Monitoring Service

9.19 This enhanced service was launched during March 2013. It enables patients with ocular hypertension, a condition that increases the risk of developing glaucoma and requires close monitoring, to be monitored closer to their home by community optometrists rather than attending hospital clinics.

9.20 It is estimated that 5-8% of the population experience ocular hypertension. With each of these patients needing regular monitoring by the hospital eye service to ensure glaucoma does not develop, it is estimated that approximately 5,000 patient appointments per annum are used for this purpose. By moving monitoring to primary care practitioners, monitoring can be performed more conveniently for patients whilst enabling greater outpatient capacity for the hospital eye service.

9.21 The service is provided by local optometrists accredited to undertake this work at a locally approved high street optometric practice.

9.22 At at 31 March 2013, 38 accredited optometrists will monitor patients with ocular hypertension, within 23 practices across the county (Appendix 7).

Low Vision Services

9.23 Low vision services in Somerset are separately commissioned by Somerset PCT and the Local Authority, as set out in paragraph 9.27. The services aim to provide a seamless service to people with a visual impairment, linking ophthalmology out-patients, GP Services, optometric practices and rehabilitation services.

9.24 The Low Vision Service commissioned by Somerset PCT, provides a range of services for people with low vision, to enable them to make best use of their residual vision in order to maintain their choice of independent living. Patients receive an initial assessment at which they are given information, advice, provision of appropriate optical low vision aids and training and referral or signposting to other statutory or voluntary organisations as appropriate. Reviews are undertaken as appropriate, to reinforce, monitor and reassess the appropriateness of the equipment and any further training requirements.

9.25 The service is provided at multiple locations across the county and during the period 1 January to 31 December 2012, 579 patients were newly referred into the service and received a total of 1144 visual aids.

9.26 The monitoring and improvement of Low Vision services in Somerset is supported by Somerset Low Vision Committee, part of a national network of Low Vision Committees. It is a multi-agency group, consisting of service users and representatives from NHS Somerset, ophthalmology departments in secondary care, Adult Social Care, Somerset Sight, Education Services and the low vision service provider. The committee aims to improve low vision services in Somerset, by ensuring they comply with national guidance and by identifying pathway improvements. The group works to influence local policy and service development by establishing links with relevant commissioning and provider bodies.

Local Authority Adult Social Care

9.27 Teams of specialist social care staff based around the county, provide support to people with sensory impairments, including sight loss. The teams work with anyone who has a sight loss, regardless of severity, and referrals are accepted from any source, via Somerset Direct. Services provided include:

- assessment of needs relating to sight, hearing loss, or dual sensory loss
- provision of specialist equipment
- rehabilitation for people with sight loss, including one-to-one training in mobility, independent living skills and communication skills such as Braille
- provision of advice and information on a range of specialist organisations and services
- referral to specialist services
- referral to home care and other forms of generic social care support
- liaison with other agencies, e.g. housing, Department of Work and Pensions, voluntary sector organisations
- advice and signposting on employment issues
- registration of people with sight loss
- long term care management of people with complex needs

General Practice Services

9.28 GP practices provide a non-specialist eye-care service as part of the General Medical Services and Personal Medical Services contractual arrangements.

9.29 Irnham Lodge Surgery, Minehead, currently provides eye clinics at Minehead Community Hospital, under Local Enhanced Service arrangements.

9.30 Activity data is not currently available but will be sought as part of an overall review of the service by SCCG in 2013/14.

Community Pharmacy Service

9.31 As at 31 March 2013, 57 community pharmacies provide the Enhanced Minor Ailments Service, which includes the treatment of red-eye using chloramphenicol, against a Patient Group Directive (PGD). This represents 51% of Somerset pharmacies.

Childhood Vision Screening

9.32 A single one off childhood vision screen is offered to all children aged four to five years living in Somerset. The screen is overseen by orthoptists and takes place in a school setting. Children who do not pass the initial screen are referred to the orthoptic service within secondary care for diagnostic tests (fast track). They may then be referred to an opthalmlogy consultant if indicated.

9.33 A target of 90% acceptance was set for 2010/11. The uptake has been pleasing, as reported in the following table. Data identifying those who declined, rather than were absent, will be available next year but is estimated to be 3%.

Table 22: School age entry programme 2010/11

	Cohort	Examined	% Examined	FastTrack	% FastTrack	% All Referrals
Taunton	3101	2793	90.1%	334	12.0%	13.2%
Yeovil	1566	1343	85.8%	156	11.6%	14.2%
Mendip	624	598	95.8%	50	8.4%	10.5%
PCT	5291	4734	89.5%	540	11.4%	13.2%

9.34 The screening service for the whole county will continue to be provided by Taunton & Somerset NHS Foundation Trust, under current arrangements, until 31 March 2014.

9.35 However children screened and requiring diagnostics or treatment may be referred to either Taunton & Somerset NHS Foundation Trust, Yeovil District Hospital NHS Foundation Trust or the Royal United Hospital Bath, depending on the child's home location.

9.36 There is currently no effective outcome monitoring mechanism, to support understanding of the number of children screened who are subsequently diagnosed with a sight condition as a result of the screen.

9.37 Even if this data were available, there is currently no benchmark available; the National Screening Committee Child Health Sub-Group Report on Vision Screening (May 2005) on referral criteria states 'there is still debate as to the level of impairment that requires treatment'. Nationally this programme is for review in 2013.

Diabetic Retinal Screening

9.38 The Diabetic Retinal Screening Service (DRSS) was set up in Somerset in response to the Diabetes National Service Framework and available activity from 2010 to 2012 is shown below.

Table 23: Diabetic Retinal Screening Programme Activity

Date	Programme Size	Total Eligible	Eligible - New registrations	Total Inactive	% Total Inactive
31/03/2012	**22,705**	**19,680**	**3,602**	**3,025**	**13%**
31/03/2011	21,605	18,548	2,474	3,057	14%
31/03/2010	20,265	17,410	2,628	2,875	17%

9.39 A total of 54 patients were listed for a first laser treatment following a positive test. Data is not available from secondary care for 2009/10. A number of patients are registered annually as visually inpaired, as a result of diabetic retinopathy.

Table 24: Patients receiving laser treatment

Period	Total Patients	R1 / M1	R2	R3
2011/2012	54	23	20	11

2010/2011	53	18	26	9
2009/2010	N/A	N/A	N/A	N/A

Table 25: New certificates of visual impairment due to diabetic retinopathy

Period	Sight Impaired	Severely Sight Impaired
2011/2012	5	1
2010/2011	8	10
2009/2010	4	0

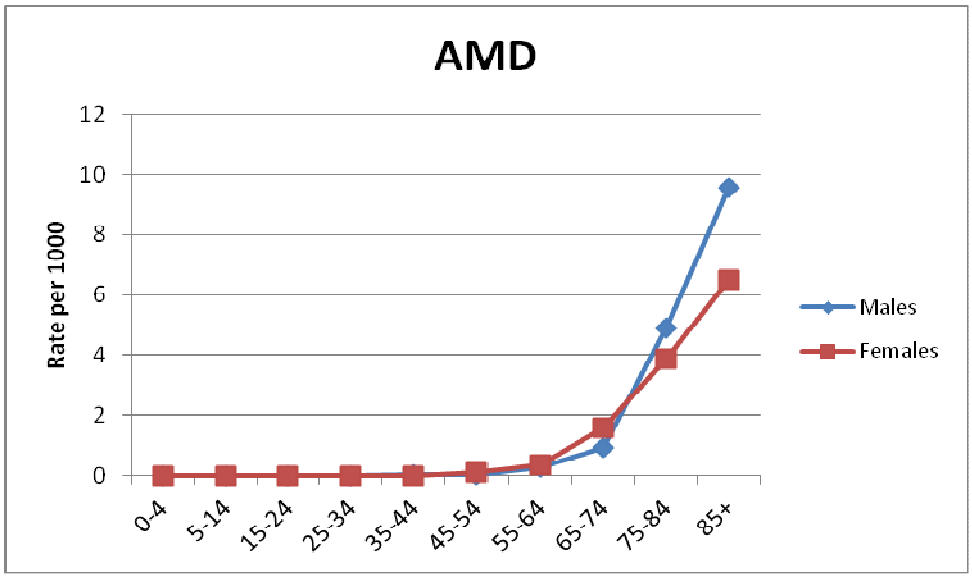
Secondary Care

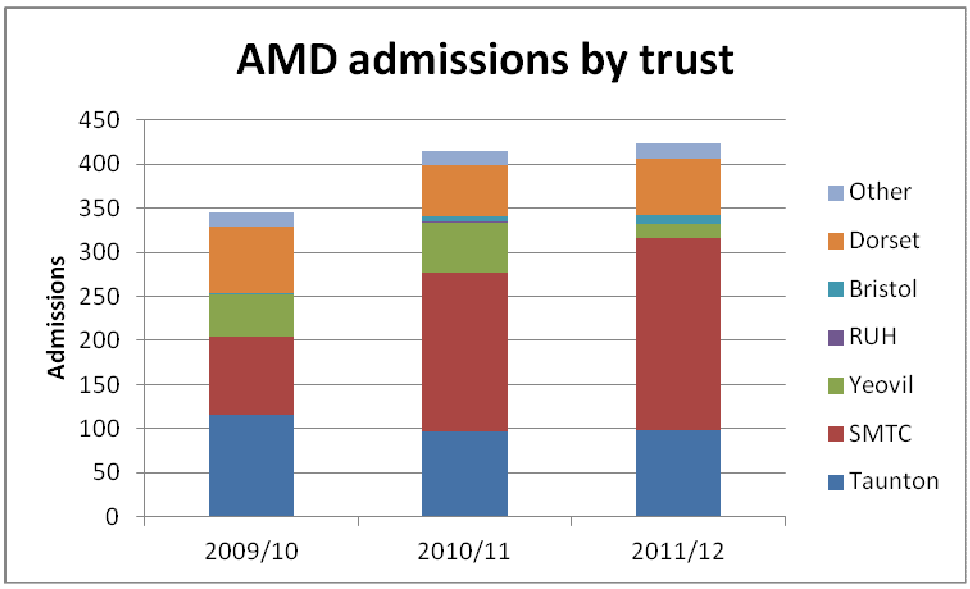
9.40 Approximately 60% of all hospital eye condition admissions are for cataract, although following a recent review this proportion has fallen recently, from 64% to 58%. AMD and Glaucoma account for 5% and 4% respectively, but both are showing a rising trend. The following tables and graphs illustrate how the great bulk of activity is in the elderly population. In contrast to admissions, first outpatient activity has been declining over recent years, although projected to increase in the next decade with population change. Emergency Department attendances are projected to be fairly flat over the next decade, but in the last year increased by about a sixth over the previous year.

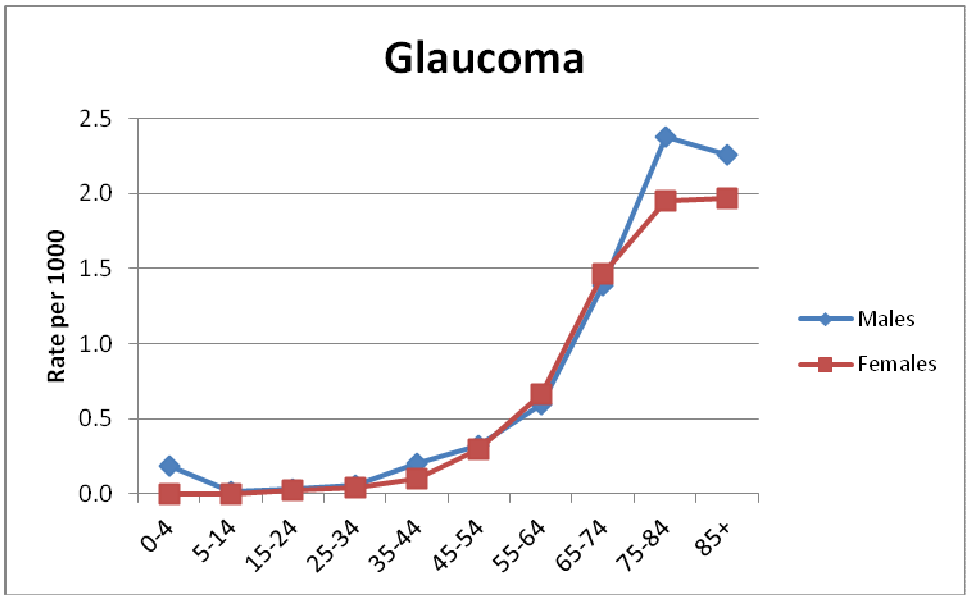
Table 26: Admissions to hospital with either an ICD10 code for Eye conditions and/or Treatment Function Code 130: ophthalmology or Treatment Function Code 216: paediatric ophthalmology

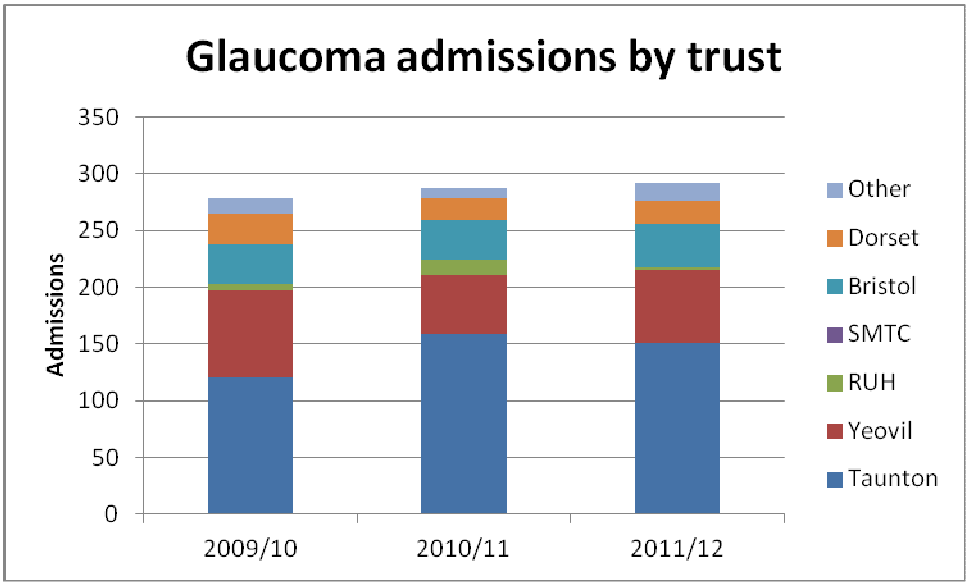
Condition	Admissions					People Admitted*		Admissions (in 3 year period) per person
	2009/10	2010/11	2011/12	Total	% eye admissions	Total	% people admitted for eye conditions	
AMD	345	414	423	1,182	5	667	4	1.8
Benign neoplasm of eye and adnexa	2	6	6	14	0	13	0	1.1
Carcinoma in situ of eye	1	1	1	3	0	3	0	1.0
Cataract	4,905	5,115	4,517	14,537	62	11,017	64	1.3
Diabetes	215	211	249	675	3	487	3	1.4
Glaucoma	278	288	292	858	4	662	4	1.3
Injury	58	60	65	183	1	165	1	1.1
Low vision	55	71	74	200	1	191	1	1.0
Malignant neoplasm of eye and adnexa	12	18	17	47	0	40	0	1.2
Other eye codes	1,517	1,593	1,657	4,767	20	3,858	22	1.2
Other	285	316	274	875	4	794	5	1.1
Total	7,673	8,093	7,575	23,341	100	17,207	100	1.4

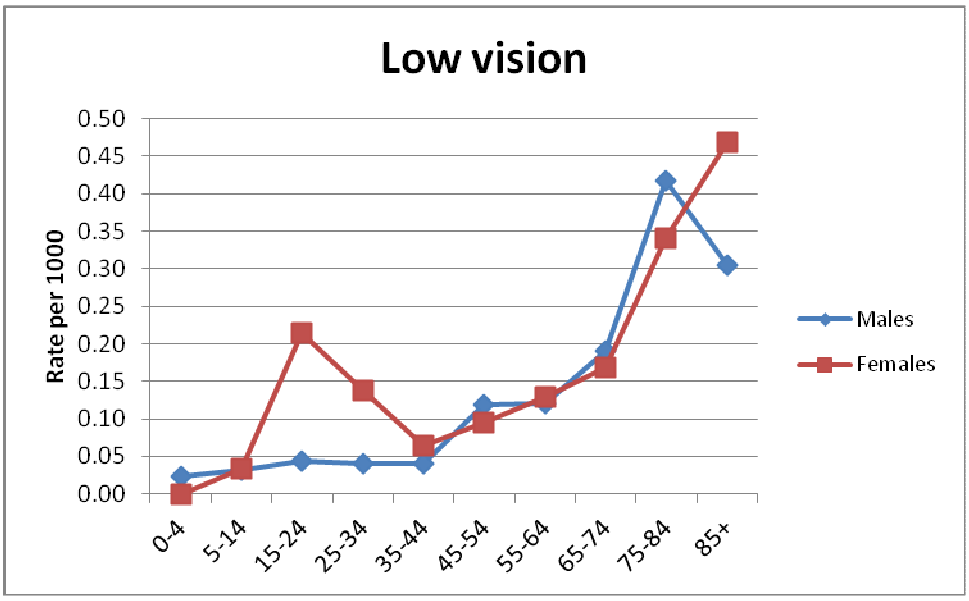
*if people have more than one condition they will appear more than once in the figures above

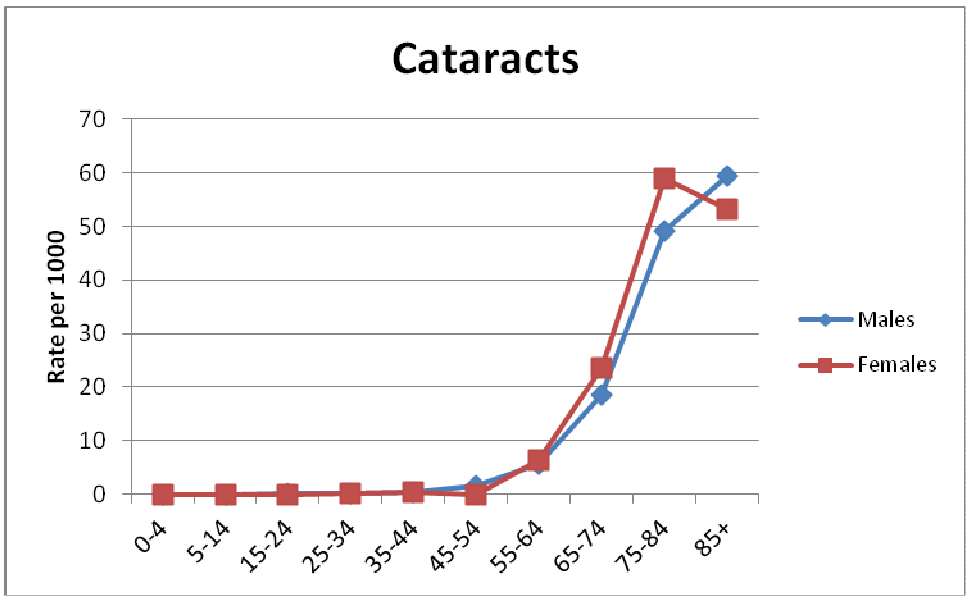

AMD
Rate per 1000
12
10
8
6
4
2
0
0-4
5-14
15-24
25-34
35-44
45-54
55-64
65-74
75-84
85+
Males
Females

