Summary

Are you answering on behalf of an organisation?

Yes	1	*(Orthoptic Service, Nobles Hospital)*
No	47	
Not Answered	1	

May we publish your response?

No, please do not publish my response	8	16%
Yes, you can publish my response in full	10	20%
Yes, you may publish my response anonymously	31	63%

Most Popular Answers

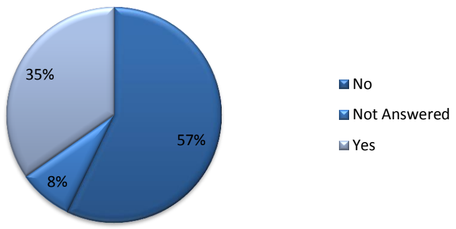
Q1	No	**Q6 (2)**	Both
Q2	Yes	**Q7**	Yes
Q4	No	**Q8**	No
Q5	Yes	**Q10**	No
Q6 (1)	Yes		

There were **52** respondents

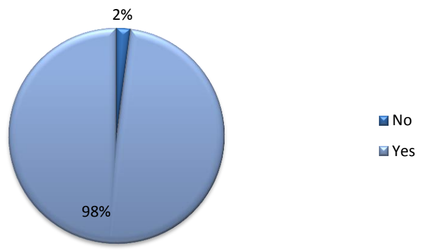
49 online responses and **3** paper responses*

100% of online respondents visited every page of the consultation

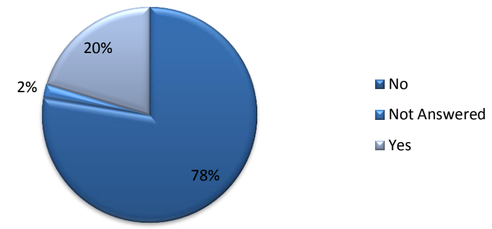
Are the needs of at risk groups currently being met?



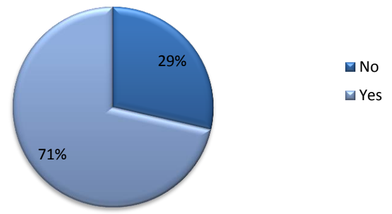
Should optometrists be able to refer directly to Noble's?



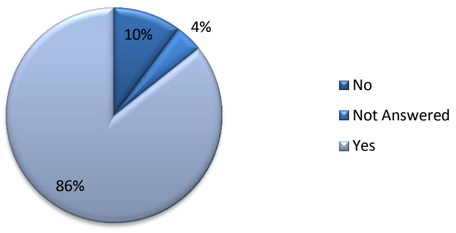
Are there any reasons why these services should not be provided within primary care?



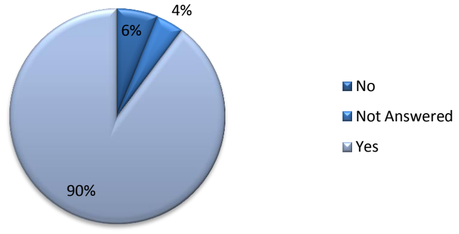
Where a locally provided service is available, should patients who choose to be seen in the UK have to pay for their own treatment and travel costs?



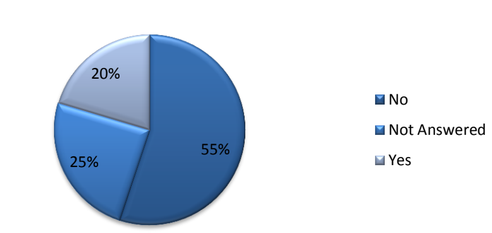
Should the Department be providing annual diabetic retinopathy screening?



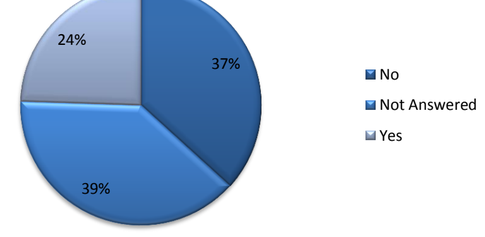
Should the Department seek to adopt the Certificate of Visual Impairment?



Is there sufficient support for people where permanent sight loss occurs, in terms of emotional support and rehabilitation?



Are these services meeting people's needs?



* Paper responses not analysed in the above radio button response questions but have been considered in the 'general consensus' summary section and full text responses can be viewed on each question tab

Q1 - Are the needs of at risk groups currently being met?

Key
Support the proposals

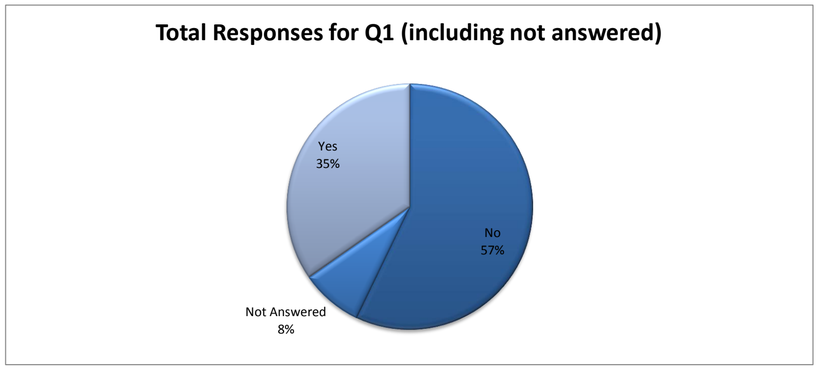
Online Yes/No Responses

No. & % Answered	45	92%	of all respondents
Yes	17	38%	of those that answered
No	**28**	62%	of those that answered

Not Answered	4

Online Text Responses

30	Gave a text response	61% of possible respondents	67% of those that answered Q1 yes/no
19	Gave no text response	39% of possible respondents	



General Consensus;

- We require more specialised services offered on island
- Current waiting lists are too long
- More public education needed around risk factors and personal responsibilities for health

