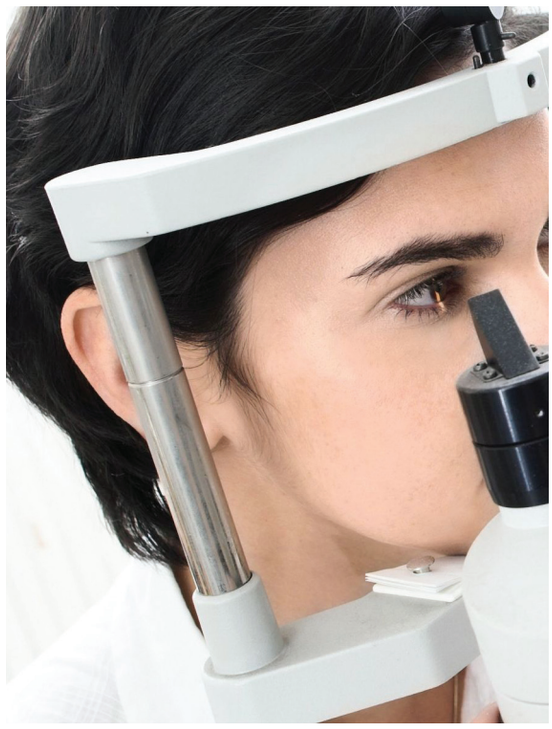
OPHTHALMOLOGY

SEEING THE HIGH STREET'S POTENTIAL

The demand on secondary care for eye care services has never been higher but much can be done within primary care to take the strain, as Jennifer Trueland explains



Eye health is one of the great 21st century successes, with new technologies and treatments available to prevent or even reverse loss of sight.

But while this is fantastic for individuals and their families, it's a potential headache for the NHS. Rising demand is placing a huge burden on secondary care services; according to the Royal College of Ophthalmologists, eye clinic attendances in England increased by 30 per cent over the last five years.

It's a perfect storm, says college president Carrie MacEwen: an ageing population is developing eye problems, for which there are now treatments, causing hugely increased demand with no appreciable rise in resources.

What's more, these therapies often require long-term care – and if patients don't get timely treatment and follow-up, they are at risk of further sight loss. While devastating for individuals, this also has knock-on costs for social care (as people lose independence), and, with consequences of sight loss including falls and accidents, costs the NHS dearly, too.

This is real and it's happening. In April, for example, *HSJ* reported that East Kent Hospital University Foundation Trust said its department was "overwhelmed", with a backlog of patients.

And it's by no means alone. Research by the National Reporting and Learning System identified almost 500 incidents of loss or deterioration from delays in follow-up between 2011 and 2013 in England and Wales. The college is conducting its own study, and early findings suggest that at least 20 patients per month suffer sight loss from delays.

'We have overcrowded hospital services, while this primary care workforce is under-utilised. This simply doesn't make sense'

"In lots of ways it is a good news story," says Professor MacEwen. "We're able to give people treatments that are really making a difference to their lives. But there is a huge rise in demand on eye clinics, and action is needed to optimise effective patient care."

According to Dharmesh Patel, chair of the Greater Manchester Local Eye Network, the NHS should be looking to the high street optical practice – and the expertise within – to reduce pressure on secondary care, while offering patients care closer to home (incidentally one of the aims of the *Five Year Forward View*).

For example, minor eye conditions services (MECS), run by local optical practices for the NHS, allow patients to be seen quickly for a range of conditions, without having to go to hospital.

Among many other roles, Mr Patel represents primary care on the strategic partnership board of Greater Manchester Health & Social Care Partnership, which means he's intimately involved in the Manchester devolution initiative. But an optometrist with his own practice, he is personally at the sharp end of providing NHS eye services in the community, as well as influencing wider service transformation across Greater Manchester.

"It's an exciting time for eye health because there are fantastic new technologies that are saving people's sight. But that also means increasing demand on the NHS," he says. "The challenge is ensuring that the system can cope with this level of demand – and making sure that delays in follow-up don't lead to loss of sight."

Hotch potch

The current commissioning environment in England does not make it easy to respond to demand, he says. "It's a complex picture. There are more than 200 CCGs responsible for commissioning ophthalmology, while NHS England is responsible for NHS eye tests in primary care. It's fragmented.

"Then, there are a lot of professions involved in eye care; a real hotch potch of people. But I believe that those who are working in primary care, particularly optometrists, can add real value to the sector.