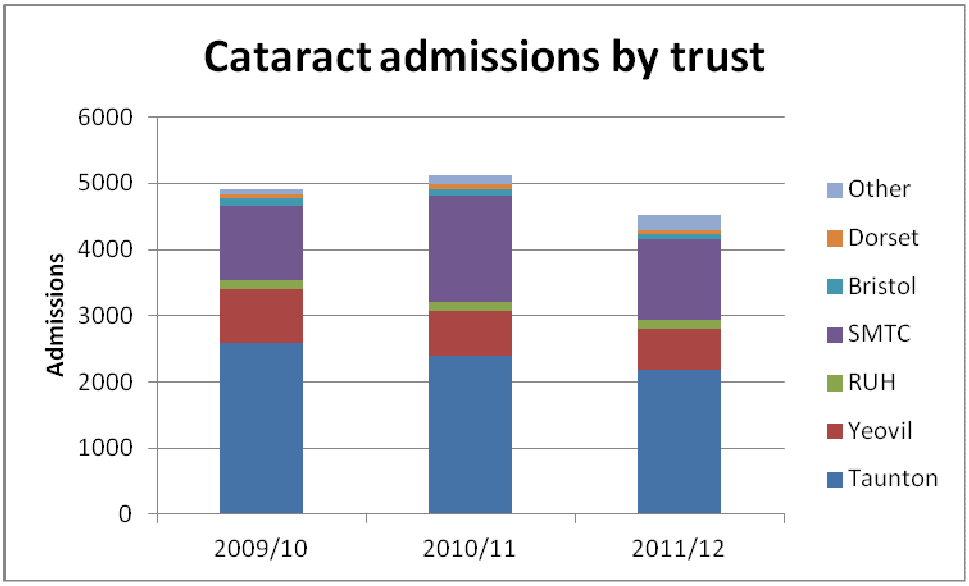

AMD admissions by trust
Admissions
450
400
350
300
250
200
150
100
50
0
2009/10
2010/11
2011/12
Other
Dorset
Bristol
RUH
Yeovil
SMTC
Taunton


Glaucoma
Rate per 1000
2.5
2.0
1.5
1.0
0.5
0.0
0-4
5-14
15-24
25-34
35-44
45-54
55-64
65-74
75-84
85+
Males
Females


Glaucoma admissions by trust
Admissions
350
300
250
200
150
100
50
0
2009/10
2010/11
2011/12
Other
Dorset
Bristol
SMTC
RUH
Yeovil
Taunton


Low vision
Rate per 1000
0.50
0.45
0.40
0.35
0.30
0.25
0.20
0.15
0.10
0.05
0.00
0-4
5-14
15-24
25-34
35-44
45-54
55-64
65-74
75-84
85+
Males
Females


Cataracts
Rate per 1000
70
60
50
40
30
20
10
0
0-4
5-14
15-24
25-34
35-44
45-54
55-64
65-74
75-84
85+
Males
Females



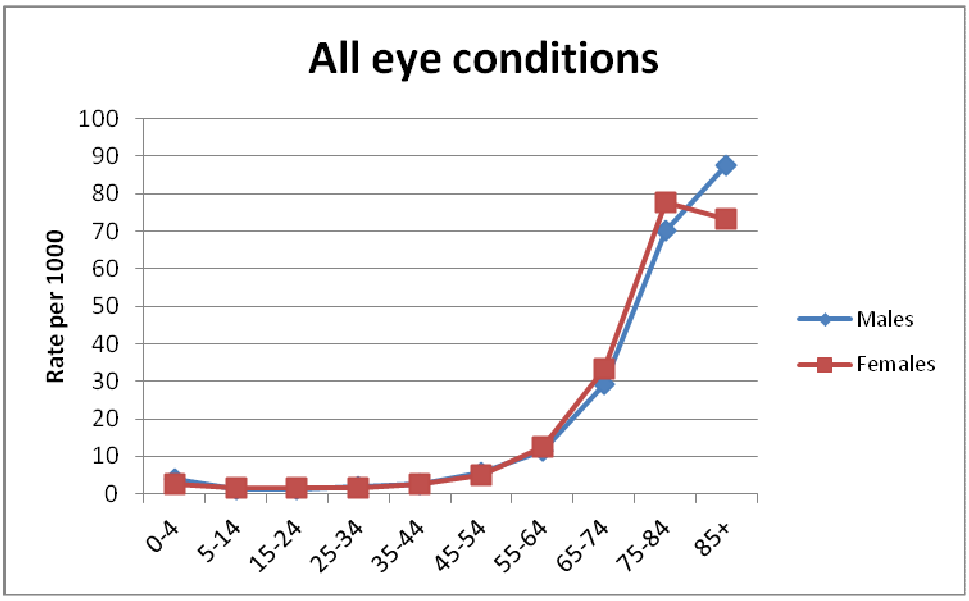
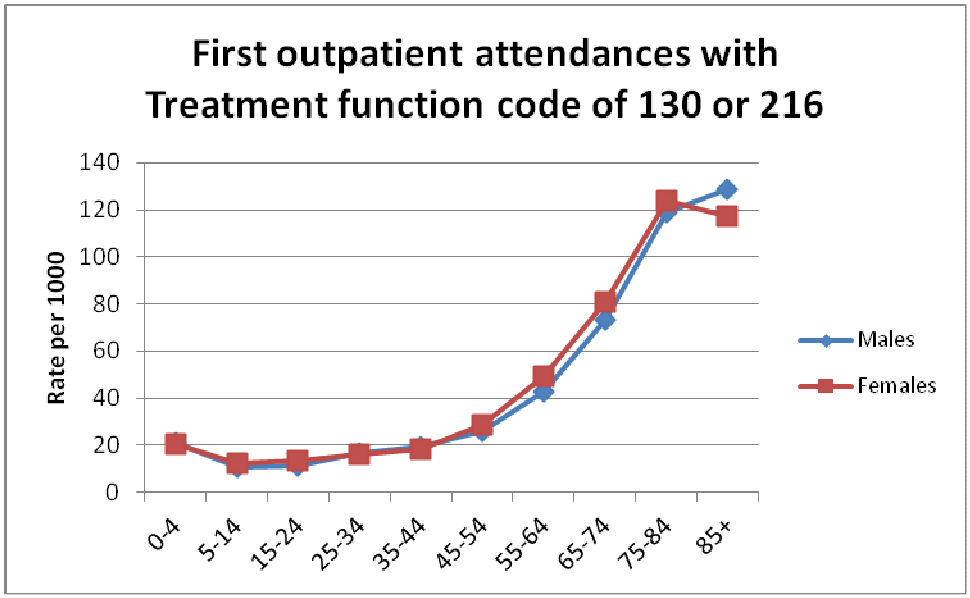
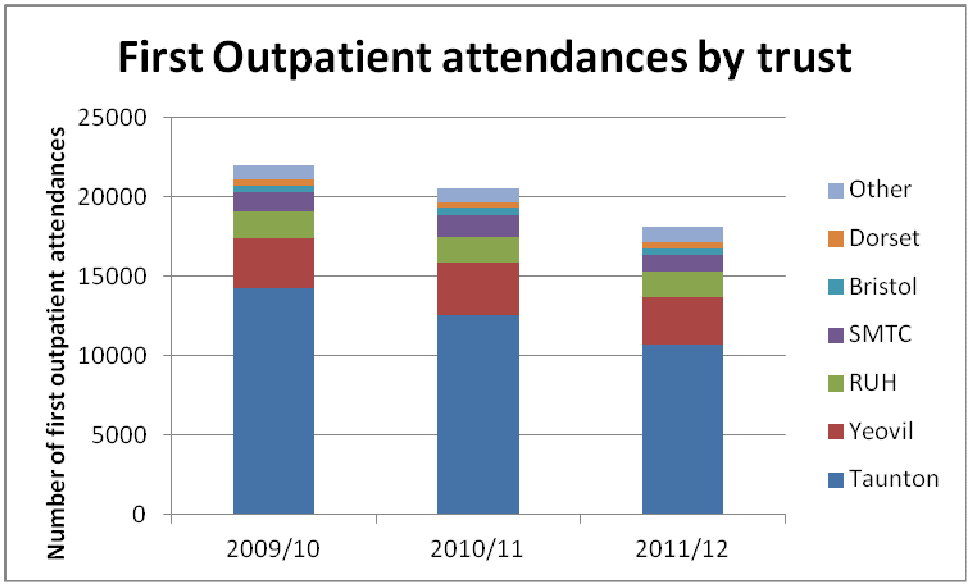


Table 27: First outpatient attendances with Treatment Function Code 130: ophthalmology or Treatment Function Code 216: paediatric ophthalmology

Condition	First outpatient attendances				People with a first outpatient attendance	First outpatient attendances (in 3 year period) per person
	2009/10	2010/11	2011/12	Total	Total	
Total	21,650	21,090	19,473	62,213	48,965	1.3


First outpatient attendances with
Treatment function code of 130 or 216
Rate per 1000
140
120
100
80
60
40
20
0
0-4
5-14
15-24
25-34
35-44
45-54
55-64
65-74
75-84
85+
Males
Females


First Outpatient attendances by trust
Number of first outpatient attendances
25000
20000
15000
10000
5000
0
2009/10
2010/11
2011/12
Other
Dorset
Bristol
SMTC
RUH
Yeovil
Taunton

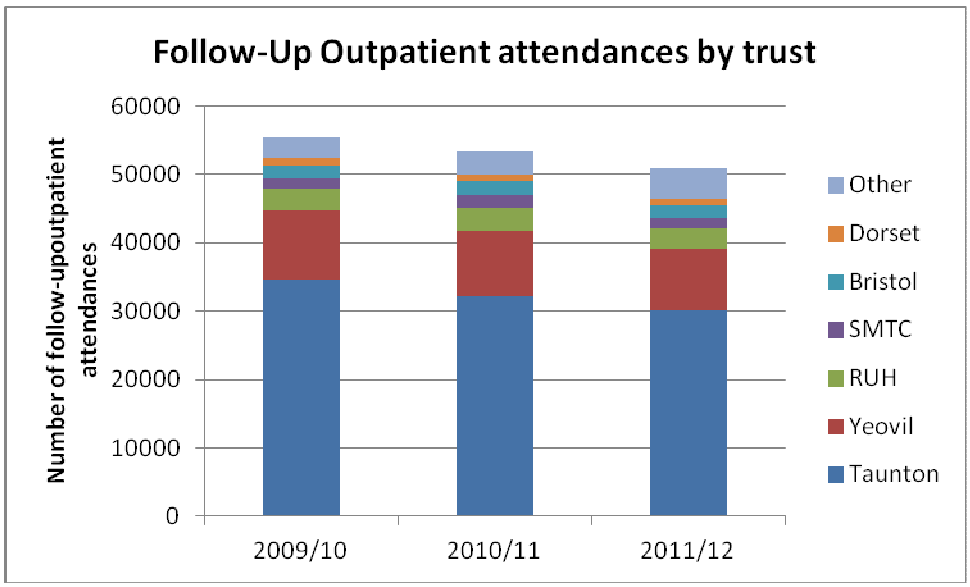

Follow-Up Outpatient attendances by trust
Number of follow-upoutpatient attendances
60000
50000
40000
30000
20000
10000
0
2009/10
2010/11
2011/12
Other
Dorset
Bristol
SMTC
RUH
Yeovil
Taunton

Table 28: Projected number of first outpatient attendances based on rates per year during 2009/10-2011/12 and ONS projected populations

Condition	Projected number of admissions			Increase over 2012 estimate		
	2012	2017	2022	2012	2017	2022
Total	21,368	22,968	24,776	0%	7%	16%

Table 29: Accident and Emergency attendances with Treatment Code 53: Eye

Condition	Attendances				People attending	Attendances (in 2 year period) per person
	2009/10	2010/11	2011/12	Total	Total	
Total		3,049	3,406	6,455	5,921	1.1

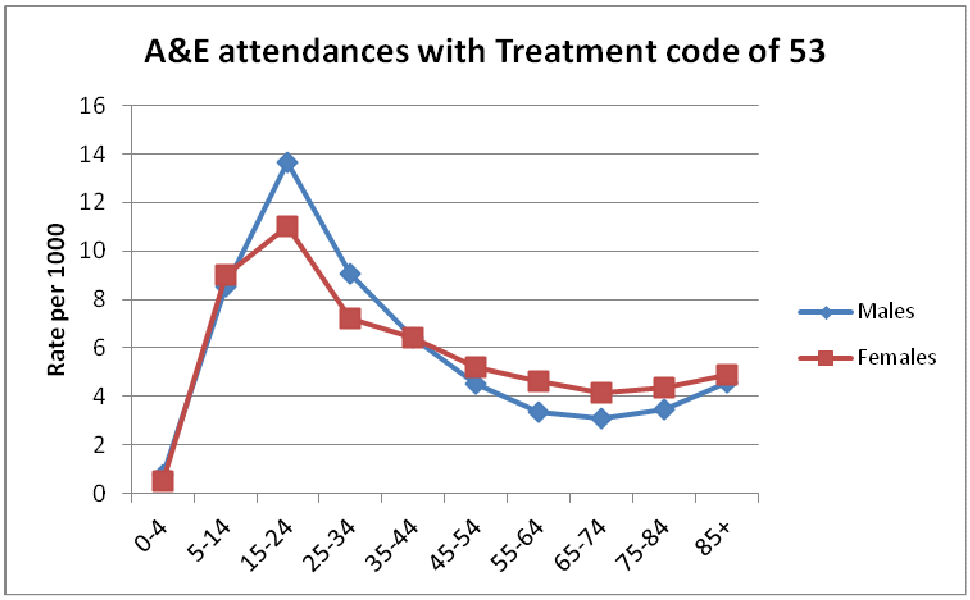


Table 30: Projected number of Accident and Emergency attendances based on rates per year during 2010/11-2011/12 and ONS projected populations

Condition	Projected number of attendances			Increase over 2012 estimate		
	2012	2017	2022	2012	2017	2022
Total	3,218	3,264	3,328	0%	0%	2%

Education Support Services – Vision Support Team

9.41 Somerset County Council has a team of Advisory Teachers who work closely with visually-impaired babies, children and young people, their families and schools, to ensure they receive appropriate developmental and educational support.

9.42 Services commissioned by the PCT and Local Authority work alongside the voluntary sector.

Voluntary Sector – Somerset Sight

9.42 Somerset Sight is a local charity providing services and activities for visually impaired people which help them to live as independently as possible within their local communities, throughout the county of Somerset.

9.43 This independent charity based in Taunton, provides a visiting service, a well stocked resource centre, a mobile resource unit, which provides a service across the whole county, an Information Point in the Musgrove Park Hospital eye clinic and an audio library. A Rehabilitation Officer is employed and training is offered and provided to the Local Authority, care homes, schools and the private sector. The charity also teaches braille, runs computer classes and social activities and acts as agents for the British Wireless for the Blind Fund.

Voluntary Sector - Action for Blind People

9.44 This is a national organisation with bases in Bristol and Exeter. It provides some services within Somerset, including welfare rights and benefits advice, employment advice, and support with technology.

Voluntary Sector – SeeAbility

9.45 Seeability is a national organisation which provides residential and day services for people with visual impairments and learning or physical disabilities. It has a residential home in Wellington.

Voluntary Sector - National Blind Children's Society

9.46 This national organisation supports children with visual impairments in education. It is based in Burnham-on-Sea, and provides information, educational advocacy, education books in accessible formats, and equipment to help children with sight loss in schools.

Voluntary Sector - Guide Dogs for the Blind

9.47 This is a national charity providing dogs to assist visually-impaired people with mobility. It provides services in Somerset from its Bristol

and Exeter bases. People with sight loss can apply for a dog, but there is an assessment and screening procedure, and training is necessary. It also campaigns nationally on mobility issues.

Voluntary Sector - RNIB Kathleen Chambers House

9.48 This is a residential home in Burnham-on-Sea for people who are visually-impaired or who have a dual sensory loss. It is run by the Royal National Institute of the Blind.

10 DEVELOPING AND MAINTAINING AN EFFECTIVE WORKFORCE

10.1 While the limited workforce survey response rate is not statistically reliable, the results provide a flavour of the current workforce in Somerset.

10.2 Local Optical Committees are the interface between the optometry profession, the commissioner and secondary care and are funded by a 1% levy on General Ophthalmic Service sight tests. The Somerset Local Optical Committee (LOC) has an active relationship with the Primary Care Trust.

The Workforce

10.3 In order to perform General Ophthalmic Services in England, optometrists must be registered on the Primary Care Trust Ophthalmic Performers List where the majority of their NHS work is undertaken; there are currently 113 optometrists on the Somerset Ophthalmic Performers List.

10.4 There is a skilled and resourceful pool of qualified professionals currently delivering primary eye care in Somerset. More detail is available in the Workforce Survey at Appendix 4.

10.5 Of the 25 optometrists responding to the workforce survey, just over half reported working in more than one location, with a large proportion indicating they worked in locations other than traditional high street practices.

10.6 While acknowledging the limitations of the workforce survey, the results indicate a healthily mature and stable workforce with 60% of respondents having over ten years experience and 92% with over five years experience; just two respondents reported retirement plans in the short-term.

Education and Training

10.7 Primary Care Trusts are responsible for Continuing Educational Training allowance payments to General Ophthalmic Services contractors, for training undertaken personally or by an ophthalmic

practitioner providing services on his behalf; this allowance was £503 for 2012/13.

10.8 In addition, practices were incentised by the Primary Care Trust in 2008/9 to develop their clinical governance arrangements, to meet the requirements of the professional bodies' own govenance programme 'Quality in Optometry'; it is now a requirement that all practices providing enhanced servicesparticipate in the programme.

10.9 In order to increase the range of service delivered in the community by optometrists, education workshops are regularly provided to support optometrists achieve accreditation for the provision of the current enhanced services, the Acute Community Eye Care, Intra-Ocular Pressure Referral Refinement and Ocular Hypertension Monitoring Services. A list of practices with enhanced service accredited optometrists can be viewed at Appendix 6.

10.10 The Somerset LOC also provides study days and is an approved provider of enhanced services accreditation in Somerset.

10.11 A third of optometrists responding to the workforce survey report having enhanced qualifications with a further third indicating their intent to pursue further training or higher optical qualifications.