Online Text Responses	No of Responses
No	**28**
Associated & existing health conditions "mask" eyesight issues and each condition is treated individually rather than holistically. Travel to UK is traumatic for elderly & caters alike, post treatments checkups still require a 15 hour day	1
Contact with health care services inevitability includes a BP reading and pulse check however we do not conduct a basic eye examination. this may help target vulnerable or at risk groups.	1
Equipment and staff are not as sophisticated as across. I went to Liverpool on a referral from Nobles to be told the condition diagnosed at Nobles was incorrect (a 'hole' in my macula did not exist it was only a tear in the surrounding membrane)	1
Failure to address waiting list issues / pooling between Consultants at Nobles Lack of overall Nobles management and planning for off island treatments Insufficient medical staff with required skills Lack of management knowledge on eye treatment needs and priorities Lack of political needs empathy and understanding of VIP clients	1
First of all I agree people should take responsibility ...I am amazed at the number of "health workers" who are smokers, obese etc .What can be dome when they MUST know the risks and choose to ignore them. From a personal point of view , my partner who is of Afro - Caribbean decent and is a non smoker, non drinker and not obese is a Type 1 Diabetic has a poor service from the Diabetic clinic at Nobles. We have the Abbott freestyle Sensor so she is able to control her bloods better but I feel that there must be at least an annual full sight examination to determine if sight loss is advancing so it can be controlled at an early stage.	1
For those who are elderly, with other health problems, and who have to travel to Aintree for regular treatment for AMD, the stress of the travelling is making their other problems worse.	1
From the figures stated in this survey, and the lack of numbers given for those in the 'At Risk Groups' it would appear that their needs can't be being met.	1
Having to travel to Liverpool for quite simple treatment is having an effect on my other health issues, it cannot be cost effective to fly a person and escort over once each month and must be a drain on the NHS.	1
I do not think the needs of high risk groups are being meet and the eye care and testing of children and adults of people with learning disabilities are not being met at all.	1
I don't think that there is sufficient public awareness of the risk factors for sight loss. I think there is also insufficient public information about the services available for people with sight loss.	1

I have always found ophthalmology impossible to communicate with. I never seem to get through to a human being and messages left on the answerphone are ignored despite people being reminded to ring back and promising to do so. Despite complaints these people are still employed in the same positions. Also the system of prioritising cases leaves a lot to be desired. Despite both my optician and GP stressing that my case was very urgent it was twice treated as routine and I had to attend A&E to finally get an urgent appointment.	1
I used to work within the DHSC, Older Persons Div., and noted over many years that eye problems are simply not addressed early enough. Sometimes it is due to older people saying "well this is what comes with age" but often it is because they have limited access to opticians and the eye services. However, people tend to cover up their failings especially if they consider it due to age. Awareness of problems would play a major part especially for families and friends of the older person.	1
Insufficient highly qualified permanent opthalmic staff on island.	1
My 90 year old Mother-in-Law has needed to travel to Liverpool for her Eye Care for years now; frequently it is once a month. She needs to be accompanied due to her poor sight & because the treatment involves her not being able to see at all when she leaves the clinic. My Husband or his Brother accompany her or we ask for a carer (which I imagine costs the department money?). If my Husband does the trip he has to take it as a days annual leave from work. It involves getting up at around 5 am to catch the early plane which is particularly difficult for her in the winter months	1
Nobles does not currently provide a comprehensive service for those patients with multiple conditions. Such a service is provided at Liverpool St Paul's, but involves exhausting and stressful travel.	1
Not sure but my father who has dementia has not had specific eye screening.	1
Significant emphasis is placed on AMD and cataract patients. Glaucoma is also a major cause of non reversible blindness and long waiting times for diagnosis and treatment can lead to visual impairment. Diabetic screening, vision loss due to Stroke and children's eye care are low on the priority list	1
Some of the at risk groups would be very difficult to engage with.	1
There is no formal diabetic eye screening service	1
To my knowledge, the government is not targeting the At Risk groups with any particular marketing in relation to their eye health. I am not aware of any Opticians or Optometrists who specialise in dealing with people with learning disabilities.	1
Waiting lists for hospital too long. People with AMD tend to be elderly therefore travelling off Island is an issue. More outreach clinics on Island would be better.	1
My real answer is I don't know.	1
You didn't provide a don't know option. I am unsure whether their needs are being met.	1
(blank)	5
Yes	**17**
Annual check up for those needing it.	1
At no point does your evidence suggest that people are not being treated - just that it's too expensive and takes too long to get treatment	1
I think the risk groups are covered in that people in these groups can seek treatment and care. However, I note that four of the risk groups, smoke, obese, drink heavily and look at the sun, are groups who are risk because of their lifestyle choices. This being a 'at risk group' out of choice should denote somewhat less sympathetic treatments than those who have little choice in their 'at risk' group. Simply put, why should the tax payer, the public treat those that have purposely put themselves into this risk group? Perhaps, the strategy should be one of better education to those people.	1
Personal experience. Diagnosed with OHT. But, long waiting lists are particularly risky for eyes. And more services on Island would be a big improvement.	1
Speaking to others yes the same to be although there is some concern at the costs of glasses	1
The root cause needs to be addressed and additional funding allocated to treat those conditions e.g. substance abuse, obesity etc.	1
Whilst some members of the groups identified may be hard to locate (who can say who's looked directly at the sun until they present themselves?), I believe that annual eye tests will help identify the affected individuals. Waiting times remain a concern however, as does the need to travel off Island in the event of an issue.	1
(blank)	10
Not Answered	**4**
N/A	1
(blank)	3
Total	**49**

Paper Responses

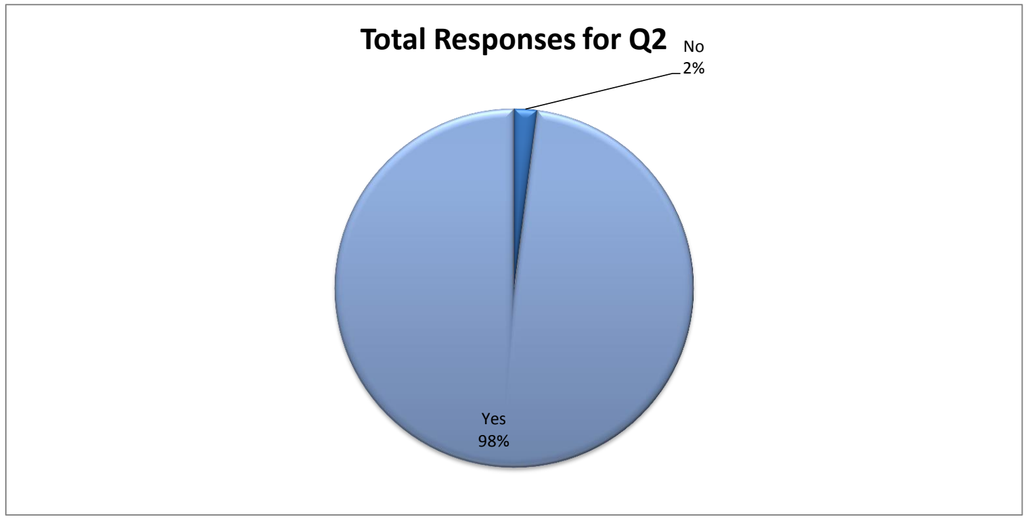
- The needs of the At Risk Groups are currently being met, if at all, on an ad hoc basis, as there is no specific identification or targeting of these groups within either GOS or the HES
- Some more then others