"But currently we have overcrowded hospital services, while this primary care

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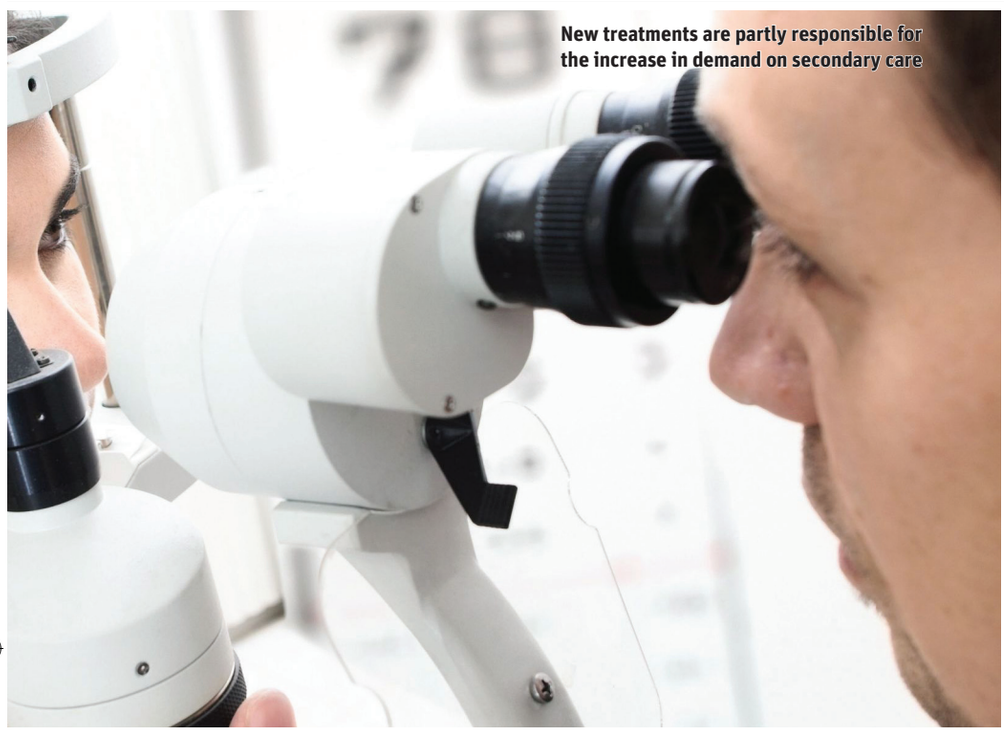

New treatments are partly responsible for the increase in demand on secondary care

workforce is under-utilised. This simply doesn't make sense."

He runs a minor eye conditions service in his own practice, and is promoting the concept throughout Greater Manchester. "We're talking about minor, low risk work, at a place and time that's convenient for the patient. The primary care workforce has the equipment, and it has the knowledge, and is able to respond quickly."

Indeed, as well as the minor conditions (such as red eye or floaters) that are the meat and drink of MECS, he believes that more can and should be done in primary care, including some less serious glaucoma care, and follow-up for people who have had cataract operations.

A great deal to offer

Wolverhampton CCG is among those to have taken the decision to commission a community eye service, with a contract that includes MECS.

In the first full year, A&E activity was down 2 per cent – all the more remarkable since this followed successive years of increases, including a 4 per cent rise the year before the new service came into being.

The CCG has also reported a fall in outpatient appointments, and GPs have welcomed the service, referring eye cases through MECS. An audit of the service has shown it is working effectively, is managing 80 per cent of patients in the community, while making appropriate referrals.

Helen Hibbs, clinical accountable officer with Wolverhampton CCG, says the new service started in 2014 after a procurement process was won by a primary eyecare company (a model similar to GP federations).

"We commission it from a group of 28 local opticians, which involves 50 professionals. Demand [on secondary care] is going down slightly, but we believe it would have gone up even more had we not introduced the new service. And the good thing is that patients really like it – 99 per cent of them are happy. It's easier for patients, it's closer to home, and they don't have to wait for ages. And I think it's a good use of ophthalmic practitioners, too."

Mr Patel points to a similar MECS network in Stockport which manages more than three quarters of patients in primary care without the need for referral to hospital. But nationally, he wants to see many more.

Collaborative commissioning would be one solution to the current fragmented landscape, and sorting out IT would be another, he adds.

But the overarching issue is bringing primary care eye services firmly under the NHS banner. "We are part of the NHS and have a great deal to offer." ●

KATRINA VENERUS ON CCGS' NEED TO FOCUS ON OPTOMETRISTS

With many column inches devoted to pressures in general practice and on the hospital eye service, tapping into the skills of optometrists in high street optical practices is an obvious part of the solution.

Every year there are around seven million ophthalmology outpatient appointments, along with five million GP and 400,000 A&E eye-related visits in England. Yet a significant proportion of these could be delivered by optometrists and meet the key aims of the *Five Year Forward View* to dissolve traditional boundaries, use the most appropriate health professional and deliver care closer to home.

A recent study suggested that primary care as currently delivered in England could be reaching saturation point. When it comes to eye problems, universal commissioning of ready-made solutions such minor eye conditions services would allow the community optometrist to become the first point of contact for patients with non-emergency eye problems, taking the strain off GPs and mirroring the arrangements in place in Scotland and Wales.

With the burgeoning capacity problems hospital eye services are facing, it is also time to scale up services to deliver routine follow-ups in the community for patients with conditions such as glaucoma. Where these services exist, patients with low risk conditions are identified by the consultant ophthalmologist as suitable for management by trained optometrists in practices that have the required equipment.

At the Local Optical Committee Support Unit (LOCSU) we support community optometrists and opticians to work with commissioners, acute trusts and other stakeholders to redesign local care pathways and have developed a suite of national pathways and other tools to facilitate change. Such is the growing demand for this support that we have recently doubled the size of our dedicated team that advises on eye care commissioning.

To their credit, around 30 per cent of CCGs in England have already commissioned the LOCSU MECS pathway (or an equivalent), meaning that patients with eye problems who contact their GP surgery can be directed to the network of local optical practices for an assessment. However, the current piecemeal approach to commissioning has resulted in fragmentation of services, with patient access being dependent on which CCG their GP belongs to.

CCGs working together over a large footprint is the answer to a more cost-effective and efficient approach to commissioning eye services, something we hope will be addressed by the sustainability and transformation plans.

Katrina Venerus is managing director of LOCSU. www.locsu.co.uk