Developing the workforce

10.12 There is a strong desire from the optometric community for existing and potential skills and knowledge to continue to be considered in the development of all future ophthalmic care pathways. Examples include:

- the use of specialist skills in the diagnosis and management of glaucoma within a shared care model/level 3 service

- the use of specialist equipment available in the community, such as Ocular Coherance Tomography (OCT) in the management of patients with stable AMD

non-clinical roles such as low vision Eye Clinic Liaison Officers, to providethose recently diagnosed with an eye condition with the practical and emotional support they need to understand their diagnosis, deal with their sight loss and maintain their independence

Challenges to Local Enhanced Service Provision

- Information Technology

    * with the level of enhanced services provided by optometric contractors increasing in Somerset, and the possiblility of shared-care services in the future, improved methods of

communication through integration with NHS information technology systems is essential

* practices are increasingly computerised with internet access, which has been achieved by private investment, however, the lack of integration with NHS systems leaves optometrists to use hard copy, secure fax or NHS secure email for the transfer of patient and confidential data

11 PRIORITIES AND THE DEVELOPMENT OF AN EYE CARE STRATEGY FOR SOMERSET

11.1 Three stark messages arise from the analysis of the local eye health need in Somerset, as similarly identifed by Imperial College[39]:

- the burdens of eye disease, visual impairment and blindness increase exponentially with age (both for individuals and populations)
- half of this is preventable if caught early
- health outcomes of eye disease are significantly better if detected and treated early

11.2 The recommended broad strategy aims required to meet the Somerset eye health need are set out in the following Table 31. These aims and objectives are considered to support those of the Health and Wellbeing Strategy, SCCG's priorities as described in paragraphs 4.6 and 4.7 and those of the World Health Organisation, as previously set out briefly in paragraph 4.8 as follows:

a) to improve the eye health of people by:

- raising awareness and understanding of eye health among the public, including those people most at risk of eye disease, to allow every individual to develop personal responsibility for their eye health and to achieve maximum eye health for all
- raising awareness of eye health among health and social care practitiioners and to ensure the early detection of sight loss and prevention where possible

b) to eliminate avoidable sight loss and deliver excellent support to those with a visual impairment by:

- improving the co-ordination, integration, reach, and effectiveness of eye health services and services and support for those people with permanent sight loss

c) to enhance the inclusion, participation and independence of people with sight loss:

- working in partnership, particularly with the Local Authority, to improve attitudes, awareness and actions of service providers, employers and the public towards people with sight loss and to remove significant barriers to inclusion, so

[39] Imperial College Liberating the NHS: Eye Care – Making a Reality of Equity and Excellence 2010

that people with sight loss can exercise independence, control and choice

* to improve compliance with disability discrimination legislation

11.3 Somerset Primary Care Trust will be abolished on 31 March 2013 and its commissioning responsibilities transferred to Somerset CCG, the NHS Commissioning Board, the Local Authority and Public Health England.

11.4 The recommended strategy, to address the issues identified in this rapid needs assessment and to support the JSNA ,will require all relevant commissioning organisations to work in partnership to deliver better eye health outcomes for the population of Somerset.

RECOMMENDED EYE CARE STRATEGY

Table 31: Recommended strategy to address the issues identified in this rapid needs assessment

AIM & OBJECTIVES	ACTIONS REQUIRED TO ACHIEVE AIMS AND OBJECTIVES	LEAD
Implementation of an integrated eye health strategy to meet the eye health needs of the population of somerset		
To provide awareness to organisations of the strategy and implementation	Develop strong links between NHS Commissioning Board Area Team, SCCG and Somerset Local Optical Committee by continuation of a regular forum, whether through a reformed Eye Care Local Professional Network (eLPN) or a similar group, with appropriate representation to oversee the implementation of an eye care strategy.	
	Identify a clinical eye health champion.	
a) To improve the eye health of people and ensure the early detection of sight loss		
Raise awareness and understanding of eye health among commissioners	Implement the new Public Health Indicator for eyes detailed in the Public Health Outcomes Framework "Improving outcomes and supporting transparency" indicator, which will track the rates of three major causes of sight loss including glaucoma, age-related macular degeneration (AMD) and diabetic retinopathy.	
	Undertake a local Health Equity Audit of the main causes of sight impairment, identifying barriers to accessing eye health and sight loss services	
	Promote the requirement for captured GOS claims data, currently via the Exeter, or an alternative system, to be available in a meaningful and pragmatic manner, to support useful analysis of patterns of NHS sight test uptake.	

RECOMMENDED EYE CARE STRATEGY

Raise awareness and understanding of eye health among the public	Develop a targeted Public Health campaign that concentrates specifically on eye health and emphasises the importance of regular sight tests, particularly around at-risk groups such as older people (including nursing & residential homes), BME communities, and those with learning disabilities.	
	Incorporate eye health messages into public health campaigns concerning obesity, smoking cessation and the management of diabetes and glaucoma.	
Raise awareness of eye health among health and social care practitioners	Involve eye care professionals in the develop of all pathways and services with links to eyecare, including for example, stroke, falls, dementia, mental health and learning disabilities, plus education in liaison with the Local Authority.	
	Encourage service providers to consider and respond to the needs of disadvantaged groups, including supporting the use of available documentation to support appropriate communication with adults and young people with learning disabilities.	
Continue to utilise and develop the primary care eye care workforce	Undertake a full review of the current workforce in liaison with the LOC, building on the Workforce Survey, to ensure full use of existing resources and to understand the development needs of the workforce to support any future shift of activity from secondary care.	

b) Support the elimination of avoidable sight loss		
Improve the co-ordination, integration reach, and effectiveness of eye health services.	Undertake review of local eye care systems and pathways relating to the main eye conditions. This should include review of medical and social aspects of the eye care pathway. Agreed pathways should be set out and included within contracts where not already.	
	Promote and develop further integration of primary, secondary eye care and Local Authority pathways to achieve the most effective, timely and accessible services and treatments for each individual and the best use of community, hospital and social care resources. This could be achieved by identifying and considering implementation of national learning, including Local Optical Committee Support Unit (LOCSU) eye health pathways, for example: • Community Eye Care for Adults & Young People with Learning Disabilities • Children's Vision Pathway • Community Optical Pathway for Adult Low Vision Service • Post operative cataract surgery • Assessment/Monitoring of stable AMD patients	
	Develop integrated IT systems to support development of effective shared care services, innovating around available systems until N3 available in optometric practices providing NHS services.	
	Improve capture of information from hospital eye services by requiring Provider Organisations to implement the use of software systems which enable clinicians to usefully capture and monitor their own outcomes	

Utilise and develop the primary care eye care workforce	Increase engagement with local optometrists	
	Utilise the skills and knowledge of optometrists in pathways review and development through strong links between NHS Commissioning Board Area Team, SCCG and Somerset Local Optical Committee	
	Enable shared learning by improving outflow of information from hospital eye services by requiring Provider Organisations to provide all referrers, particularly optometrists, with timely patient discharge/outcome summaries.	
ci) Deliver excellent support to those with a visual impairment		
Improve the co-ordination, integration, reach, and effectiveness of eye health services and services and support for those people with permanent sight loss	Strengthen joint working opportunities between the Local Authority Sensory Loss and Public Health functions, SCCG and Voluntary Organisations.	
	Improve the integration of early intervention services to provide support at time of sight loss, including access to rehabilitation support, counselling services or Eye Care Liaison Officer to help people adjust to sight loss.	
	Strengthen the CV1 registration data set to improve its utility as a public health measure by ensuring timely submission of fully completed submissions of CVI's by ophthalmologists, for: • inclusion in the national data set by Moorfields, where national data is collated, analysed and published and • the relevant department of the Local Authority to support planning of and access to, effective interventions	

	Encourage the Somerset Low Vision Committee to influence and monitor the development and implementation of the Eye Health Strategy across the various organisations.	
Cii Enhance the inclusion, participation and independence of people with sight loss		
Working in partnership, particularly with the Local Authority, to improve attitudes, awareness and actions of service providers, employers and the public towards people with sight loss and to remove significant barriers to inclusion, so that people with sight loss can exercise independence, control and choice	Strengthen health and social care pathways for people who experience visual impairment by ensuring they reflect SCCG's Equality Delivery System (EDS) and Patient Experience, Equality, Diversity and Human Rights Strategy.	
	Utilise available partnership opportunities, including the Somerset Equality Officers Group and the Somerset Equality Delivery System Cluster Group to promote the needs of people with visual impairment.	
	Encourage service providers to enhance communication skills with adults and young people with learning disabilities with the use of appropriate and available documentation, for example, that produced by See Ability "Telling the Optometrist About Me" and "The Results of my Eye Test" .	

12 GLOSSARY OF ABBREVIATIONS

ACES	Acute Community Eyecare Service
AREDS	Age Related Disease Study
AMD	Age-related Macular Degeneration
anti VEGF	Anti-vascular endothelial growth factor
BME	Black and Ethnic Minority
COAG	Chronic Open Angle Glaucoma
CRP	C-reactiveprotein
CVI	Certificate of Vision Impairment (CVI)
DH	Department of Health
DMO	Diabetic Macular Oedema
DRSS	Diabetic Retinal Screening Programme
EHNA	Eye Health Needs Assessment
GOS	General Ophthalmic Services
GP	General Practitioner
IOP	Intra-Ocular Pressure
IOPRRS	Intra-Ocular Pressure Referral Refinement Service
JSNA	Joint Strategic Needs Assessment
LOC	Local Optical Committee
LSOA	Lower Super Output Area
NEHEM	National Eye Health Epidemiological Model
NVAMD	Neo-vascular Age-related Macular Degeneration
NICE	National Institute for Health and Clinical Excellence
PANSI	Projecting Adult Needs and Service Information
PCAG	Primary Closed Angle Glaucoma

PCT	Primary Care Trust
PHAST	Public Health Action Support Team
POAG	Primary Open Angle Glaucoma
POPPI	Projecting Older People Population Information
RCGP	Royal College of General Practitioners
RNIB	Royal National Institute for the Blind
SCC	Somerset County Council
SCCG	Somerset Clinical Commissioning Group

WORKSHOP1 – responses (all groups participated)

Question:

Are the vision and underlying principles/values to support achievement of the vision correct?

Vision Statement

- Aspirational
    - Does not anyone to anything
    - Should it be more challenging?
    - Should mention detection / prevention / management
- But a good general (short) statement

Principles / Values

- Problems of postcode healthcare (? Not in Somerset)
- Workforce will be utilised and developed
- Eyecare services … partnership with informed patients
- Services commissioned to reflect health needs
- Available evidence and professional advice

Fair & equitable access

- Lack of understanding of learning difficulties among professionals
- Concentrate efforts on more 'at-risk' groups
- Increase awareness of people with LD (mental & physical)
    - Education of carers
    - Older people with dementia
    - Reluctance to have eye test in case cost prices
- Other info available
- Deprived areas

  - Rural location
  - Transport links
  - Mobile unit
- Support organisations (Citizen Advice)
- School education
  - Sure start
  - Nursing / res homes

Care direct line in Somerset

Premises / physical environment

How to assess

Education

- Include ‘educate’ or ‘awareness’ in statement
- Statement needs to include something about education of the public
- Info needs to be available about what services there are
- Value for money
  - Understanding what you’re commissioning and comparing like with like
  - Must equate cost versus quality of life when defining ‘Value for Money’
- How do we encourage people to have an eye test?
  - Publicity campaign to encourage people to go to the optom
  - More focus on at risk groups
  - Improve /increase detection and therefore management of sight loss by improving take-up of services and improving public education
- Self help – smoking, etc

WORKSHOP2 – responses (group 1 participated)

Workshop 2 - Questions:

Group 1

1) Why don't people go to the optometrist/optician? How do we encourage people to attend?

Lack of knowledge, don't understand that eye test is more than whether/not need to wear glasses

Encourage people to go through education, publicity, start early at schools

Health campaign to educate everyone, going for a check up

Optoms to use their adverts to promote eye health

Everyone knows about optoms and where to find them – but if they can see OK they don't think they need to go

Don't realise problem

Fear of cost

Fear of condition / outcome

Rural access / residential or nursing home

2) What should be expected from an average high street optometric practice / hospital clinic?

Professional well trained staff (who talk to each other), share experience, expertise

Good communication

Expect to have an eye check-up (like a dental check-up)

Not about new specs

Physical accessibility, dignity

Polite / customer services / not a conveyor belt

What next after diagnosis?

- Immediate support
- Clear information

- Who / where next
- Clinical signposting

3) What choices should be available in optometry?

Services: monitoring of eye health, dispensing of glasses

Flexible / times / date

4) What should the 3 main priorities be for Somerset over the next five years, with particular regard to AMD, Glaucoma and Low vision?

Education – prevention – care

Raising awareness of need for sight test

Standard equipment – standard eye sight test components

WORKSHOP2 – responses (group 2 participated)

Workshop 2 - Questions:

Group 2

1) How can optometric/optical services be improved?

Prioritising

- Better geographical distribution
- Bear in mind commercial / business nature of optometric practices
- More integrated working between services
- (GOS, HES, Social Services, Low Vision services)
- Improve communication

Pay more money, fair reimbursement – minimum standards

Inequalities in waiting lists and services available

2) How do we develop and maintain an effective workforce?

Recognise and utilise existing skills

Encourage participation in enhanced services

Involve patients more at all stages of development and education

What's wrong at present – work force (more integration of services)

3) Are there any specialist roles that should be developed in primary care?

Encourage optoms to achieve higher diploma status, eg independent prescribing

Eye clinic liaison officer (ECLORS)

- Employed by Hospital
- Not voluntary basis but sight charities etc.

4) What should the 3 main priorities be for Somerset over the next five years, with particular regard to AMD, Glaucoma and Low vision?

Prioritise

- uptake of sight tests by educating the wider population and health care / social care professions and voluntary orgs
- improve care pathways and integration of service providers and patient information at all steps
- deal with increasing numbers of patients with eye disease / sight loss

Education, 17000 people undiagnosed glaucoma

Passing the bar in optometry? – raising awareness

Inequalities in waiting lists / services available

NHS Somerset

ASSESSMENT OF EYECARE SERVICES

9 January 2013

ASSESSMENT OF EYECARE SERVICES
CONTENTS

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ASSESSMENT OF EYECARE SERVICES

1 INTRODUCTION

1.1 NHS Somerset is looking at eyecare services currently provided and an Eyecare Needs Assessment will be produced to identify areas that need to be improved. As part of this NHS Somerset has been seeking the opinions of members of the public who currently use eyecare services.

1.2 A questionnaire was handed out at Optometrists across Somerset during November and December 2012, with a closing date of 14 December 2012 (see Appendix 1). The questionnaire was completed and returned by 90 members of the public and the results of these are shown in Section 3.

2 QUESTIONNAIRE

2.1 The questionnaire was split into four sections:

- How often members of the public visit their optician
- Other eyecare services that are available
  - Somerset Diabetic Eye Screening Service
  - Hospital Eye Services
  - Domiciliary Eye Services
  - Acute Community Eyecare Service (ACES)
- Information about the optician they currently use
- Equality and diversity monitoring information

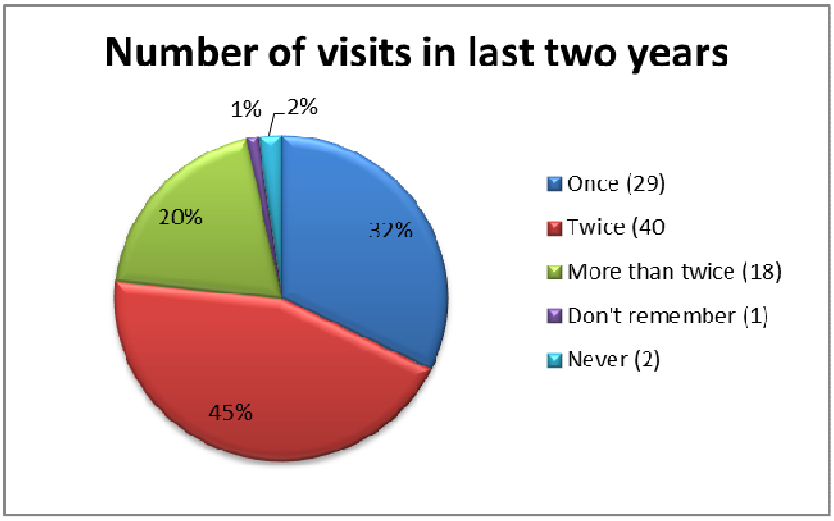
3 SECTION ONE:

HOW OFTEN MEMBERS OF THE PUBLIC VISIT THEIR OPTICIAN

Question 1
How often have you visited an optician in the last two years?

3.1 Table 1 below shows the breakdown of how many times members of the public visited their optician in the last two years.

Table 1



Question 2

3.2 Part 2 of this question asked why you visited an optician and a list of possible reasons where given:

- for a routine sight test
- for a routine eye health check
- for a contact lens check
- to purchase or repair/replace spectacles
- for glaucoma monitoring
- for cataracts monitoring
- for monitoring of macular degeneration
- for monitoring vision in regards to standards required for work or driving
- for an emergency eye examination, for example ACES
- low vision aids
- other

3.3 Two people did not complete this question, but everyone else put in their reasons for their visit. Respondents were not limited to how many of these options they could tick, 34 people ticked only one option and these were as follows in table 2:

Table 2

Routine eye test	30
Routine eye health check	1
Purchase or repair/replace spectacles	1
Glaucoma monitoring	2

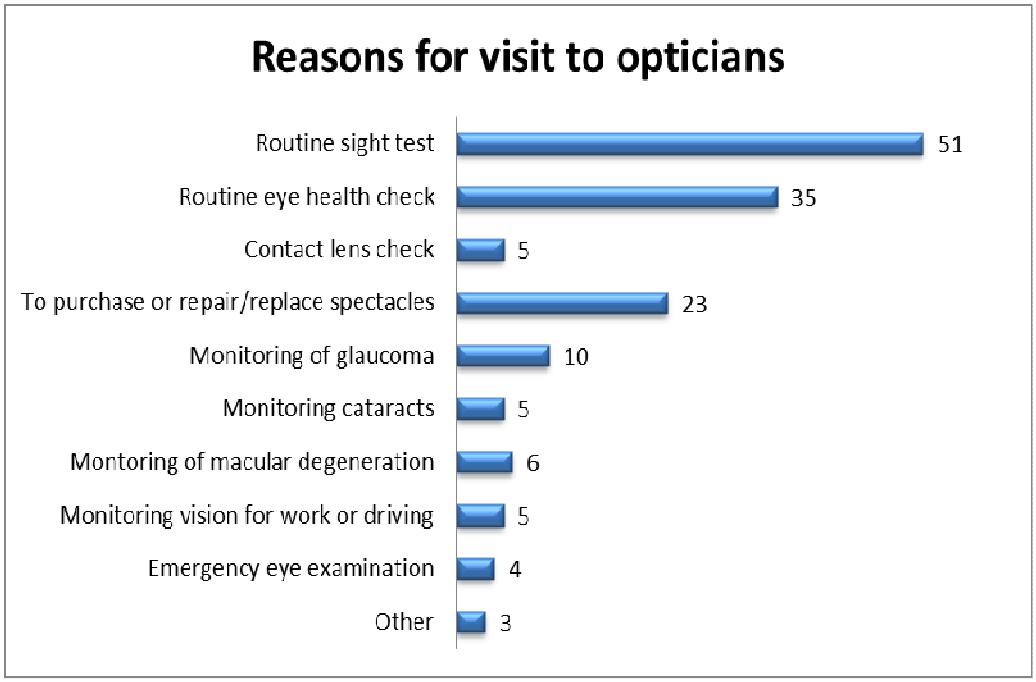
3.4 The most common reason that people visit their optician for is a routine sight test with 30 people (33%) stating this was the only reason for their visit.

3.5 Everyone else visited their optician for more than one reason.

3.6 There were 17 people who had both a sight test and eye health check, with nine people having a sight test and also purchasing new spectacles or having existing spectacles repaired or replaced.