- As well as promoting regular sight test, the Department should clearly communicate the links between a number of systemic public health issue and sight loss. For example, diabetes, smoking, obesity, alcohol consumption, stroke prevention, falls cardiovascular disease and dementia. RNIB would recommend that sight loss prevention messaging is embedded into all related public health strategies. RNIB is willing to assist the Department in awareness of the need for regular eye sight testing amongst young people. A promotional your using the "Eye Pod" (an eye sight simulator vehicle) was made use of on the island, visiting all areas in prime locations. many visits were made to the pod (over 600) and people were given information about eye health and were able to experience some of the difficulties certain eye conditions would present if sight loss was present. the pod has also visited the island some years ago when we were able to work in conjunction with other health professionals to show the direct link between smoking and sight loss. We believe that initiatives such as Eye Health Week and the provision of Visual Awareness training are crucial in promoting eye health and establishing a strong prevention message across the island. There are also opportunities to bring educational programmes such as the Eye Hero's programme, developed at eye health in a manner appropriate to the educational curriculum.

Q2 - Should optometrists be able to refer directly to Noble's?

Yes/No Responses

No. & % Answered	49	100%	of all respondents
Yes	**48**	98%	of those that answered
No	1	2%	of those that answered



Text Responses

38	Gave a text response	78% of possible respondents	78% of those that answered Q1 yes/no
11	Gave no text response	22% of possible respondents	

General Consensus;

- Yes - Optometrists should be able to directly refer to Noble's

Text Responses	**No of Responses**
No	**1**
Record keeping issues and continuity - access to other health care records Not skilled enough for complex conditions Can not take overall responsibility for management of treatment plans Lack of clinical responsibilities Blurring of lines of clinical responsibility Communication systems not sufficiently developed / identified Public knowledge on roles, responsibilities and payments not yet determined.	1
Yes	**48**
Definitely has they have expertise in the area and will be detecting issues. It also reduces in necessary delay in referral and the use of GP appointments.	1
Delay in specialist diagnosis could aggravate existing eye conditions. However I was referred directly to the Eye Clinic by my optometrist. Ensuring island optometrists are fully equipped with up to the moment technology including OCT scanners and Optimap facility would speed up referral. (See Eyesite Optometrists in UK).	1
Direct referral will help reduce pressure on GPs who by virtue of being 'generalists' may not have the current knowledge and training in ophthalmics that Optometrists do. However, in doing so it could mean that if referrals were possible this way, the workload at Nobles would increase especially in the 'early months' of the new way of doing things. If this increase in demand resulted in delays in Nobles, then there would be cries of why was the service changed. Hopefully by putting routine work into the community and using Nobles as a specialist centre, the numbers would balance out.	1
Efficiency	1

GPs already have a large workload. Anything to speed up the pathway would be a good idea.	1
I believe my optometrist is more qualified than my GP to make a referral but this does require the optometrist to know the patient well and understand their eye history. This is not always the case with high street opticians where patients move around for their eyecare in which case their GP would know more about their history.	1
I believe that optometrists are highly skilled professionals whose judgement should be trusted to refer directly to hospital for more involved procedures. This would hopefully also decrease admin and remove a layer of bureaucracy, as well as impacting upon waiting times.	1
I had to be refered for a scan on my eye, but by the time I got the letter from Noble's it was 3 months and the hole had healed but it has now left scar tissue in that eye, which may have been avoided had I been refered direct from the optometrist instead of having to be refered by the doctor.	1
I have had a recent experience where my optician had to refer me to a and e with a hole in my retina. I had to wait until the next day to see Mr Chohen who was very rude about the optician and miss diagnosed my condition. Fortunately Mr Ali recalled me a month later made a correct diagnosis and treated me there and then. I was very lucky. Something needs to change. The work of the optometrists needs to be recognized and there should be more liaison between them and the hospital staff.	1
I have more confidence in the ability of the optician to spot a problem than my GP. GPs are4 not "experts" in everything. Opticians spend many years studying and should be able to refer patients direct to Hospital. I speak as someone who had a detached retina, which was identified by the optician.	1
If the situation is dire, then yes, an optometrist should be able to refer. However, optometrists know the eyes inside and out, better than doctors in most cases. As such, it would surely make more sense to allow optometrists to treat a variety of eye issues, including but not limited to minor eye infections, and providing prescriptions for such minor treatments.	1
If they detect a problem then the sooner it is dealt with the better - just as a GP can make a referral to a department - it will save money for one thing and possibly and more importantly possibly someone's sight	1
It is a waste of GP time, introduces delay and the possibility for people slipping through the net using the current system whereby the optometrist writes to the GP who then refers. However there needs to be strict guidelines /thresholds for referrsls	1
It saves time, cuts out a layer of bureaucracy and reduces work for the GP. Also it should mean that the optician gets to know the progress and result of the referral rather than the GP as at present.	1
It would prevent a visit to your doctor to arrange a referral.	1
It would speed up diagnosis and treatment and in some cases protect degree of sight loss.	1
Makes so much sense	1
More efficient use of resources. My optometrist referred me privately and I was seen for a non urgent problem within 24 hours. The level of private work by consultants is to the detriment of the NHS	1
Most definitely yes! I have low tension glaucoma and was eventually referred to Nobles in 2011. I say eventually. On two occasions over the previous few years my optometrist had asked the GP to refer me to Nobles as I had small bleeds near the optic nerve (in either eye at different times) and on both occasions the doctor said no. Third time lucky however. But after waiting for 6 months I went back to my GP to ask how much longer I would have to wait, only to be told that the waiting list was 12-15 months, so that would mean another 6-9 months! As this had gone on for long enough, and against my principles I may add, I decided to "go private" just to get myself into the system. That was in 2012. Now, five years and one operation later the condition seems to be stable with the help of drops.	1
Ocular hypertension may be monitored by optometrists but guidelines and protocols must be in place BEFORE patients are cared for in the primary sector. Most AHP/nurse specialist led glaucoma clinics have access to a doctor on site for advice but this is not available in the primary setting. In house optometry clinics may be a better use of resources. Guidance should be given to advise which cases to refer and when and allow for good communication within the eye care team. Optometrists currently refer direct to the orthoptist and vice versa.	1
Optometrists should be able to refer directly to Nobles Opthamology for PROMPT treatment. This should not be via A and E, where personal experience has shown that necessary expertise may not be available.	1
Optometrists are highly-skilled professionals who will be able to ascertain how urgent the problem they have discovered is.	1
Optomotrists are qualified to triage eye patients, GPs are not. Waste of GPs time.	1
Pretty obvious !	1
Prevents delays	1
Quite obvious common sense	1
Reducing delays is a good thing. However how does the patient follow up or confirm that they have been referred. What is the process and what rights or recourse do they have in the event of mistakes? How will the govt measure the quality of the service being provided? In the event of misconduct by the optician, what will be done?	1
Surely that is a no-brainer?	1