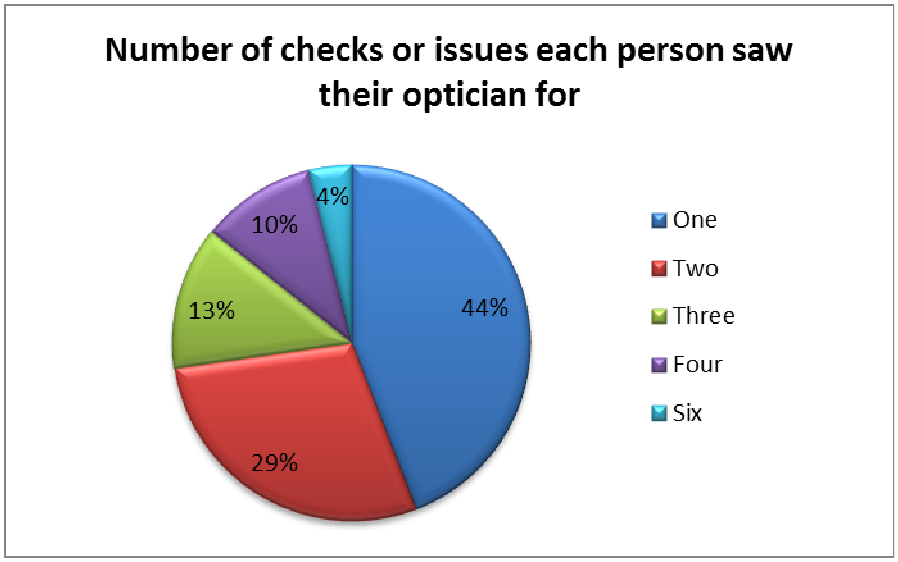
3.7 Table 3 shows the number of treatments and issues that people visited their optician for.

Table 3



3.8 The number of treatments/issues that the respondents visited their opticians for is shown in table 4.

Table 4



Question 3
If you have not attended in the last two years please indicate why.

3.9 Three people put in other reasons for visiting their optician and these were:

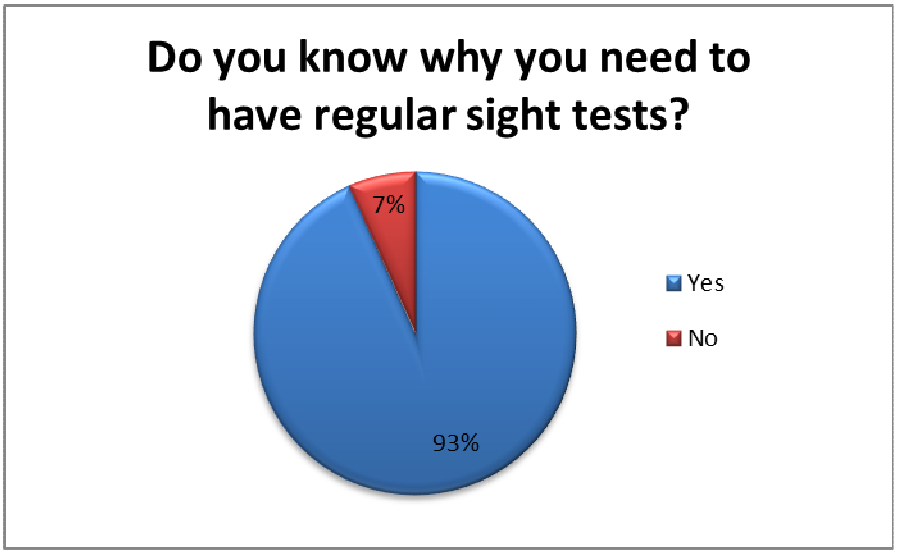
- problem with eyelid
- type 2 diabetes eye check
- sight problems due to a previous cataract operation

3.10 The two people who said they had not visited their optician in the last two years both stated that they do not attend regular sight tests, one of them felt that it was not necessary.

3.11 Question 4 gave the reasons why people should attend a regular sight test as it is not just to check whether they need to wear glasses.

3.12 Everyone answered this question with 94 people (93%) saying they were aware of the reasons and six people (7%) said they were unaware. Table 5 shows the percentage scores for this.

Table 5



Question 5
Do you find the opening times of your local optician convenient?

3.13 Everyone responded to this question with 87 people (97%) saying they found the opening times convenient, two people (2%) said they did not find the opening times convenient and one person (1%) did not know. The person who did not know had stated in a previous question that he or she had not visited the opticians in the last two years.

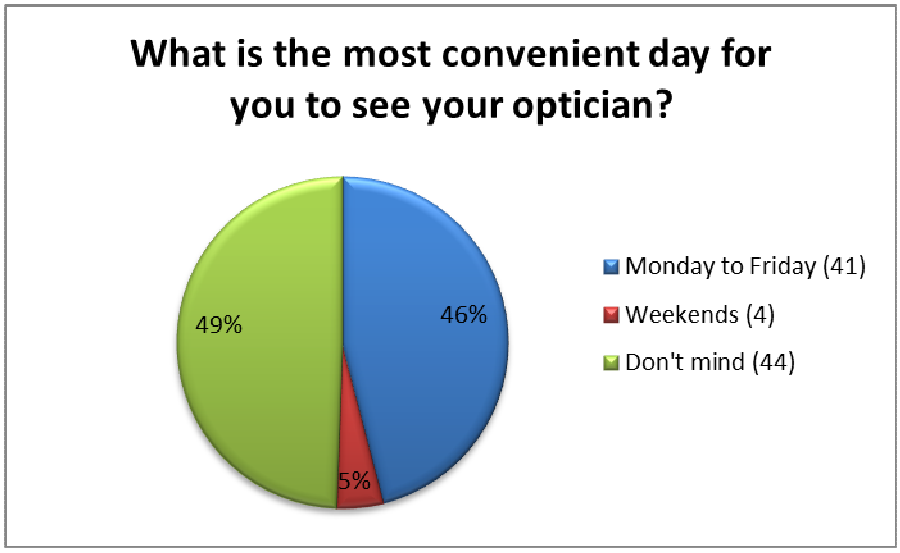
Question 6
What is the most convenient day for you to visit your opticians?

3.14 Three options were given for this answer:

- Monday to Friday
- Weekends
- Don't mind

3.15 The responses are shown in table 6.

Table 6



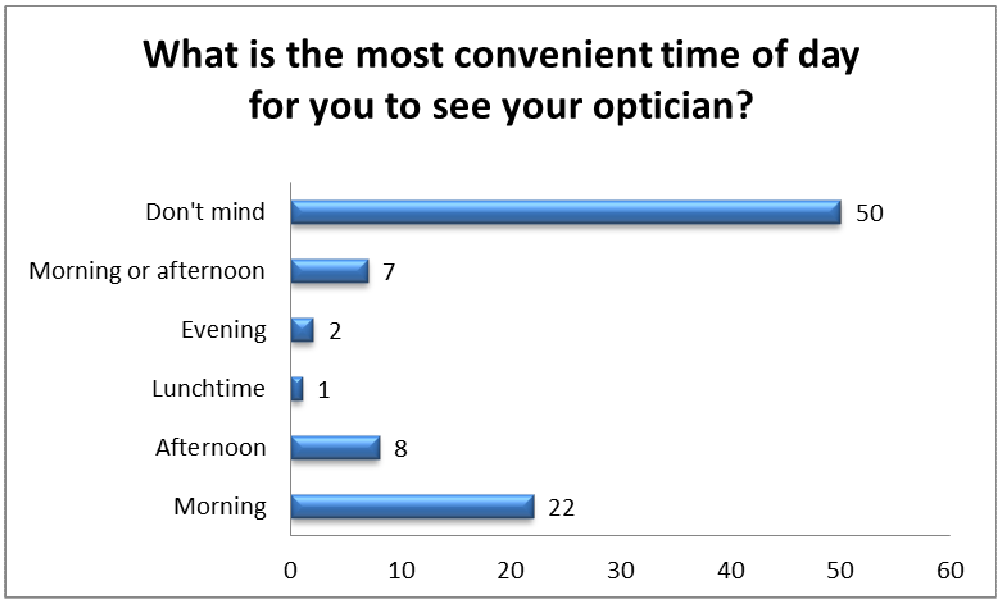
Question 7
What is the most convenient time for you to visit your optician?

3.16 There were five options given for this question, which were:

- Morning
- Afternoon
- Lunchtime
- Evening
- Don't mind

3.17 The responses for this question are shown in table 7 below, you will see that seven people chose both morning and afternoon.

Table 7



4 SECTION TWO:

OTHER AVAILABLE EYECARE SERVICES

Somerset Diabetic Eye Screening Service

4.1 The next set of questions were about the Somerset Diabetic Eye Screening Service and firstly people were asked whether they attended the service, nine people said they did. The next set of answers is based on these nine responses.

4.2 The respondents were asked which location they normally attended this service and these are:

- Bridgwater
- Burnham on Sea
- Crewkerne
- Shepton Mallet
- Taunton (two people – one also attended Yeovil)
- Wellington (two people)
- West Mendip
- Yeovil (this person also attended Taunton)

4.3 Respondents were asked:

- whether they had any difficulty accessing the service

- whether they had any difficulty in getting a convenient appointment
- is the screening centre in a convenient location

4.4 The responses to each of these questions can be seen in tables 8, 9 and 10.

Table 8

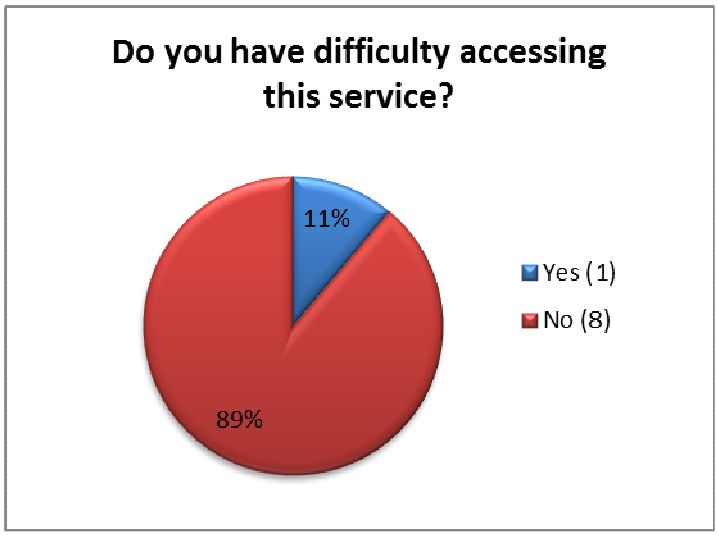


Table 9

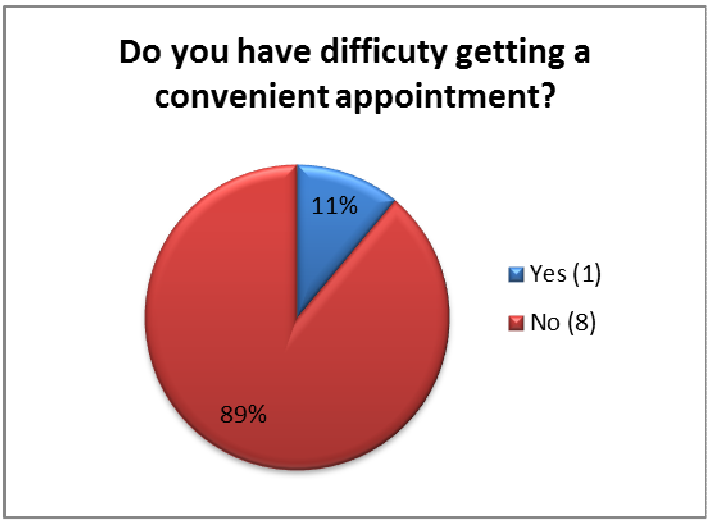
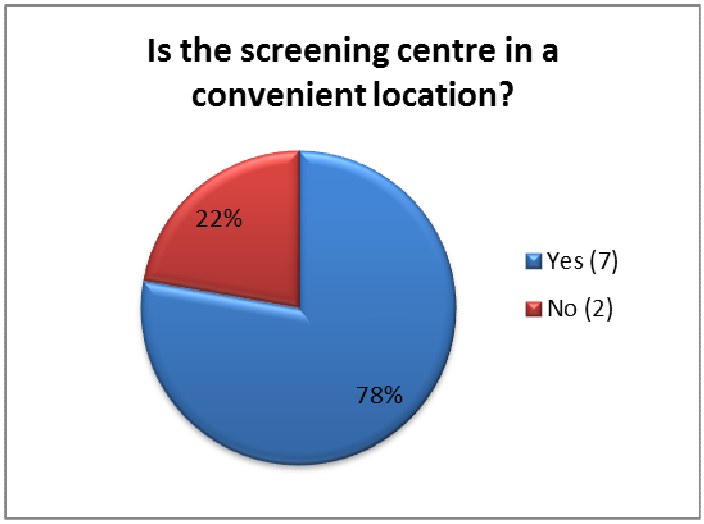


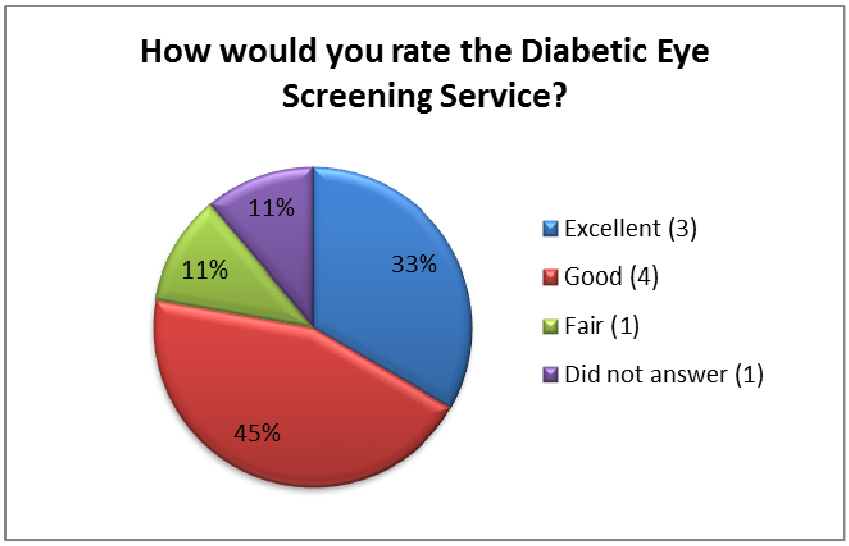
Table 10



4.5 The two people who said that the screening centre was not in a convenient location for them lived in Taunton. One had gone to centres in both Yeovil and Taunton, but would prefer to be seen in Taunton and the other had gone to Wellington and would prefer to go to Taunton.

4.6 Finally respondents were asked to rate the service that they had received at the Somerset Diabetic Eye Screening Service. These are shown in table 11.

Table 11



Hospital Eye Service

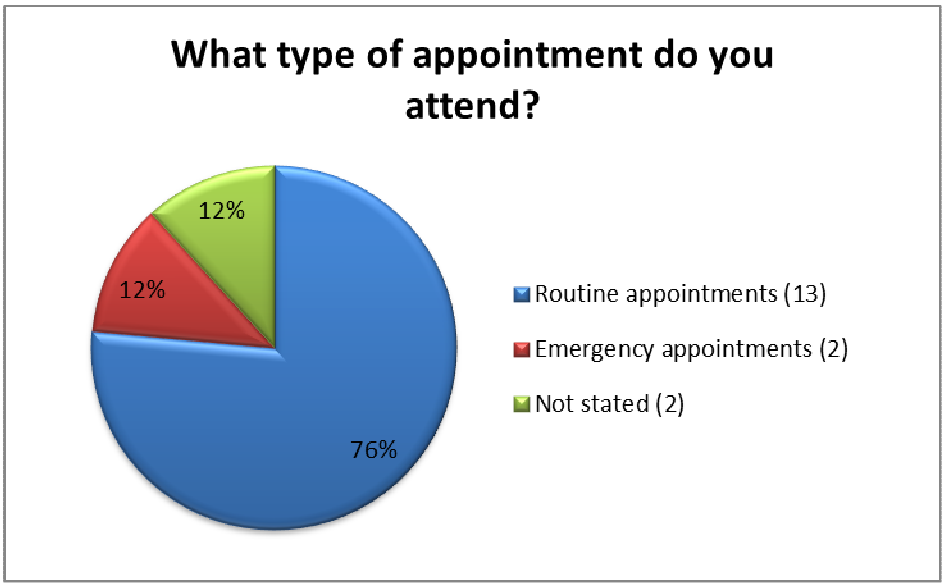
4.7 The next set of questions referred to the Hospital Eye Service and these results are based on the answers from the 17 people who said they used this service.

4.8 Firstly the respondents were asked which hospital they normally attend. The following responses were given:

- Frenchay Hospital
- Minehead Community Hospital
- Musgrove Park Hospital, Taunton (3 people)
- Nuffield, Taunton
- Salisbury Hospital
- West Mendip Hospital (2 people)
- Yeovil District Hospital (3 people)

4.8 They were then asked whether they attended this service for routine visits or whether they have used the service only for emergency appointments. These answers are broken down in table 12.

Table 12



4.9 When respondents were asked whether they had any difficulty in accessing the service all 17 people said no.

410 The next two questions asked:

- whether they had any difficulty in getting a convenient appointment
- are the hospitals in convenient locations

4.11 The responses to these questions can be seen in tables 13 and 14 below.

Table 13

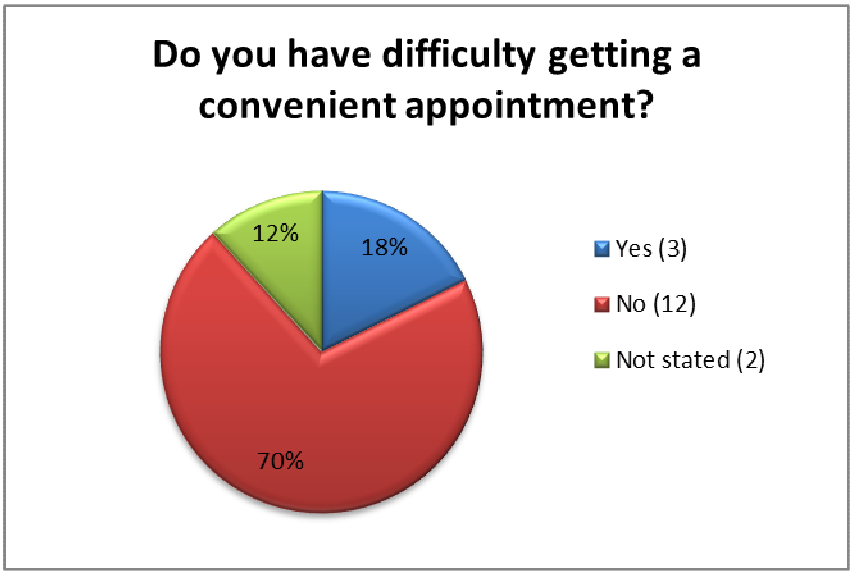
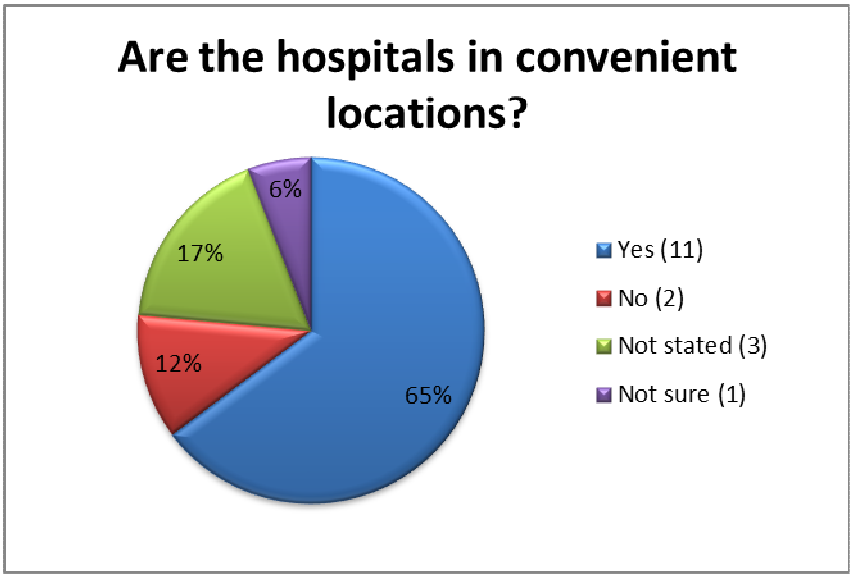


Table 14



4.12 One person who was not sure put down that it depended on how he/she travelled to hospital. If driving then it was convenient but if travelling by public transport it was not convenient. This person did not state which hospital he or she travelled to, but lived in Taunton and would prefer to go to Dene Barton Hospital Community Hospital.

4.13 Respondents were asked at which Community Hospital they would prefer to attend. Table 15 below sets out where people would prefer to be seen, alongside the hospital they attended and where they lived.

Table 15

Preferred Hospital	Hospital attended	Where they live
Crewkerne	Yeovil	Crewkerne
South Petherton	Yeatman, Sherborne	Bradford Abbas
Bridgwater	Musgrove Park, Taunton	Bridgwater
Nuffield	Nuffield	Wedmore

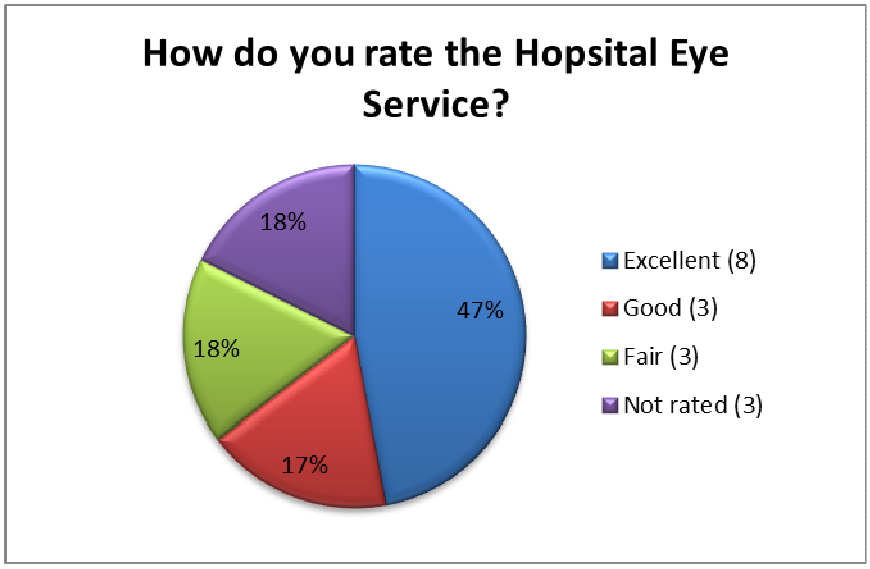
4.14 Other hospitals requested were:

- Minehead
- Dene Barton
- West Mendip

4.15 These respondents either did not put down the hospital where they had attended or where they lived.

4.16 Finally respondents were asked to rate the service that they had received at and eye clinic in hospital and these are shown in table 16.

Table 16



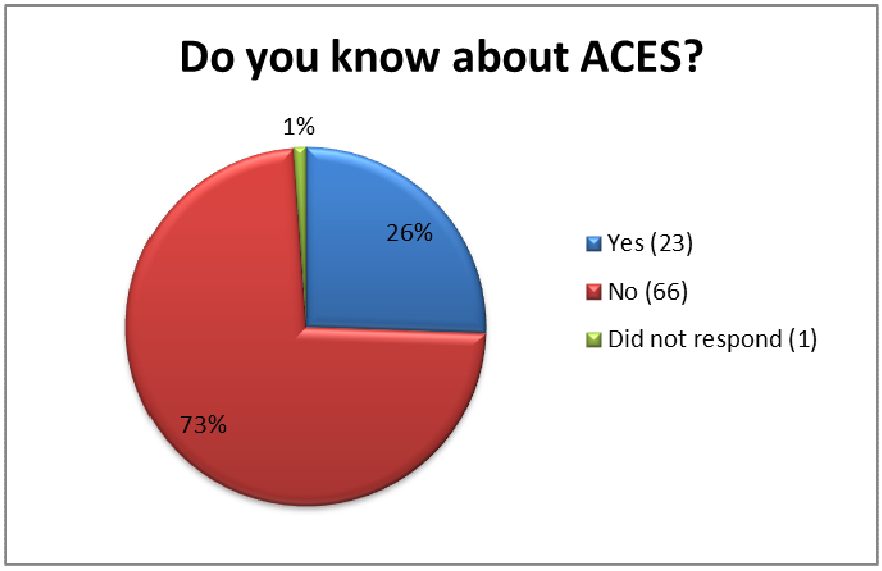
Domiciliary Eye Service

4.17 The next section asked about the Domiciliary Eye Service, however no one who completed the questionnaire had attended this service.

Acute Community Eyecare Service (ACES)

4.18 Question 11 began with a brief explanation of the Acute Community Eyecare Service and asked whether people were aware of this service. The response to the question is shown in table 17 below.

Table 17



5 SECTION THREE:

INFORMATION ABOUT THE OPTICIAN YOU USE

5.1 This section was all about the advice received from the optician that people currently use. The first question in this section asked whether they were happy with the advice they receive regarding:

- their spectacle prescription
- their eye health
- the risk of future eye problems
- emergency appointments using ACES
- overall advice

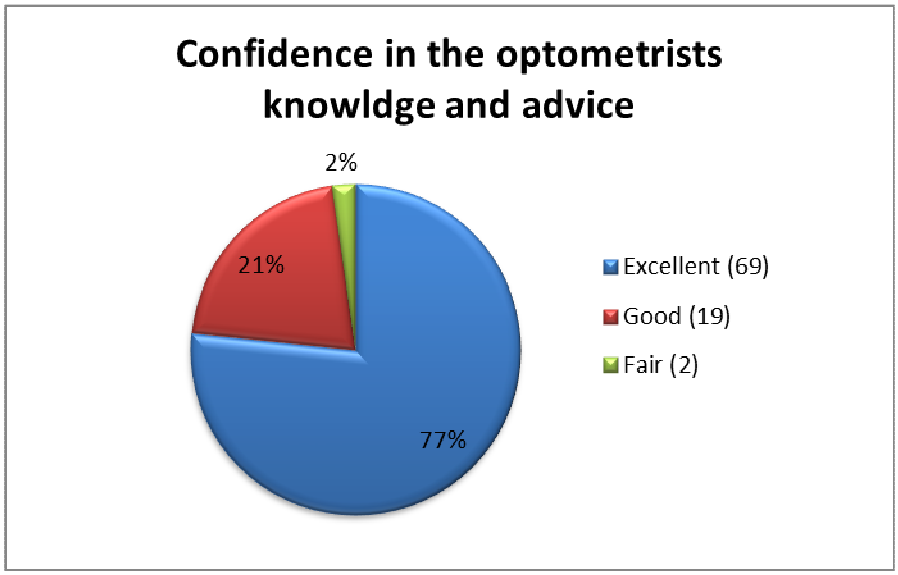
5.2 Table 18 shows the responses received for this question:

Table 18

Advice given on:	Yes	No	N/A	did not respond
Spectacle prescriptions	80		2	8
Eye health	80		1	9
Risk of future eye problems	75	1	1	13
Emergency appointments (ACES)	32		29	29
Overall	78		3	9

5.3 Respondents were then asked how they would rate the confidence in the Optometrists knowledge and advice. The results of this question are shown in table 19 below.

Table 19



6 SECTION FOUR:

THE OPTICAL PRACTICE YOU USE

6.1 This section asked for details of the Optometrists that people use, the area and how they rate the overall satisfaction with the practice. The results for this are set out in table 20.

Table 20

Optometrists and location	Responses Received	Overall Excellent	Overall Good	Overall Fair	No rating given
Beswetherick, Chard	6	6			
Boots, Chard	4	2	2		
Boots, Taunton	6	4	2		
Cranmers, Minehead	6	4	2		
David Bull, Burnham-on-Sea	6	6			
Earlam & Christopher, Taunton	10	8	1		1
Mansfield, Wells	4	3	1		
Martock Optometrists	7	4	3		
Matthews, Sherborne	1		1		
Max Davison, Watchet	5	6			1
Millican Eye Centre, Wells	1	1			
NK Opticians, Cheddar	1	1			

Richard Mansfield, Wells	2	2			
Richard Stent, Ilminster	7	7			
Robert Frith, Glastonbury	1	1			
Robert Frith, Castle Cary	3	2	1		
Robert Frith, Crewkerne	1				1
Sarah Gibson, Wincanton	1	1			
Specsavers, Bridgwater	1	1			
Specsavers, Minehead	1	1			
Tesco, Yeovil	1	1			
Vision Express, Taunton	5	4	1		
Watson & Smith, Taunton	2	1		1	
Watson & Smith, Wellington	1	1			
Young, Shepton Mallet	1	1			

6.2 Four people did not give information on which optometrist they visited or give a rating.

6.3 Respondents were asked what other eyecare services they would like to see provided by the NHS. Only a few people put in comments for this as below:

- OCT (Ocular Coherence Tomography) screening
- surgery if necessary
- no retinal photography Unit at Yeovil District Hosiptal
- better eye checks at schools
- access to eyecare for individuals with complex needs
- assistance for virtually impaired in their homes
- immediate support for those diagnosed with macular degeneration
- mobile cataract clinic

6.4 They were then asked if there are any new NHS eyecare services required to meet the needs of the population in their area. Only two comments were received which were:

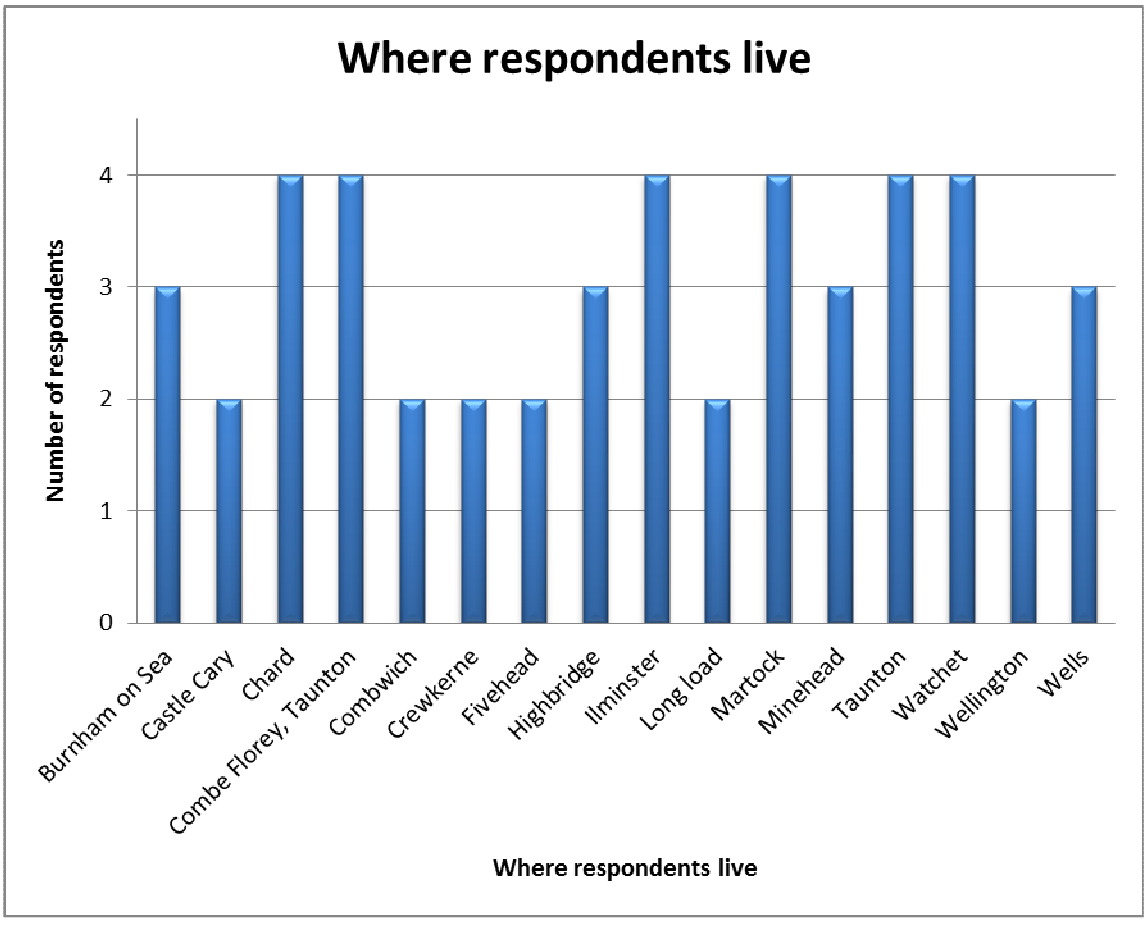
- *"sight test should be taken prior to taking driving test and at regular periods thereafter"*
- *"Local facility for glaucoma checks"*

6.5 Respondents were then given the opportunity to make any other comments about eyecare services. These are shown below:

- *"very helpful staff - recommend them to my tenants and friends"*
- *"we have used the same optometrist for at least 20 years and find him excellent, considerate and trustworthy"*
- *"very pleased to have laser x-rays to check health at back of eyes"*
- *"education of general public as to the importance of regular checks on sights and eye health is needed"*
- *"how do you access ACES never heard of"*
- *"centre in West Country for diagnosis of eye tumours"*
- *"should be tested more frequently than every 2 years as eyes cannot be replaced like teeth you see Dentist every 6 months"*
- *"diabetic screening at opticians"*
- *"Musgrove Park Hospital give better eye exams than local optometrists*
- *"local services good but consultant eye specialists in large hospitals too far away"*

6.6 Respondents were asked to state in which town or village they lived. These are shown in table 21 on the next page.

Table 21



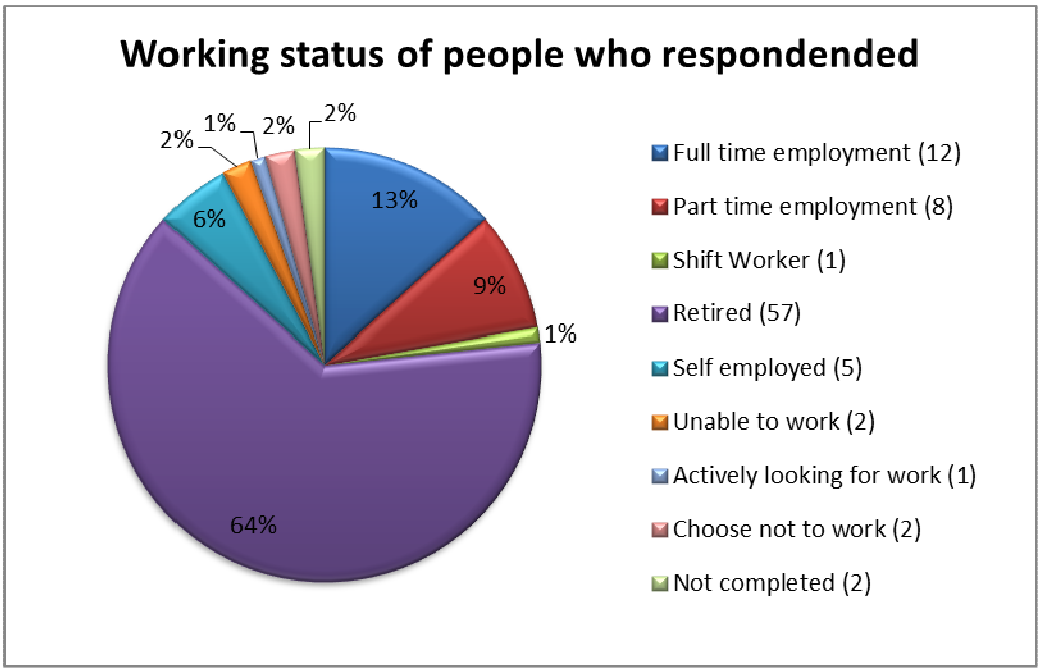
6.7 There were quite a few places that only one respondent came from which were:

- Ashill
- Bishops Hull
- Bishops Lydeard
- Bridgwater
- Broadway
- Bruton
- Catcombe
- Cheddar
- Chedzoy
- Chilton Polden
- Donyatt
- Dunster
- Frome
- Honiton
- Kingston St Mary
- North Curry
- Seavington St Michael
- Shepton Mallet
- Somerton
- Stoke sub Hamdon
- Tatworth
- Wedmore
- West Bagborough
- Westbury Sub Mendip
- Winsford
- Yeovil

6.8 Twelve people did not include where they live and three people who completed the questionnaire lived outside of Somerset, they came from Bradford Abbas, Totnes and Mere. However they had visited an Optician in Somerset.

6.9 The final question in this part section asked for their work status. The breakdown of this is in table 22.

Table 22



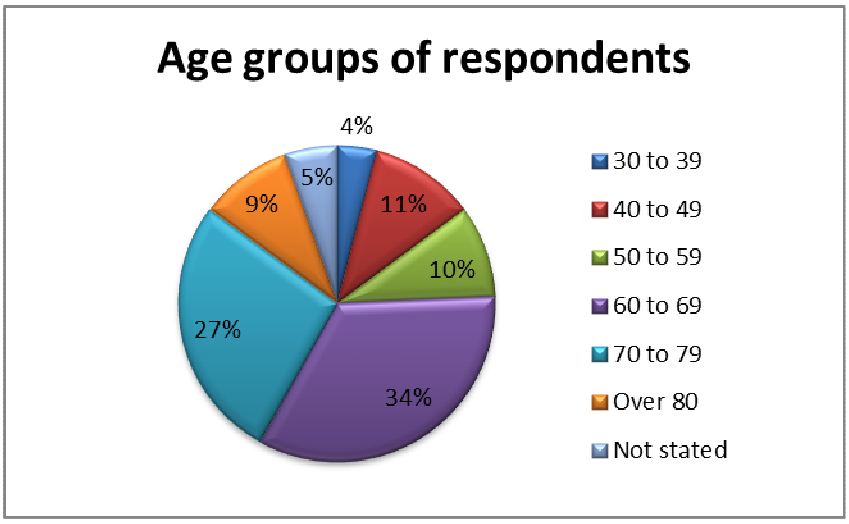
7 EQUALITY AND DIVERSITY MONITORING INFORMATION

7.1 NHS Somerset is committed to providing equal access to healthcare services for all members of the community. To achieve this, NHS Somerset gather monitoring information from everyone who completes questionnaires and surveys which helps ensure that the most effective and appropriate healthcare is delivered. The monitoring forms are completed entirely voluntarily and all the information collected is anonymous.

7.2 Of all the completed questionnaires that were received 16 people chose not to complete the monitoring form, so the following information is based on the responses of 84 people.