there have been circumstances where visual deficit secondary to stroke have been noted by an optometrist but they have been unable to refer directly to the service and ED has always been accessed even if the deficit is weeks old.	1
There may be cases where an eye condition indicates an urgent medical issue	1
They are best placed specialists to assess primary issues with eyes. GP's are just that... GP's.	1
They know their patients well, by the time you have made an appointment to see dr then waited for referral time is moving on. Plus dr are over stretched so will be one less for them.	1
Time is wasted going via gp services who then refer to hospital. Or via other hospital sources. Surely an optometrist should be able to directly refer.	1
When I had a macular problem I was seen by my optician immediately. Who although unable to diagnose the problem with the equipment they had referred me for further investigation. However, I then had to wait for my GP to refer me to the eye clinic at Nobles. This added delay but no value to diagnosis or treatment. I would say that there was greater delay in scheduling by the eye clinic.	1
Where they are trained to diagnose or have a real concern of a loss of sight. However introduction of a 'charge' for eye tests would reduce the number access this vital service, and therefore the 'preventative' aspect could be reduced.	1
Yes but ONLY where they are sure there is a genuine reason for referral. The hospital cannot cope with the amount of referrals received now let along a huge increase.	1
Yes so long as they are monitored so ensure that the quality of the referrals are correct.	1
(blank)	11
Total	**49**

Paper Responses

- Optometrists and Registered (Dispensing) Opticians (it is within the GOC requirements for dispensing Opticians to refer persons with pathology if it is in their area of competency) should be able to refer direct into Noble's Hospital Eye Service. This should reduce waiting times and ensure more timely interventions
- Yes

- RNIB is aware of services in the UK where direct referral from optometry to the hospital operates successfully. This approach can be particularly beneficial where hospital consultants provide feedback to optometrists on their referrals. Building effective relationships between primary and secondary care, effectively shared care of patient, can help ensure the quality and appropriateness of referrals develops over time. However, clearly the hospital needs to be aware of patient medical history and so the Department needs to put a mechanism in place for that to be provided by the GP. Direct referral from the optometry can clearly save GP consultation time and can be beneficial to both patient and GP.

Q3 - What should be included in the specification of a sight test?

45	Gave a text response	92% of possible respondents
4	Gave no text response	8% of possible respondents

Text Responses	No of Responses
as above plus patient / client concerns (or will these be ignored and end up with visit to GP and /or A and E?	1
Above criteria would be appropriate	1
Age - perhaps starting at 60 years to spot things sooner - again there would be long term cost savings	1
Age General health Occupation Any medical pre-disposition to eye conditions I would agree that yearly is not always appropriate, although I have found it necessary to have on occasion found it necessary to get a new prescription several times in one year. Without a reason to ask for a more frequent test why not 2 or 3 years. As has been pointed out, there are costs associated with poor vision or loss of vision and I would be concerned about the withdrawal of free testing. It certainly doesn't help in dental care.	1
Age, diabetes or condition with similar acuity. 1 year	1
Age. Elderly people should have access to more frequent tests.	1
Age; family history of sight difficulties; identified sight difficulties; early signs of cataracts, macular degeneration; decreasing sight ability. I would prefer to have an annual free visit as I suffer from myopia, am aged 65+, have decreasing sight ability and have early signs of a cataract.	1
All children up to 16 years - 1 year interval for a free test (6 months if have sight issues) All adults 16 years and over – 2 years interval for a free test All adults 16 years and over with diabetes/high risk factors/sight issues – 1 year interval for a free test (6 months if severe/degenerative)	1
Annualy as on one of my tests they could just see something strange so sent to liverpool it was a tumour if left for another year i wouldnt be here. Eye tests annually and free for all	1
Any underlying medical condition that can be diagnosed or monitored by a routine eye test. In my case, in addition to my specific eye problems there is also a faily history of glaucoma.	1
As above is acceptable	1
As people forget when they last had a sight test, I would wish to retain a one year test frequency. Not too many people will wait an exact 365 days between tests, so the defacto test interval will be more than one year	1
At risk categories i.e. diabetics/MD should be yearly. Children up to 18 should have yearly tests as poor eyesight could be a serious detriment to their studies. Aged 70+ should also be annually as poor vision can lead to more accidents and falls in the elderly	1
At risk factors If the patient already had identified sight issues, i.e. a prescription/glasses that should be checked more often Other medical diagnosis that could cause sight issues.	1
Base it on advice and guidance from College of Optometrists	1