7.3 The age groups of people who responded have been broken down into groups shown in table 23.

Table 23

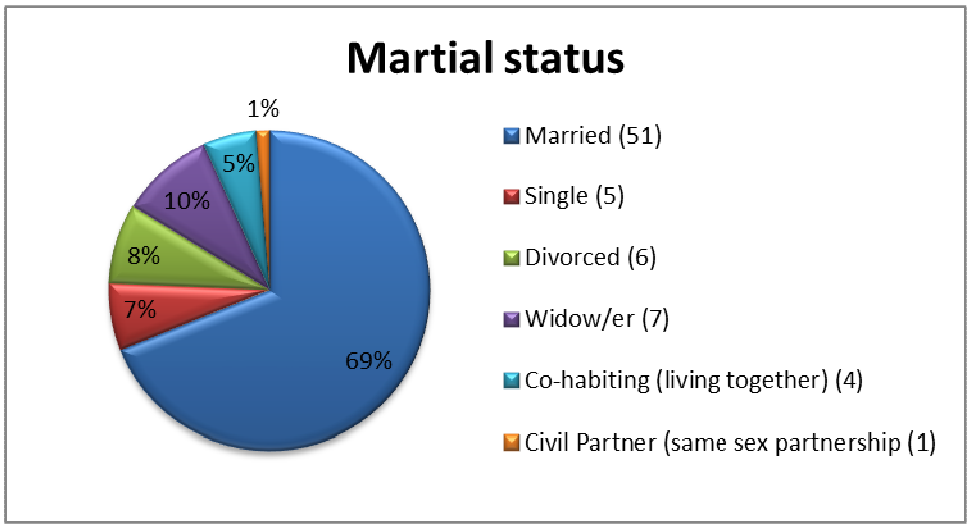


7.4 The youngest person to complete the questionnaire was 32 with the oldest person being 93. The highest proportion of questionnaires was completed by people who had retired from ages 61 to 93 of 64%.

7.5 The questionnaire was returned by 29 (39%) males and 45 (61%) females.

7.6 Respondents were asked about their marital status, and the breakdown of responses is shown in table 24 below.

Table 24

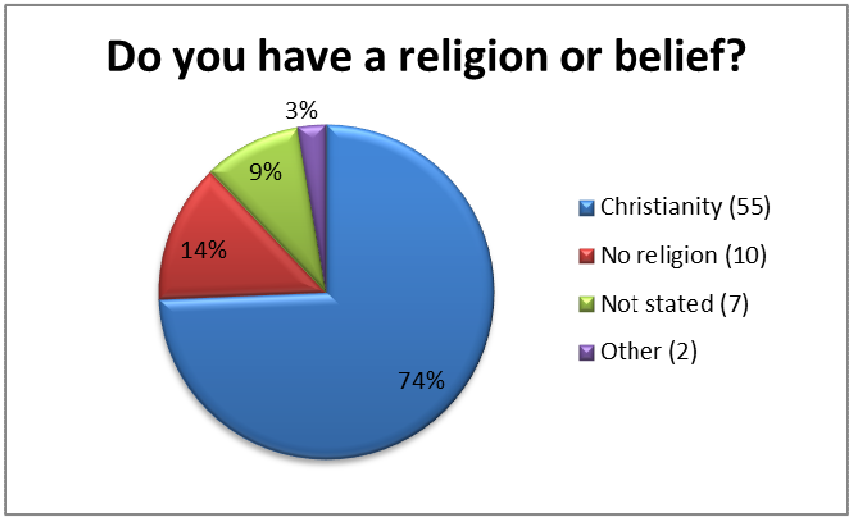


7.7 Respondents were asked whether they considered they have a disability and if so, the type of disability. 12 people (16%) said they had a disability, 58 (78%) said they did not have a disability and six people did not answer this question. Of the 12 people with a disability, ten said it was physical, one person said sensory and one did not state which type of disability.

7.8 Respondents were asked whether they considered themselves to be a carer for either a relative or friend. Two people (3%) did not respond to this question, with six people (8%) saying they were a carer and 66 people (89%) were not a carer.

7.9 Respondents are asked whether they have a religion or belief and the responses to this question are broken down in Table 25.

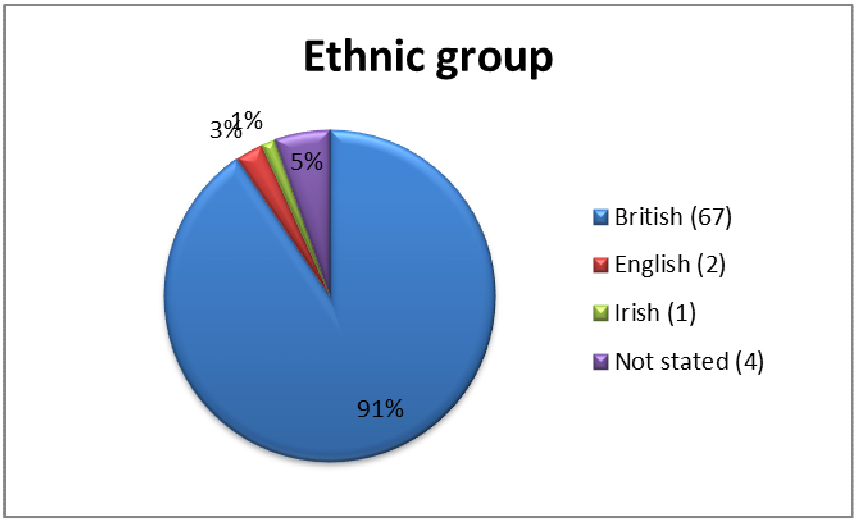
Table 25



7.10 The final question on the monitoring asked for respondent's ethnic group. You will see below in table 26 that 67 people (91%) said they were British with two people (3%) saying they were English. One

person (1%) was Irish and four (5%) people chose not to answer this question.

Table 26



NHS Somerset

ASSESSMENT OF EYECARE SERVICES

Public Questionnaire

As part of the development of Eyecare services within NHS Somerset we are formulating an Eyecare Needs Assessment identifying areas where there is a need for improvement of the eyecare services currently provided. As part of the research for this project we are seeking the opinions of members of the public currently using eyecare services. We would be grateful if you would take a few minutes to answer the questions below about your own experience and views.

- Do not write your name on the survey as all the information you provide is confidential and anonymous

- Please be honest with your answers so we can accurately assess areas where optometrists are already performing well and areas that need improvement

Please hand the completed questionnaire to the optician / optometrist or post to:

Freepost RRKL-XKSC-ACSG
Patient and Public Involvement Team
NHS Somerset
Wynford House
Lufton Way
Yeovil
Somerset
BA22 8HR

Closing date for this questionnaire is **14 December 2012**

Thank you for taking the time to complete this questionnaire

EYECARE NEEDS ASSESSMENT

Patient Questionnaire – November 2012

1. How often have you visited an optician in the last two years?

☐ Once ☐ Twice ☐ More than twice
☐ Don't remember ☐ Never attend

2. In the last two years, did you visit an optician? If so, please indicate why;
tick all that apply

☐ For a routine sight test
☐ For a routine eye health check
☐ For a contact lens check
☐ To purchase or repair/replace spectacles
☐ For monitoring glaucoma
☐ For monitoring cataracts
☐ For monitoring macular degeneration
☐ For monitoring vision in regards to standards required for work or driving
☐ For an emergency eye examination, for example ACES (Acute Community Eyecare Service)
☐ Low Vision Aids
☐ Other, please state

3. If you haven't attended in the last two years, please indicate why not;
tick all that apply

☐ Do not attend routine sight tests
☐ Have not yet made my next appointment
☐ Do not think it is necessary at the moment
☐ Cannot afford spectacles or contact lenses
☐ Do not have time to attend appointments
☐ Other, please state

4. A regular sight test is not just to check whether you need to wear glasses it can actually look into your overall health. An eye check can detect eye conditions which have no symptoms and other conditions such as diabetes

and high blood pressure. Were you aware of this? ☐ Yes ☐ No

5. Do you find the opening times of your local optician convenient?

☐ Yes ☐ No ☐ Don't know

6. What is the most convenient day for you to visit your optician?

☐ Monday to Friday ☐ Weekends ☐ Don't mind

7. What time is most convenient for you to visit your optician?

☐ Morning ☐ Afternoon ☐ Lunchtime
☐ Evening ☐ Don't mind

Other Available Eyecare Services

8. Do you currently attend the Somerset Diabetic Eye Screening Service?

☐ Yes ☐ No ☐ Don't know

If Yes, which location do you normally use? (If **No**, please go to question 9)

Do you have difficulty accessing service? ☐ Yes ☐ No

If Yes, please give explain why in the 'Comments' below

Do you have difficulty getting convenient appointment times?

☐ Yes ☐ No

Is the screening centre in a convenient location? ☐ Yes ☐ No

If No, where would you like to be screened? (Name of town)

How would you rate the service you receive?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

COMMENTS

9. Do you currently attend the Hospital Eye Service (an eye clinic in a hospital)?

☐ Yes ☐ No ☐ Don't know

If Yes, where do you normally attend? (If **No**, please go to question 10)

Was this a routine or an emergency appointment?

☐ Routine ☐ Emergency

Do you have difficulty accessing services? ☐ Yes ☐ No

Do you have difficulty getting convenient appointment times?

☐ Yes ☐ No

Are the hospitals in convenient locations? ☐ Yes ☐ No

Where would you like to be seen? (Name of Community Hospital)

How would you rate the service you receive?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

COMMENTS

10. Do you currently use the Domiciliary Eye Service (home visits for housebound patients)?

☐ Yes ☐ No ☐ Don't know

If Yes, was this for a routine or an emergency appointment?

(If **No**, please go to question 11)

☐ Routine ☐ Emergency

Do you have difficulty getting convenient appointment times?

☐ Yes ☐ No

How would you rate the service you receive?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

COMMENTS

11. Do you know that NHS Somerset provides the Acute Community Eyecare Service (ACES) for Somerset patients needing an emergency eye examination for recently developing eye problems, such as sudden loss of vision or for removal of a foreign body in your eye?

☐ Yes ☐ No

Advice

12. Are you happy with the advice you receive from your optician?

Regarding you spectacle prescription ☐ Yes ☐ No ☐ N/A

Regarding your eye health ☐ Yes ☐ No ☐ N/A

Regarding risk of future eye problems ☐ Yes ☐ No ☐ N/A

Regarding an emergency appointment (ACES) ☐ Yes ☐ No ☐ N/A

OVERALL ☐ Yes ☐ No ☐ N/A

13. How would you rate your confidence in the Optometrists knowledge and advice?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

The Optical Practice You Use

14. Please could we have the name and town of your usual Optical practice or domiciliary eye service provider?

Practice Name

Town

15. How would you rate your overall satisfaction with this practice?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

16. What other eyecare services would you like to be provided by the NHS?

17. Are there any new NHS eyecare services required to meet the needs of the population in your area?

18. Any other comments you would like to make about eyecare services?

A Bit About You

Town/village where you live:

Are you: ☐ Student ☐ Retired ☐ Full time parent/carer

- ☐ Employed full-time
- ☐ Employed part-time
- ☐ Employed (shift worker)
- ☐ Self-employed
- ☐ Seeking employment
- ☐ Choose not to work
- ☐ Unable to work due to disability/ill health

NHS Somerset is committed to providing equal access to healthcare services to all members of the community. To achieve this, gathering the following information is essential and will help us ensure that we deliver the most effective and appropriate healthcare. **Responding to these questions is entirely voluntary and any information provided will remain anonymous.**

What is your age? please write in the box below ☐ Prefer not to state

What is your gender? ☐ Prefer not to state

☐ Male ☐ Female

Do you/have you ever identified yourself as trans or transgender? ☐ Prefer not to state

☐ Yes ☐ No

What is your status? ☐ Prefer not to state

☐ Single ☐ Married ☐ Divorced
☐ Widow(er) ☐ Separated ☐ Co-habiting (living together)
☐ Civil partnership (same sex partnership) ☐ Other

Are you a carer? for a relative or friend ☐ Prefer not to state

☐ Yes ☐ No

Are you pregnant or have you had a baby in the last six months? ☐ Prefer not to state

☐ Yes ☐ No ☐ Not applicable

Which of the following best describes how you think of yourself? ☐ Prefer not to state

☐ Heterosexual (attracted to the opposite sex) ☐ Bisexual (attracted to both sexes)
☐ Lesbian/Gay (attracted to the same sex) ☐ Other

Do you consider that you have a disability? ☐ Prefer not to state

☐ Yes ☐ No ☐ I don't know

If yes, how would you describe your disability? ☐ Prefer not to state

☐ Sensory ☐ Learning ☐ Mental Health
☐ Physical ☐ Other

Do you have a religion or belief? ☐ Prefer not to state

☐ Buddhism ☐ Islam ☐ No Religion
☐ Christianity ☐ Judaism ☐ Other Religion/Belief
☐ Hinduism ☐ Sikhism

Please tell us your ethnic group ☐ Prefer not to state

White ☐ British ☐ Irish
☐ Gypsy, Romany or other traveller heritage
☐ Any other White background, please state

Dual-Heritage ☐ White and Black Caribbean
☐ White and Asian ☐ White and Black African
☐ Any other Dual-Heritage, please state

Asian or Asian British ☐ Indian ☐ Pakistani
☐ Bangladeshi
☐ Any other Asian background, please state

Black or Black British ☐ Caribbean ☐ African ☐ Any other Black background, please state	
Chinese or other ethnic group ☐ Chinese ☐ Any other ethnic background, please state	

NHS Somerset

EYECARE NEEDS ASSESSMENT

Results of the Optometrist Questionnaire – February 2013

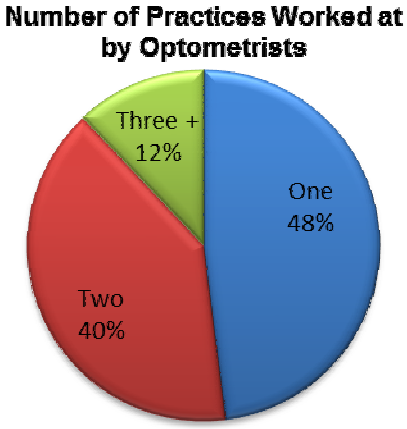
Summary of Quantitative Results

25 optometrists completed the questionnaire.

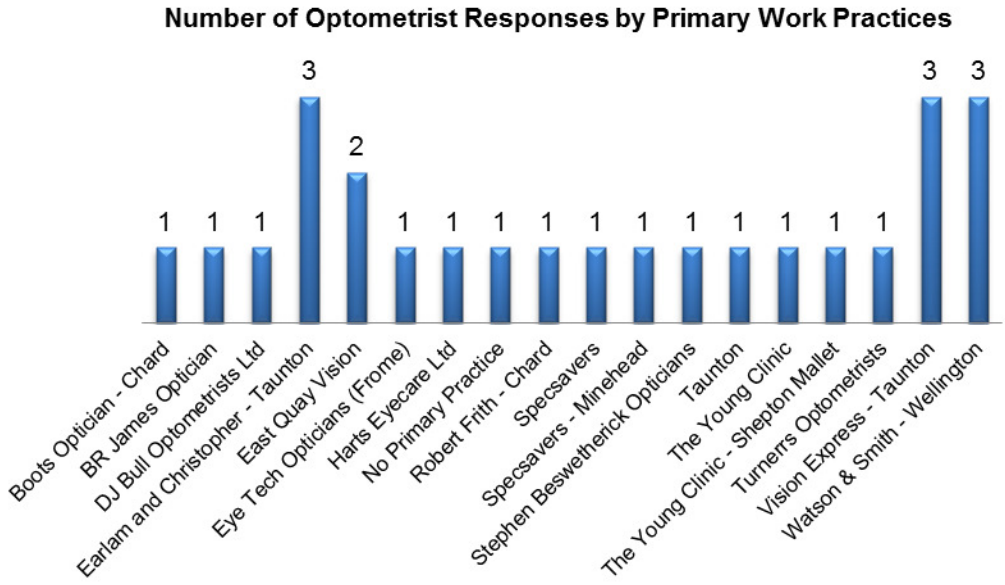
About You

Q1 - Number of Practices regularly worked in by Optometrists

Responses	No. of Optometrists
One	12
Two	10
Three +	3
Total	**25**

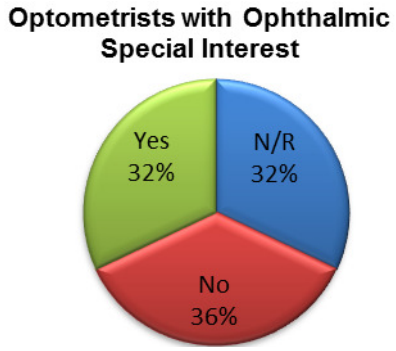


Q2 – Primary Work Practice



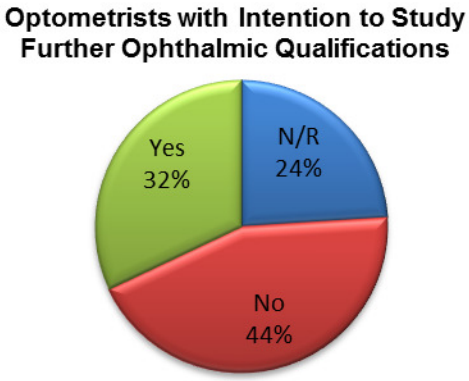
Q3 - Ophthalmic Special Interest (Supported by relevant Qualifications)

Responses	No. of Optometrists
Yes	8
No	9
No Response	8
Total	**25**



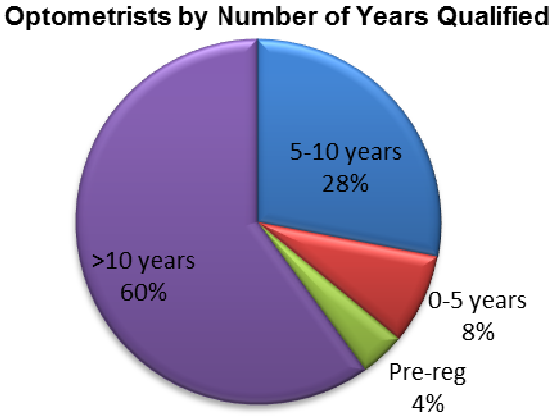
Q4 – Intention to Study Further Ophthalmic

Responses	No. of Optometrists
Yes	8
No	11
No Response	6
Total	**25**



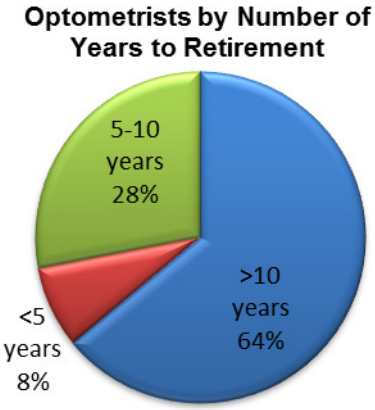
Q5 – Number of Years Dentist has been Qualified

Responses	No. of Optometrists
Pre-Reg	1
0-5 years	2
5-10 years	7
>10 years	15
Total	**25**



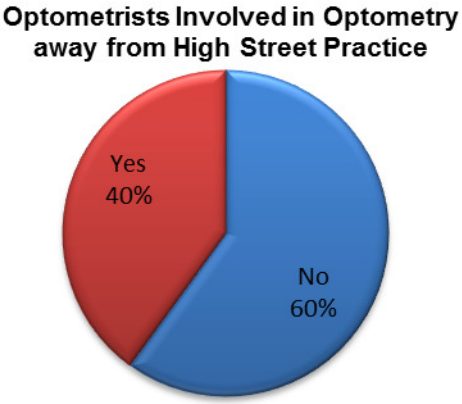
Q6 – Plan to Retire from High Street Practice

Responses	No. of Optometrists
<5 years	2
5-10 years	7
>10 years	16
Total	**25**



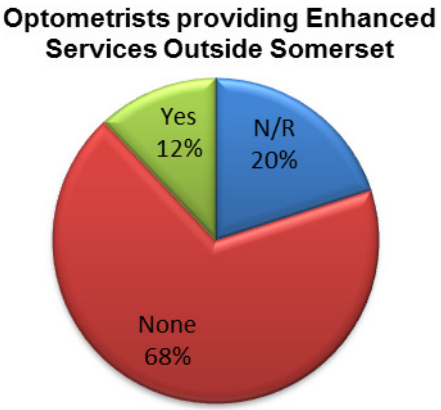
Q7 – Involvement in Optometry away from High Street Practice

Responses	No. of Optometrists
Yes	10
No	15
Total	**25**



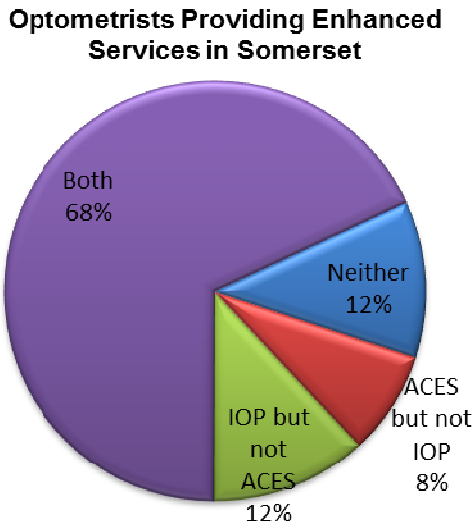
Q8 – Enhanced Services Provided Outside Somerset

Response	No. of Optometrists
No Response	5
None	17
Yes	3
Total	**25**



Q9 – Enhanced Services Provided in Somerset (ACES & IOP)

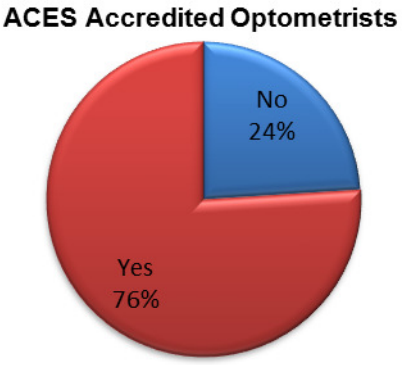
Responses	No. of Optometrists
Neither	3
ACES but not IOP	2
IOP but not ACES	3
Both	17
Total	**25**



Current Enhanced Services - ACES

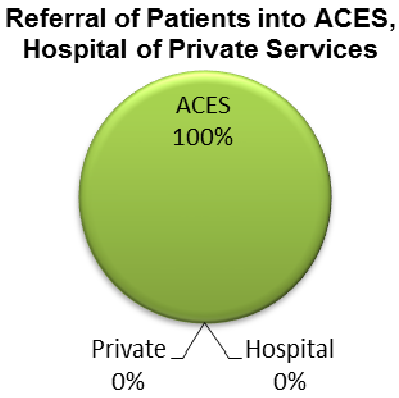
Q11 – ACES Accreditation

Responses	No. of Optometrists
Yes	19
No	6
Total	**25**



Q12 – Referral of Patients into ACES or Other Services (if not accredited)

Response	No. of Optometrists
ACES	6
Hospital	0
Private	0
Total	**6**

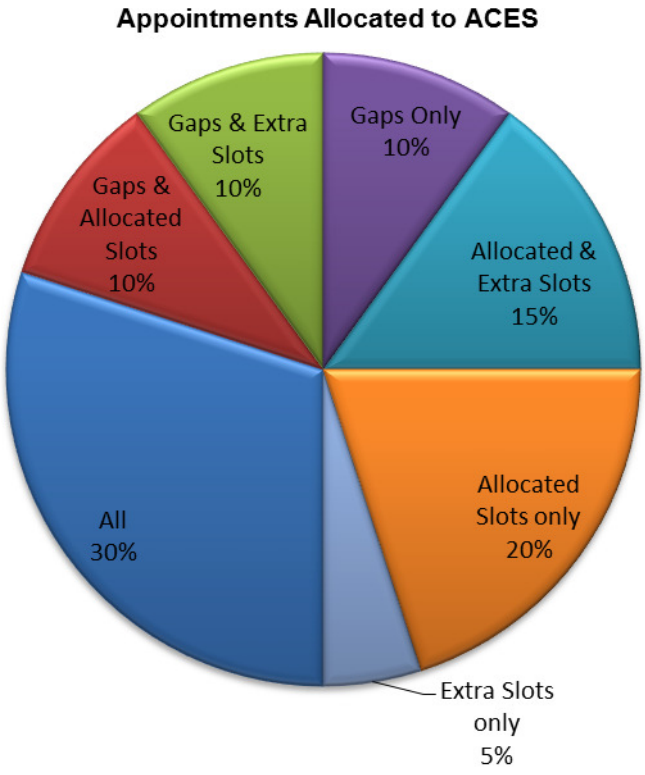


Q13 – Difficulty in Obtaining ACES Appointments for Referrals

Responses	No. of Optometrists
Yes	0
No	12
Total	**12**

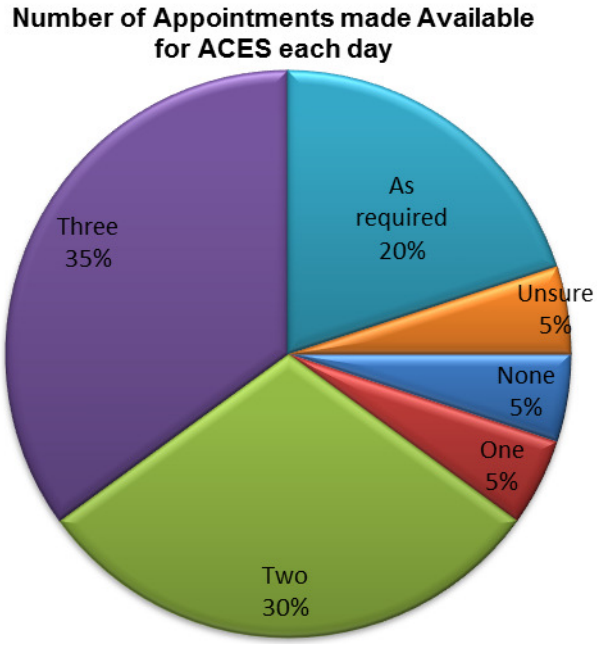
Q14 – Provision of ACES Appointments

Responses	No. of Optometrists
Gaps, Allocated & Extra Slots	6
Gaps & Allocated Slots	2
Gaps & Extra Slots	2
Gaps Only	2
Allocated & Extra Slots	3
Allocated Slots only	4
Total	**20**



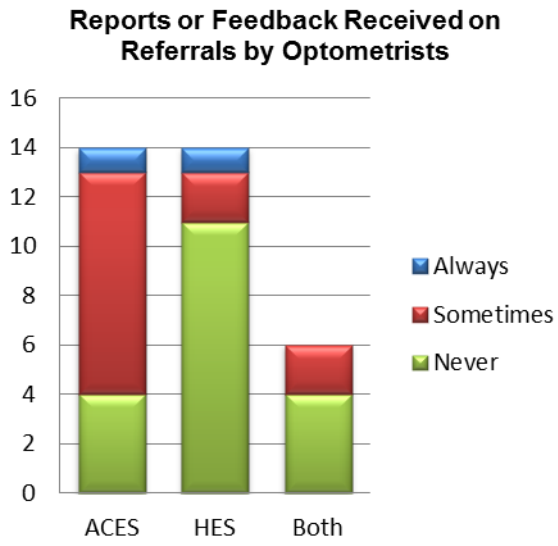
Q15 – Number of ACES Appointments made Available each Day

Responses	No. of Optometrists
None	1
One	1
Two	6
Three	7
As required	4
Unsure	1
Total	**20**



Q16 – Reports or Feedback received on Referrals

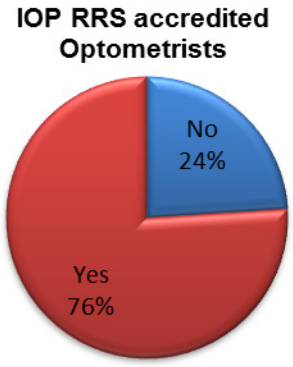
Responses	Always	Sometimes	Never
ACES	1	9	4
HES	1	2	11
Both	0	2	4
Total	**2**	**13**	**19**



Current Enhanced Services – IOP RRS

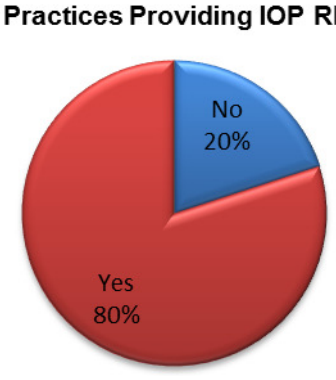
Q17 – IOP RRS Accreditation

Responses	No. of Optometrists
Yes	19
No	6
Total	**25**



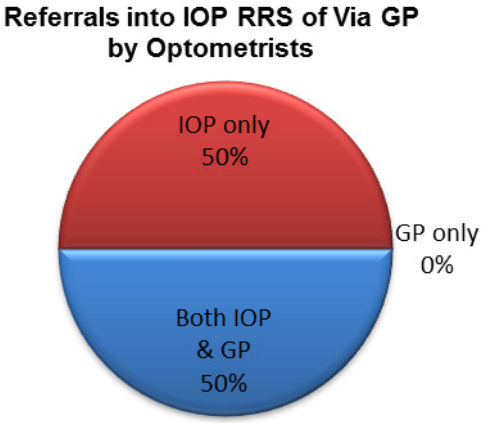
Q18 – Practices currently providing IOP RRS

Responses	No. of Optometrists
Yes	20
No	5
Total	**25**



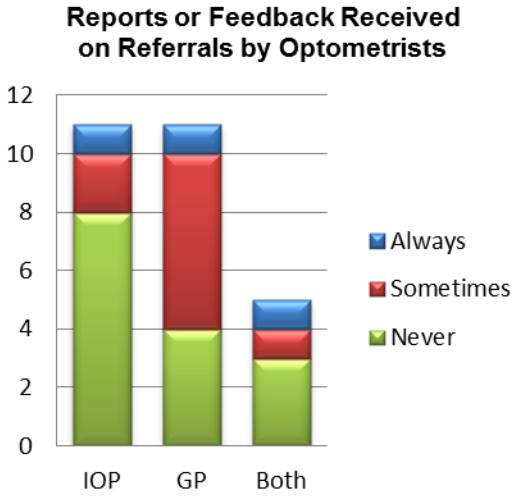
Q19 – Referral of Patients into IOP RRS or via GP

Responses	No. of Optometrists
Both IOP & GP	1
IOP only	1
GP only	0
Total	**25**



Q20 – Reports or Feedback received on Referrals

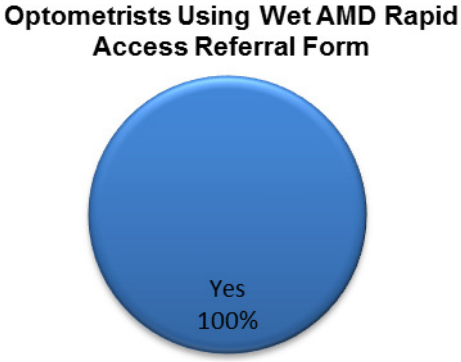
Responses	Always	Sometimes	Never
ACES	1	9	4
HES	1	2	11
Both	0	2	4
Total	**2**	**13**	**19**



Current Enhanced Services – AMD

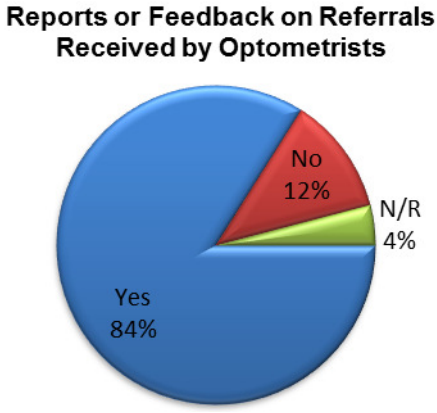
Q21 – Use of Wet AMD Rapid Access Referral Form

Responses	No. of Optometrists
Yes	25
No	0
Total	**25**



Q22 - Reports or Feedback received on Referrals

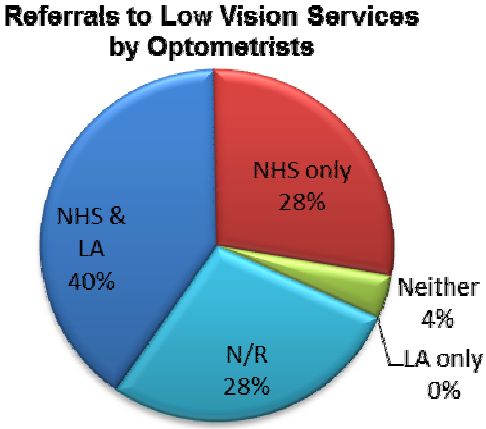
Responses	No. of Optometrists
Yes	21
No	3
No Response	1
Total	**25**



Current Enhanced Services – Low Vision

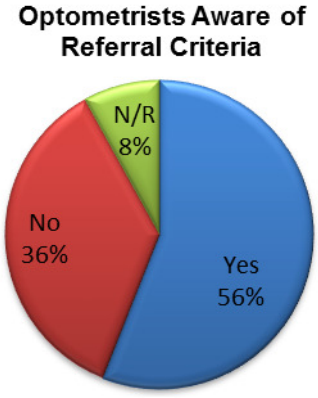
Q23 – Referrals to NHS or Local Authority Low Vision Services

Responses	No. of Optometrists
NHS & LA	10
NHS only	7
LA only	0
Neither	1
No Response	7
Total	**25**



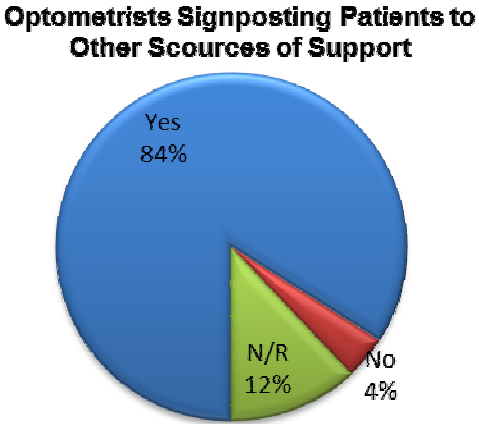
Q24 – Awareness of Referral Criteria

Responses	No. of Optometrists
Yes	14
No	9
No Response	2
Total	**25**



Q25 – Signposting Patients to Other Sources of Support

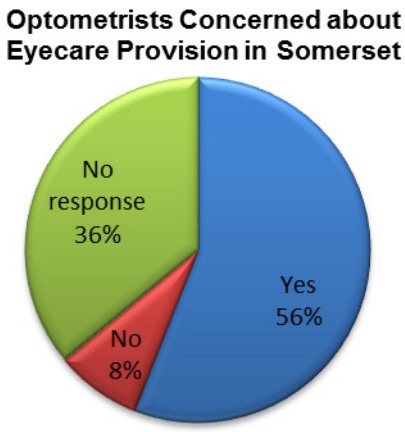
Responses	No. of Optometrists
Yes	14
No	9
No Response	2
Total	**25**



General

Q26 – Concerns about Eyecare Provision in Somerset

Responses	No. of Optometrists
Yes	14
No	2
No Response	9
Total	**25**



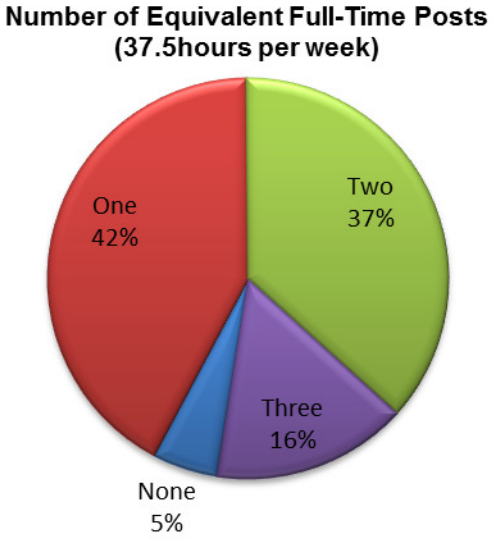
About Your Main Practice

Q31 – Number of Optometrists Employed by Practice

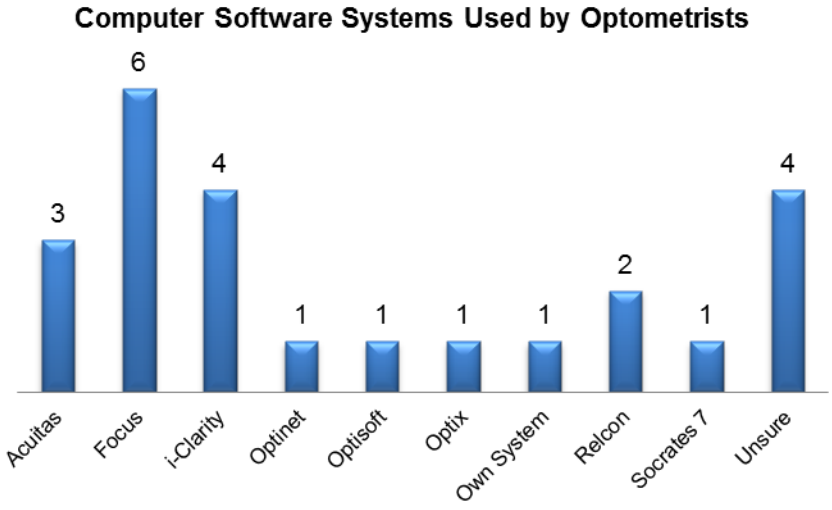
Responses	No. of Optometrists
One	3
Two	8
Three	5
Four	3
Five	1
Total	**25**

Q32 – Number of Full-Time Posts (Equivalent to 37.5 hours per week)

Responses	No. of Optometrists
One	8
Two	7
Three	3
None	1
Total	**25**

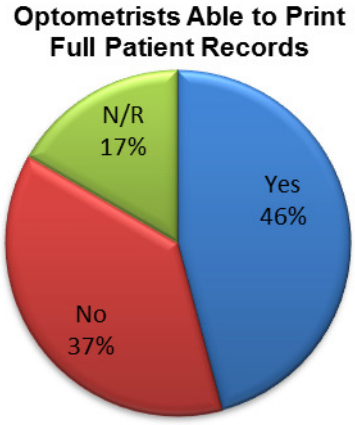


Q33 – Optometry Computer Software Systems Used



Q34 – Software System Able to Print Full Patient Records

Responses	No. of Optometrists
Yes	11
No	9
No Response	4
Total	**25**



Produced by
Lisa Jones
Primary Care Development Assistant

NHS Somerset

ASSESSMENT OF EYECARE SERVICES

Optometrist Questionnaire

As part of the development of eyecare services in Somerset we are undertaking an Eye Health Needs Assessment, which aims to identify current and future eye health needs and identify any gaps in service provision. We have undertaken a patient survey and are now seeking the opinions of optometrists and will be pleased if you will take a few minutes to answer the questions below.

The results of the collated information will be shared with the Local Optical Committee (LOC).