Clinical need	1
Clinical need should be a guide, I however found my prescription changing every year and my 20’s.	1
College of Optometrists recommendations.	1
Cost-benefit analysis. What is the comparable recommendations from Europe,US, Australia or Canada. Extending period and introduction of charge is too much. Many people will not bother attending if they have to pay. An elderly relative with memory issues was removed from eye waiting list but no follow up from go as to why she failed to attend an appointment. It's not that her eye condition has improved but she has lost ability to travel to Douglas on bus etc so didn't go. People like her are falling through gap between primary and secondary care. If this is introduced at same time as prescription charges then same group of people are paying for their own healthcare and the usual complaint that some people who neglect or abuse their health get free healthcare. The universal health care proposition works when we all pay in and it is free at point of access. I work hard and already pay fir my eye tests for me and my family through my taxes. And migrants should pay immigration health surcharge.	1
Diabetics once a year. Over sixty once a year.	1
Don't know. I normally have one every 12 months, but I don't have any problems.	1
Every two years unless eyes are affected by Health problems.	1
Everybody is different - there should be flexibility in the system to allow for this without some major drama being caused by either end.	1
Existing sight conditions including glaucoma, macular degeneration, epiretinal membrane etc. Patients at risk from early onset diabetes and dementia. Elderly patients over 70s. Half-yearly to annual free sight tests to certain categories.	1
History of previous eye conditions / problems warrant an annual check	1
I usually see my optician every two years and this seems to work well but I feel people who have certain conditions need more frequent checks as proposed. I also feel people with sudden eye problems should be encouraged to see opticians rather than the doctor. I feel the proposed charge for consultations is a backward step to achieving your aims.	1
I am not an expert so am unable to answer this question. However, if it is envisaged that for certain eye conditions some of the regular testing that would normally be done at Nobles should instead be carried out by an optometrist, then it would be up to the experts to advise on frequency of testing in such cases.	1
I don’t think free sight tests fit those able to pay should be available. Currently opticians are very actively sending reminders for eye tests 6 monthly for normal sighted children and 12 monthly fit adults, the bill being met by the IOM government. This is not a good use of limited resources. The above intervals are acceptable but if not entitled to free prescriptions should not have free eye tests	1
I feel the general criteria is fair but there are certain professions that require eye sight tests as a requirement of their employment and people who work within the emergency services and some essential services like bus drives who are required to have regular medical test including eye sight to stay within their chosen employment or require a licence to do their job will fall outside the exemptions and I feel this group of people should be considered before any changes are implemented	1
In favour of suitably equipped and trained optometrists having a greater role. For intra-ocular pressures, current equipment provides misleading low readings compared with those using ''Goldmans'' apparatus, where topical anaesthetic required. Impressed by expertise at Specsavers, but have concerns whether smaller practices have sufficient resources and throughput to offer efficient and cost-effective service. How would quality and consistency of service be monitored?	1
In my case (macula membrane degradation) the view of the specialist that I was sent to see across by Nobles was I should have a check up every 6 months.	1
It should be left to the Opticians to tell their patients/customers how long before the next appointment is needed as they are the experts.	1
Keep the tests annual. Eyes can change quickly and by moving it to 2 years increases the risk of people driving when they can't see properly. This is a high risk decision with potentially fatal consequences.	1
national guidleines	1
Ongoing clinical concern (eg intermittent or increasing frequency of double vision) Rapid change in vision at any age Migraines	1
Patient's general health and whether they have close relatives with major eye problems.	1

Rather than thinking of a 12 monthly eye test as "expensive" perhaps it may be better to think of it as "valuable". Despite the expense or alleged savings, I cannot see how the service will be improved by doubling the length of time between eye tests for most people. I think the criteria should remain with an eye test every 12 months for most people (with more frequent in higher risk cases). It also seems to me that those who wear contact lenses should also be brought into the fold of increased aftercare.	1
The criteria cited by the the College of Optometrists should be adopted. However, if a patient who is not in a specific category that requires yearly testing, but has genuine concerns about their sight, they should be able to be tested in return for paying a reasonable fee e.g. £20. This could be means-tested for those who are benefits or over 75 years old and on a state pension.	1
The latest eqt to provide as much accurate data as possible	1
The Royal College of Ophthalmology and British Orthoptic Society recommend that children 5 years and under are managed by an orthoptist with ophthalmologist/optometrist as they require a cycloplegic refraction. Not all high street optometrists are able/willing to do this and a normal sight test is inadequate. The College also recommend 12 monthly checks for children NOT 6 monthly as recommended by the College of Optometrists unless vision reduces (e.g. myopes who start to complain of not seeing board at school even with glasses on) A full examination of the fundus and media should be carried out as part of the eye test, fundus photography can be used to back up the optometrist's exam but should the patient pay - debatable, certainly not in the case of children as unethical to put a child through a test that is not required and then get parents to pay for it.	1
They should stay at yearly intervals.	1
Those over 16 who may have family history e.g.:glaucoma also opportunity to attend if patient notices changes	1
When you are young, eyes frequently change. As such, I am inclined to fully agree and support the College of Optometrists' recommendations. For most people, every two years makes absolute common sense. The only time you should need to change is if you notice a detrimental or noticeable difference with your sight.	1
Why are specific eye issues not catergoised - like signs in a patient, or that has a family history of glaucoma or cataracts that also start to indicate some signs themselves etc	1
Why when a child turns 16 their test moves to two yearly surly this should be 18 or even 21. As a child goes through puberty their vision can change and still need the care.	1
(blank)	4
Total	**49**

Paper Responses

- We feel that asking in general consultation paper as to what should be included in sight test is a technical question that is probably beyond the competency of the general public to answer. It was posed during the meetings of the Eye Care Strategy group in order that when asked, the Department could give a clear answer to members of the public as to what exactly the NHS Sight Test paid for. This is because queries have, in the past, been raised about charges for additional tests, i.e. Fundus Photography, non-NHS Contact Lens Fitting, and members of the Department have responded to members of the public with "you do not have to pay for sight test, therefore no charge can be levied". Given the changes proposed within this document discussion and using the existing protocols as a basis this would give a starting point for agreement on what would be additionally required and thus the costing that would need to be agreed.

- All that an Optometrist and Orthoptist does
- RNIB recommends that the Department takes account of the rules and regulations on sight testing and contact lens fitting in the UK - including Scotland. RNIB supports the move from annual to bi-annual testing - this is in line with practice in the UK. We also note the proposal to introduce charges for sight tests and whilst this is common practice in the UK, with the exception of Scotland, we would be concerned that on the Isle of Man introducing of charging may deter people from taking up services, particularly those suffering from social deprivation.

Q4 - Are there any reasons why these services should not be provided within primary care?