- You are not required to give your name
- Please be honest with your answers so we can accurately assess areas where optometrists are already performing well and areas that need improvement

Please post the completed questionnaire to:

Freepost RRKL-XKSC-ACSG
Patient and Public Involvement Team
NHS Somerset
Wynford House
Lufton Way
Yeovil
Somerset
BA22 8HR

Closing date for this questionnaire is **21 February 2013**

Thank you for taking the time to complete this questionnaire

EYECARE NEEDS ASSESSMENT

Optometrist Questionnaire – January 2013

Please answer in relation to the Somerset practice where you work the most

About You

1. How many practices do you regularly work in, in Somerset?

   ☐ One ☐ Two ☐ More than two

2. In which practice do you work primarily?

   Practice Name:

3. Do you have any areas of ophthalmic special interest, supported by relevant qualifications?

   If Yes, please provide details

4. Are you or do you intend to study for further ophthalmic qualifications?

   If Yes, please give details

5. How long have you been qualified?

   ☐ Pre-reg ☐ 0-5 years ☐ 5-10 years ☐ > 10 years

6. Do you plan to retire from high street practice in the near future?

   ☐ less than 5 years ☐ 5-10 years ☐ > 10 years

7. Are you involved in optometric work away from high street practice, for example in a hospital setting?

   ☐ Yes ☐ No

If **Yes**, please indicate where and the type of work undertaken

8. Which enhanced services if any, do you regularly provide outside of Somerset?

9. Which enhanced services are provided by the main practices you work in within Somerset?

☐ ACES ☐ IOP RRS

10. If enhanced services are not provided**,** please indicate why, for example are there any particular challenges for the practice in providing services, other than GOS?

Current Enhanced Services - ACES

11. Are you accredited to provide ACES?

☐ Yes ☐ No

If **No**, and you would like to be, please contact the Somerset LOC by e-mailing charles@jclconsulting.co.uk

12. If you are not accredited to provide ACES do you refer patients into the service?

☐ Yes ☐ No

If **No**, how do you manage patients with acute eye conditions?

Treat privately ☐ Yes ☐ No

Refer to Hospital Eye Service ☐ Yes ☐ No

Other:

13. When wishing to refer a patient, do you have difficulty getting an ACES appointment?

☐ Yes ☐ No

If your practice is not providing ACES, go to question 7

14. How does the practice organise its ACES appointments?

(Tick all that apply)

☐ Only use gaps in appointment book ☐ Keep slots free each day

☐ Fit extra appointments in lunch time or at end of day

Other:

15. How many ACES appointments does the practice aim to make available each day?

16. Do you or the practice receive a report or feedback regarding your referrals:

- from the Hospital Eye Service: ☐ Always ☐ Sometimes ☐ Never
- from ACES: ☐ Always ☐ Sometimes ☐ Never

PLEASE ADD ANY FURTHER COMMENTS

Current Enhanced Services – IOP RRS

17. Are you accredited to provide IOP RRS?

☐ Yes ☐ No

If **No**, and you would like to be, please contact the Somerset LOC by e-mailing charles@jclconsulting.co.uk

18. Is the practice currently providing IOP RRS?

☐ Yes ☐ No

If No, please indicate why (See ACES question)

19. If not providing the service, does your practice:

Refer to another practice providing the service ☐ Yes ☐ No

Refer via GP ☐ Yes ☐ No

20. Do you or the practice receive a report or feedback regarding your referrals:

- from other practice ☐ Always ☐ Sometimes ☐ Never
- via GP ☐ Always ☐ Sometimes ☐ Never

PLEASE ADD ANY FURTHER COMMENTS

Current Services - AMD

21. Do you currently use the wet AMD Rapid Access Referral form?

☐ Yes ☐ No

If No, please indicate why

22. Do you or the practice receive a report or feedback regarding your referrals?

☐ Yes ☐ No (See other similar question)

Current Services – Low Vision

23. Do you refer patients into the following Low Vision Services in Somerset provided by:

NHS ☐ Yes ☐ No

Local Authority ☐ Yes ☐ No

24. Are you aware of the criteria for referring patients into either of the services?

☐ Yes ☐ No

25. Do you signpost patients to other sources of support, for example Somerset Sight

☐ Yes ☐ No

PLEASE ADD ANY FURTHER DETAILS

General ***(continue on separate sheet if more space needed)***

26. Do you have any concerns about any aspect of Eyecare provision in Somerset?

COMMENTS

27. Are there any specialist roles that could be developed in primary care?

COMMENTS

28. How can we develop and maintain an effective workforce?

COMMENTS

29. What do you see as the 3 main priorities in the development of eyecare services in Somerset over the next 5 years?

COMMENTS

30. How can we continue to enhance the reputation of Optometry in Somerset?

COMMENTS

About Your Main Practice (liaise with your practice manager/contractor)

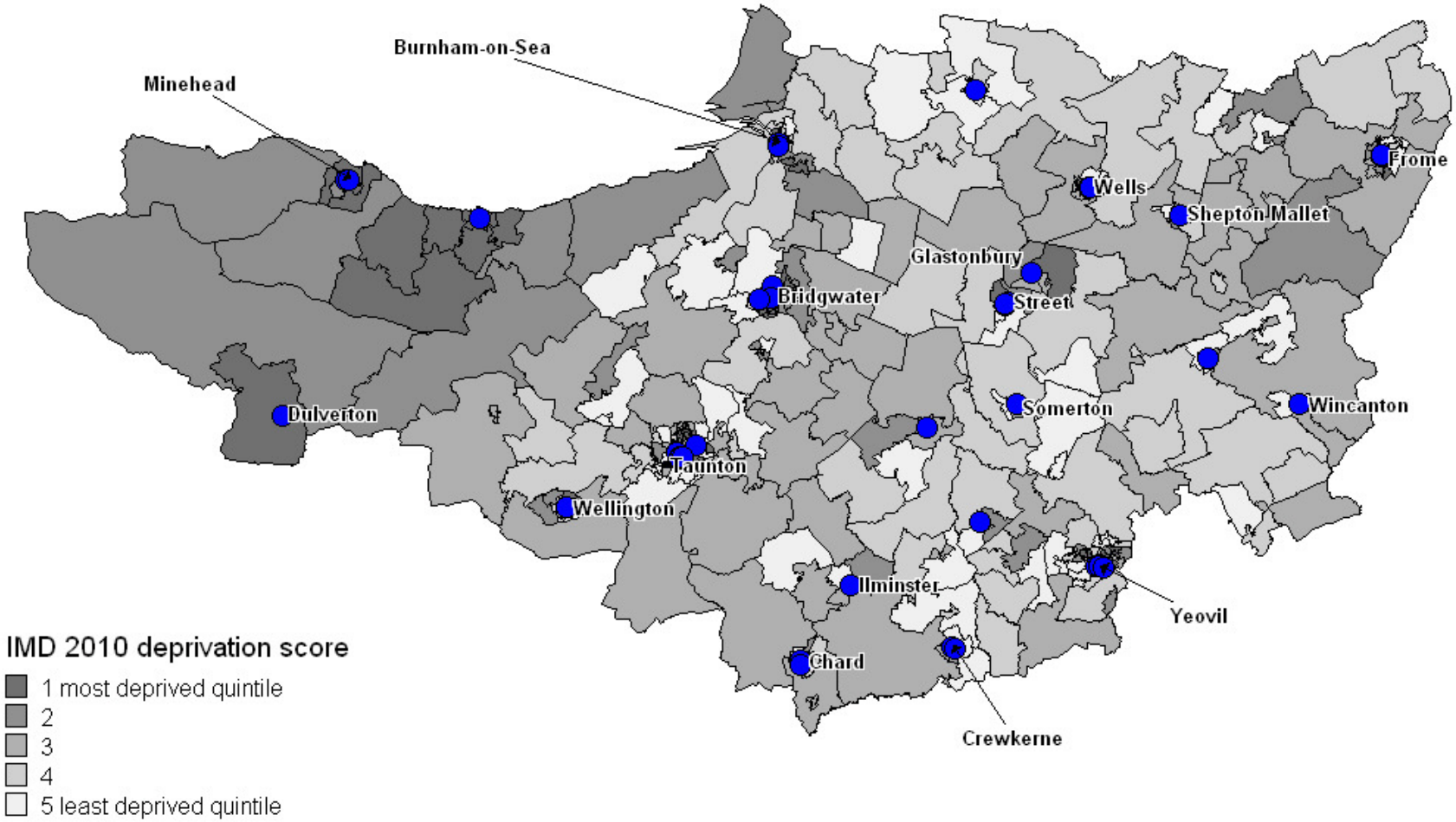
31. How many employed optometrists work in your practice?

32. What is the number of full-time equivalent posts, based on 37.5 hours per week?

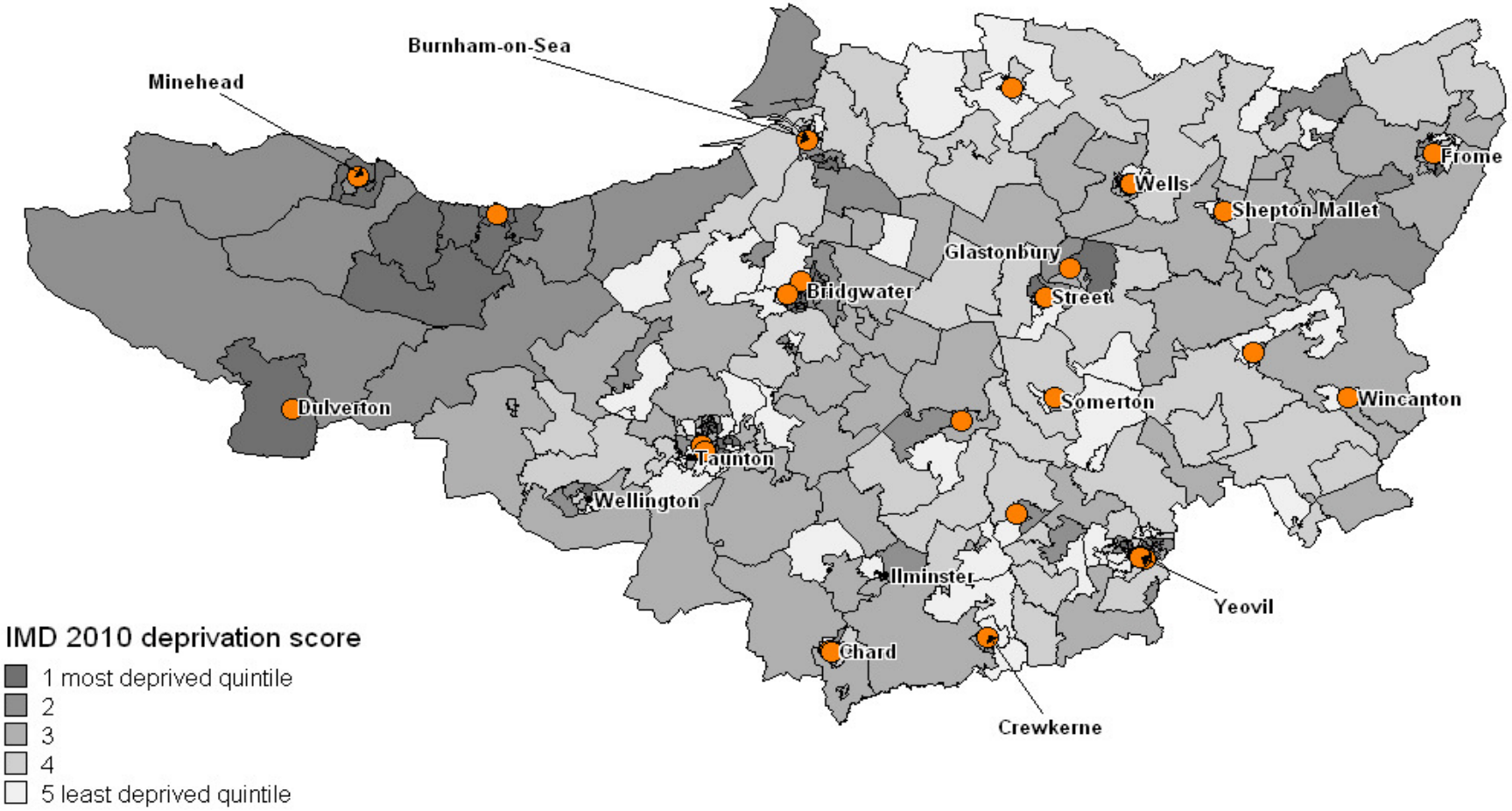
33. Which optometry computer software system does the practice use?

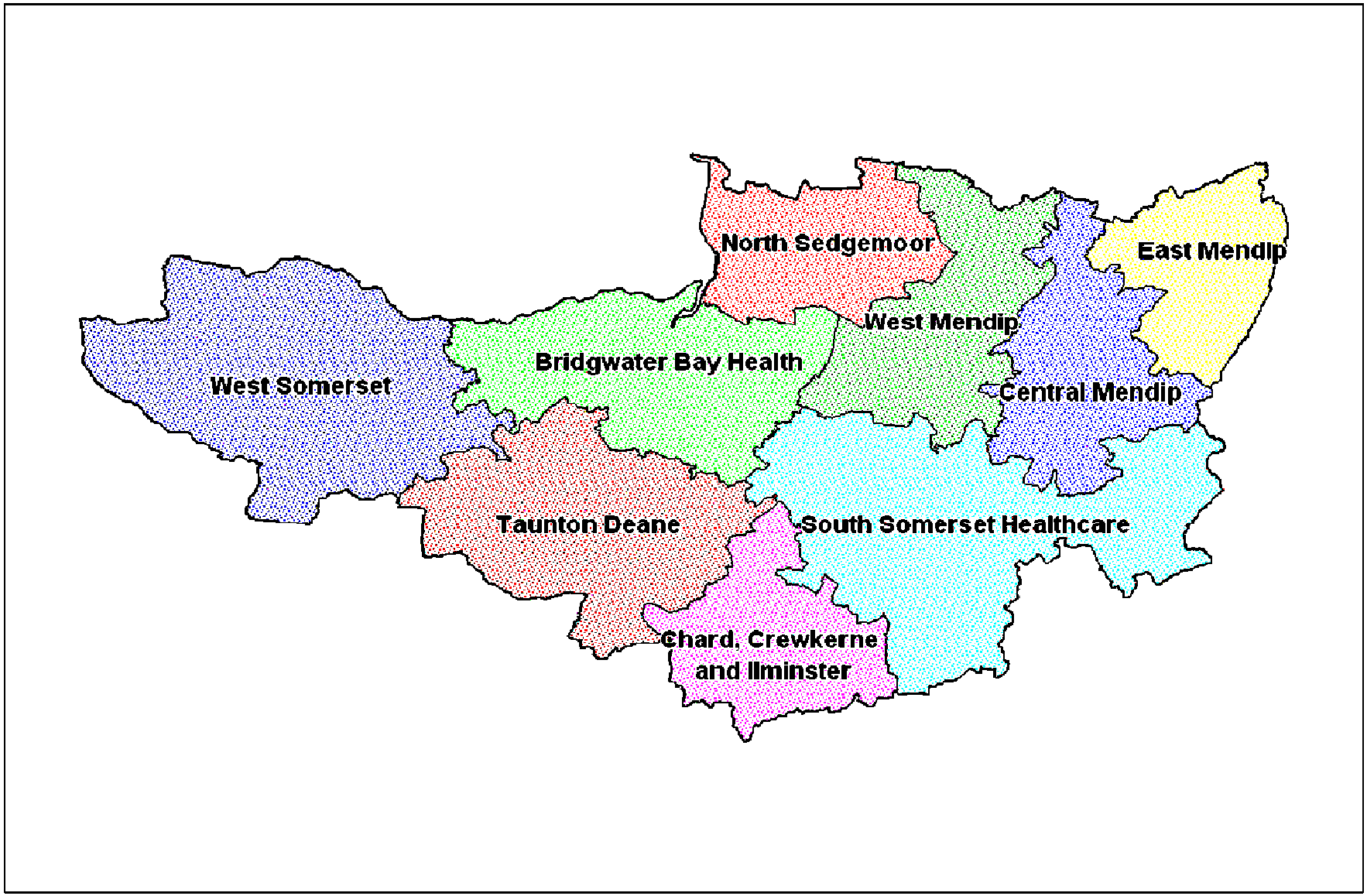
34. Does the IT system include provision to print full patient records to support clinical audit? ☐ Yes ☐ No

OPTOMETRIST PRACTICES SEPTEMBER 2012
MANDATORY SERVICES



OPTOMETRIST PRACTICES SEPTEMBER 2012
ACES SERVICES




North Sedgemoor
East Mendip
West Mendip
Bridgwater Bay Health
West Somerset
Central Mendip
Taunton Deane
South Somerset Healthcare
Chard, Crewkerne
and Ilminster

Name of Optometric Practice	Town	General Ophthalmic Mandatory and Additional Services
Cranmers	Minehead	Y
Millican's Eye Centre	Wells	Y
East Quay Vision	Bridgwater	Y
Eyetech	Frome	Y
NK Opticians	Cheddar	Y
Robert Frith Optometrists	Castle Cary	Y
Robert Frith Optometrists	Chard	Y

OPTOMETRIST PRACTICES PROVIDING ENHANCED SERVICES IN SOMERSET

APPENDIX 8

Name of Optometric Practice	Town	Enhanced Services		
		Acute Community Eyecare Service	Intra Ocular Pressure Referral Refinement Service	Ocular Hypertension Monitoring Service
B R James Opticians	Minehead	Y	Y	Y
Boots Opticians	Chard	Y	Y	Y
Boots Opticians	Frome		Y	
Boots Opticians	Street		Y	
Boots Opticians	Taunton	Y		
Boots Opticians	Yeovil	Y	Y	
Cranmers	Minehead	Y	Y	Y
DJ Bull	Burnham-on-Sea	Y	Y	Y
David Kneebone	Somerset	Y	Y	Y
Earlam & Christopher	Langport	Y	Y	
Earlam & Christopher	Taunton	Y	Y	Y
East Quay Vision	Bridgwater	Y	Y	Y
Eyetech	Frome	Y	Y	Y

Eyetech	Frome Medical Centre	Y	Y	Y
Eyetech	Street	Y	Y	Y
Harts Eyecare	Yeovil	Y	Y	Y
Martock	Martock	Y	Y	
Max Davison	Dulverton	Y	Y	Y
Max Davison	Watchet	Y	Y	Y
Millican's Eye Centre	Wells	Y	Y	
NK Opticians	Cheddar	Y	Y	Y
RA Mansfield	Wells	Y	Y	Y
Robert Frith Optometrists	Castle Cary	Y	Y	Y
Robert Frith Optometrists	Chard	Y	Y	Y
Robert Frith Optometrists	Crewkerne	Y	Y	Y
Robert Frith Optometrists	Glastonbury	Y	Y	Y
Robert Frith Optometrists	Wincanton		Y	Y
Robert Frith Optometrists	Yeovil	Y	Y	Y
Sarah Gibson Optometrist	Wincanton	Y		

Specsavers	Bridgwater		Y	
Specsavers	Burnham-on-Sea	Y	Y	Y
Specsavers	Chard		Y	Y
Specsavers	Frome		Y	
Specsavers	Street		Y	
Specsavers	Taunton		Y	
Specsavers	Wells	Y	Y	
Specsavers	Yeovil		Y	
Stephen Beswetherick	Chard		Y	Y
The Young Clinic	Shepton Mallet	Y	Y	Y
Turners Optometrists	Bridgwater	Y		
Vision Express	Taunton	Y	Y	
Vision Express	Wells	Y		
Watson & Smith Opticians	Taunton		Y	