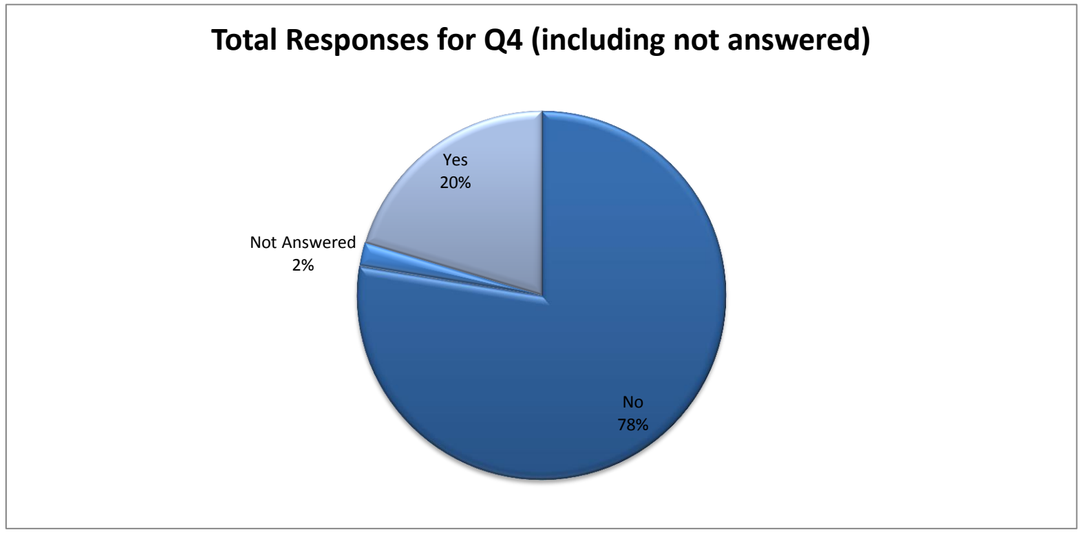
Yes/No Responses

No. & % Answered	48	98%	of all possible respondents
Yes	10	21%	of those that answered
No	**38**	79%	of those that answered

Not Answered	1

Text Responses

25	Gave a text response	51% of possible respondents	52% of those that answered Q4 yes/no
24	Gave no text response	49% of possible respondents	



General Consensus;

• The service should be provided within a primary care setting

• Some concerns over the processes involved i.e. referrals & appointments process, patient records access

Text Responses	No of Responses
No	**38**
As long as Island Optometrists have access to state of the art technology such as OCT scanners and Optimap facility. This is not the case in the majority of Island Optometrists.	1
But what is the fixed tariff?	1
Good idea	1
Hence if more emphasis is put on Optometrists then eye tests should remain yearly as they can pick up other problems, high blood pressure, diabetes etc.	1
I feel it makes sense.	1
I think an optometrist should be able to provide a variety of eye care, without the need for patients using the NHS. Optometrists know eyes inside and out. They have good equipment and excellent expertise to quickly and effectively diagnose and treat patients. This would lessen the pressures on the NHS	1
Nobles should be up to speed with experienced personnel and equipment.	1
Providing the Accredited Optometrists (ACs) are subject to the same periodic review / updating / CPD as their UK colleagues (and which is logged and regularly checked as with other health care professionals) then there are potentially strong benefits to be gained by moving services to the community. The IT issue regarding information sharing could be achieved by giving ACs access to EMIS or at least the relevant parts of EMIS, on an episodic basis and with full patient consent. In other words ACs should not have the ability to have unfettered access on everyone, only those that seek their services and for the duration of their visit to the AC.	1
These services can be provided within primary care if adequate training and competencies for extended roles are adhered to. Regular audit and evidence of continued professional development must occur.	1

They are best provided within primary care. Making Optometrists a 'one stop shop' for most eye problems should deliver more efficient services, and must surely improve patient education, provided that sufficient funding is available (supported by patient fees where appropriate).	1
this is a great idea and should be progressed	1
This makes sense and surely would reduce waiting times and make better use of skill set and resources available across the island.	1
This seems sensible, if well handled, and regularly inspected to ensure standards are met and maintained.	1
Those with Learning difficulties need specialised, experienced care	1
We all know that Noble's is stretched at staffing levels and if this was done then those staff could be transferred to other departments where staffing levels are needing increasing it would also mean that priority case could be dealt with quicker	1
Will it encourage off island businesses to bid for these contracts or only existing on island businesses with local directors/ accountability etc. A market approach may reduce costs but should we really bring moving to a system where health is commoditised? Current problems getting NHS dentist provision should serve as a salutatory lesson. Any model should be as a flat fee per service and no incentive or bonus fees.	1
(blank)	22
Yes	**10**
The systems described above are not yet available.(equipment, budget, or IT systems. lack of clinical (medical) oversight / involvement	1
Clear processes need to be put in place. How does the patient follow up or confirm that they have been referred. What rights or recourse do they have in the event of mistakes? How will the govt measure the quality of the service being provided? In the event of misconduct by the optician, what will be done? What vetting process have the opticians been through to ensure their service is up to the required standard. Are they subject to police checks?	1
If you wear contact lenses you cant get an aftercare appointment at the weekend with one of the the major Opticians on the island!.	1
In cases that Nobles keeps track of but may not have time to do the routine testing for - who would be keeping the file and therefore the information for the patient? How can we be sure that if a condition worsens the referral back to Nobles would be speedy and problem free?	1
It is all about knowing the patient history - and having suitably qualified practitioners something that I believe the iom has and will continue to struggle to recruit - from experience I do not believe the quality of eyecare on the high street in the iom is adequate	1
Please don't move this highly specialist role to the high street. I want the professionalism, continuity of care etc that nobles and Liverpool provide. Stop outsourcing services - the quality drops, the price may drop but the service is awful.	1
Strongly against optometrists acting as ''gatekeepers'' for cataract surgery. Need for consistency and not to act as ''rationers.'' Recent NIHCE guidance states hospitals should take a ''patient-oriented approach and offer operations when a patient feels their quality of life is affected by their sight loss.''	1
We could end up in the same situation as the dentist's were you can't get one, or like the doctor's where there is a 2 week wait for an appointment unless it is an emergency.	1
While some of the services stated sound routine I would be less confident of urgent care being outsourced. In some cases it may be better that referrals have a fast track to expertise within the hospital system. For example, if an increase of floaters/flashes were an indication of retina detachment then what could an optometrist reasonably be expected to do?	1
(blank)	1
Not Answered	**1**
(blank)	1
Total	**49**

Paper Responses

- As far as the Association is concerned there is no reason why these services should not be provided within primary care, subject of course to agreement on economic remuneration for said services. Given that currently all practices subsidise the NHS Sight Test from their other activities, like the sale of optical appliances, by roughly four times the current remuneration. Unless these services are funded correctly then a lot of this document will probably not happen

- Provided you have the qualified staff - then no reason

• **Glaucoma repeat readings and OHT monitoring** - RNIB accepts that it is possible to conduct repeat glaucoma and OHT monitoring in primary care. RNIB recommends that the Department looks at the additional training for optometrists that was introduced in Northern Island to support the introduction of glaucoma referral refinement arrangement including repeat readings and OHT monitoring. We are aware that since the introduction of glaucoma refinement arrangements in Northern Island, there were significant reductions in the number of inappropriate referrals made to hospital eye services. **Pre/post operative cataract pathway -** RNIB agrees that pre and post operative cataract care can be effectively provided in primary care with the appropriate training and referral processes. We believe that hospital consultants should retain the ability to call individual patients to hospital for post operative care where the individuals condition suggests that is necessary. **Children's vision (post screening) -** RNIB would like further information about the Departments plan for children's vision (post screening). In particular, the relationship between optometry and orthoptics. We note that the aim of the strategy (Page 7) was to "encompass all age groups" but also the statement that this strategy does not consider in any detail the needs of children for services and the pathways of care. This is an area for concern. the Children's services need to be specifically considered within service planning. Children with low vision have specific challenges in reaching development milestones and are at greater risk of poor outcomes with regard to basic functional development. This can have a lifelong impact, Children will require independent living skills, orientation and mobility and social and communication skills retaining - often referred to as the "additional curriculum" yet often no quality time is devoted to the needs of those children to acquire these skills. RNIB is aware of a pupil who is allocated just 30 minutes per week to acquire these essential skills. That time is often vulnerable to change to accommodate other school matters. Specific low vision services of children are necessary and stronger links should be developed between all health and education professionals working with visually impaired children and rehabilitation professionals so that our children have the best possible support to develop essential life skills. **Low Vision Services** - RNIB believes that for the population of the Isle of Man, it is likely that a single optometry provider in conjunction with a low vision therapist would provide the most effective low vision service. This is the current model on the island and we have no evidence to suggest that the Isle of Man community would be better served by a fracturing of this service across multiple providers. **Services for people with learning disability** - RNIB believes that it is important that children and adults with a learning disability have access to optometric services. There is a lack of detail on the provision of services for people with learning disabilities. RNIB would welcome the opportunity to assist the Department in considering the most appropriate model of service delivery for the island. **Urgent Care** - BNIB notes the proposal to refer patients requiring urgent care to ophthalmology within specific timescales. We welcome the clarity that this gives the public. However, the Department should consider whether measures should be taken to protect planned care within hospital eye services from the impact od high volumes of unscheduled care. **Provision of specialist contact lenses** - RNIB is content that appropriate qualified optometry practitioners should provide specialist contact lenses; however, we believe it is important that optometry and ophthalmology work together in these cases to ensure the best quality patient care and outcomes.

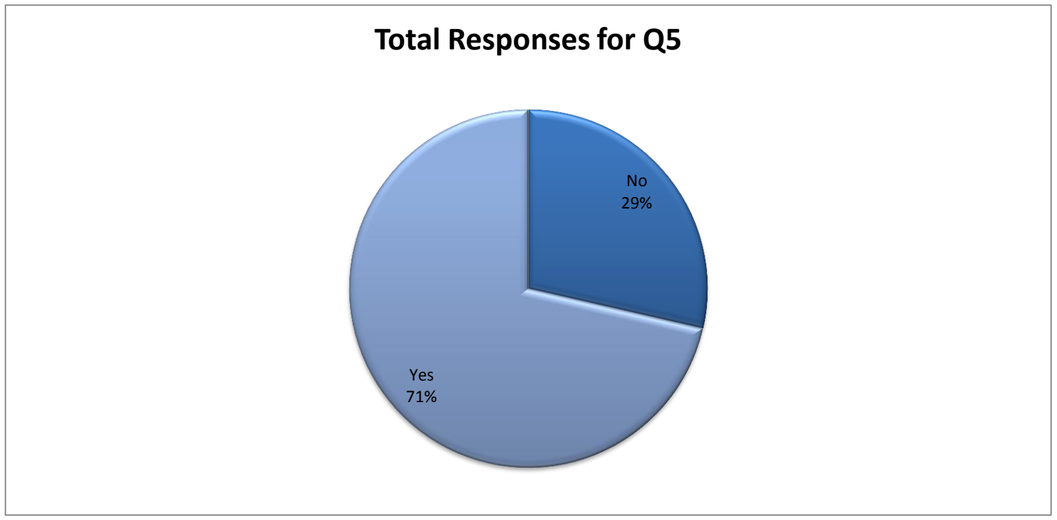
Q5 - Where a locally provided service is available, should patients who choose to be seen in the UK have to pay for their own treatment and travel costs?

Yes/No Responses

No. & % Answered	49	100%	of all respondents
Yes	35	71%	of those that answered
No	14	29%	of those that answered

Text Responses

38	Gave a text response	78% of possible respondents	78% of those that answered Q5 yes/no
11	Gave no text response	22% of possible respondents	



General Consensus;

- Yes - if there is a locally comparable service available and they choose to travel to the UK, the patient should pay for their treatment & travel
- Local services should be provided where possible
- Some concerns over the availability and quality of services provided on island

Text Responses	No. of Responses
No	**14**
Confidence and trust in local services is an important component in treatment, management and recovery and recuperations from ill health. I believe the isle of man can not at this time command the necessary levels of these criteria to justify any hard and fast rules to cover this aspect of the services. Until the DHSC provides sufficient information and analysis comprehensively, openly and honestly the impression currently in my opinion is the Department is arrogant, patronising and does not engage and listen to the public, service users and patients appropriately. Many of the transfers are for elderly patients who would rather to have to travel but are currently doing so because of a service not properly managed.	1
A friend of mine had a need for cataract surgery. He was told that he would have to wait eighteen months ,but if he paid he could have the operation the next week at Nobles by the same surgeon who wanted him to wait eighteen months. DISGRACEFUL. How could someone allow a person to have progressive blindness unless private payment is made? He did go private , but NOT in the Isle of Man. I guess that is counted a win for Nobles? I was sent for dental treatment at Nobles by my dentist. Eighteen months later I was phoned to see if I still wanted the treatment....I had sorted it out myself. Another win for Nobles? My partner had her appointments at the Diabetic Clinic rearranged and then was told she had failed to appear. I don't trust the stats coming from Nobles.	1
Depending on demand/availability, and also the sound reputation and capability of the doctor (as we know there have been some horror sorties around different doctors that should have been addressed much earlier). Also if treatment has already been started by UK or the severity of the condition means that UK is the best option. Pending the above, then yes maybe should offer the choice to be treated here or pay and go to UK.	1

Due to the IOM population size, ethnic mix and other demographic features, Nobles' consultants generally do not get to see the full panoply of conditions within their speciality. Consequently, whereas they are good at delivering treatment pertaining to common conditions, treatment of less common conditions poses higher risks to the patient due to issues of clinical 'skill fade' / lack of experience by the consultant. Consequently patients who have conditions not seem frequently on the IOM should be seen by an appropriate consultant such as found in a regional eye centre such as Liverpool. By adopting this approach the patient is still given choice, but only where the condition is not a regular feature in the population (say less that 100 cases /year) or where the 'common condition' has developed undetected to the point where 'expert' intervention is required.	1
How do you expect the good team at nobles to have the same experience that the experts have in Liverpool? Basic stuff yes but for complex cases they still need to go over. If I need to be seen by someone with more experience in the uk then I should not be expected to pay.	1
If a patient has chosen to be seen in the U.K. There must be good reasons behind doing so. Until Nobles can provide specialists like there are at Aintree then patients will still feel the need to go to the uk. If you start charging then the people who can pay will be fine, but those who can't will be let down. I for one have found the whole experience at Aintree far more professional than what is received at Nobles. I am glad to this day we had the chance to be seen across or my son would be still suffering now.	1
It would be like everything else, no savings would be made, as you will be paying for extra staff on the Island instead.	1
Only if the service is available but declined	1
Patients do not endure journeys to the UK for trivial reasons. If patients have a clinical need for treatment of multiple eye conditions, then it is sensible for ALL conditions (eg AMD, cataracts, glaucoma) to be undertaken in one location to ensure co-ordinated and timely treatment, without delays.	1
Patients who choose to be seen in the UK probably go there because they don't have to wait. I was offered for both my cataracts to be done privately by Mr Chohan at a private appointment at Nobles costing me £170 at a cost of £5,000. I decided to use my private health insurance with Benedan and had them done in the UK at a much lower cost. First operation in April and second operation in May. I have had new lenses fitted as well. The operation took place in St Helen's.	1
So long as the patient has already been seen by a specialist in the IOM and there is some disagreement as to the way forward re treatment, under the NHS a patient should have the right to a second opinion.	1
The incentive needs to be to get the Noble's service to be trusted by the patients.	1
The iom is a general hospital and will never be able to afford to offer the specialist skills required to keep up to date with the advances in eye surgery. I strongly believe that patients who have a genuine need should continue to be offered treatment in the uk - without it I would have Lost my sight 30 years ago and nothing I have seen since makes me think this would be any different today as the uk centres are way ahead of the iom	1
There may be a legitimate reason why someone would chose to travel off island & this appears to be the thin end of the wedge. Everyone is currently entitled to a 2nd opinion & should therefore not be discriminated against.	1
Yes	**35**
Again -fairly obvious !	1
As long as efficient skilled provision is available on Island equal to that provided by Aintree. A weekly inreach clinic flown in from Aintree may be cheaper than flying patients to Liverpool.	1
Definitely!	1
Fairly obvious	1
I think they should pay for travel costs but not treatment.	1
If local service is more than fit for purpose (not merely adequate) then treatment should be on IOM.	1
If the island provide the service we should not fund the same service elsewhere unless outside of our capabilities. this should relate to all conditions.	1
If the local option is there then surely it should be used. If people want to opt for treatment across when it is available on island it stands to reson that they should pay for it themselves.	1
If the service on island is of the same quality/standard then yes.	1
If the treatment/clinician is available to be seen here and the patient chooses to go to the UK then they should fund or at least partially fund the cost. I think circumstances need to be taken in to consideration such as previous problems with the clinician available or the patient's previous treatment	1

It must be clear why the patient is choosing to be seen in the UK - a long waiting list is not a reason for them to have to pay. If the Department cant see them within a normal time frame, then they cant have it both ways. But this is what they will try and it needs to be written in stone that they cant.	1
Only if the service provided locally is directly comparable to that in the UK.	1
Provided that the service is of an equal standard without a significant wait that may cause harm. Continuity of care is also a factor.	1
The more treatment provided on Island, the greater the level of expertise here. Anyone travelling when they could be treated here is wasting NHS money.	1
This consultation mostly reads like you have trouble with the current eye department and consultants being stuck in its ways and not open to new ways of working - like having a common list of patients etc. Is a simpler solution getting some new consultants on different contracts? This question is one of confidence. If s patient or their relative has previously had poor treatment in the IOM at Nobles they will naturally want the option to be treated in another hospital. If they think treatment here us 2nd class i.e. Not provided by National level specialists then should it only be those with private insurance who get the opportunity to consult the top specialists rather than IOM generalists	1
This seems to be quite a loaded survey. You have said some services eg. cataract operations are available. That more services could be provided - as long as they fit in your cost window. But you don't say anything about reducing the cost of off-island treatment. For example, it is not always necessary to have a companion. Or perhaps one employee for a group would be better than numerous companions. You also haven't mentioned the cost of provisioning equimment and support staff should you have an inreach service. Also, of most concern to me would be, for less common procedures than cataracts, is there enough through put for staff to gain and maintain expertise. And stay abreast of the latest methods and tools. Also, perhaps in choosing to go across an not burden the local facilities can we offer some of the saving made towards meeting those costs.	1
Unless referred by local provider or uk required follow up	1
We cannot find not manage the choice option	1
Whilst on-Island treatment is to be encouraged, this should not necessarily be achieved by yet more privatisation. Additional provision is fine, but presently offered public services should not be privatised - this only leads to a race to the bottom in terms of pay and conditions and the private sector notoriously cuts corners.	1
YES ! I feel that as many services as possible should be carried out on island and fully agree the cost of sending patients off island is unacceptable in the present climate , we have a wonderful health care on island and nobles hospital is amongst the best in the world so anything that can be done to improve services to island residents should be welcomed open arms	1
Yes it is their choice to do so	1
Yes provided the standard of treatment is as good as in UK and waiting times are reduced.	1
Yes, but never say never. Say a patient has a rare or unusual condition, then it may be appropriate to get a second opinion. If the patient wishes to do this, then they should pay their own travel costs, but not the treatment (which surely should be slightly cheaper than the inreach service anyway).	1
You send a 1000 patients (patient journeys) to the UK every year at tax payer expense for eye care!? What's wrong with you! The care can and should be provided here which is what this survey is about. Provide the care on the island as suggested above. If a person wishes to go to the UK despite treatment etc being available here, then they should have to pay for it themselves. Ultimately, there is only so much money in the pot. Don't waste it. Use it sensibly and proactively.	1
(blank)	11
Total	**49**

Paper Responses

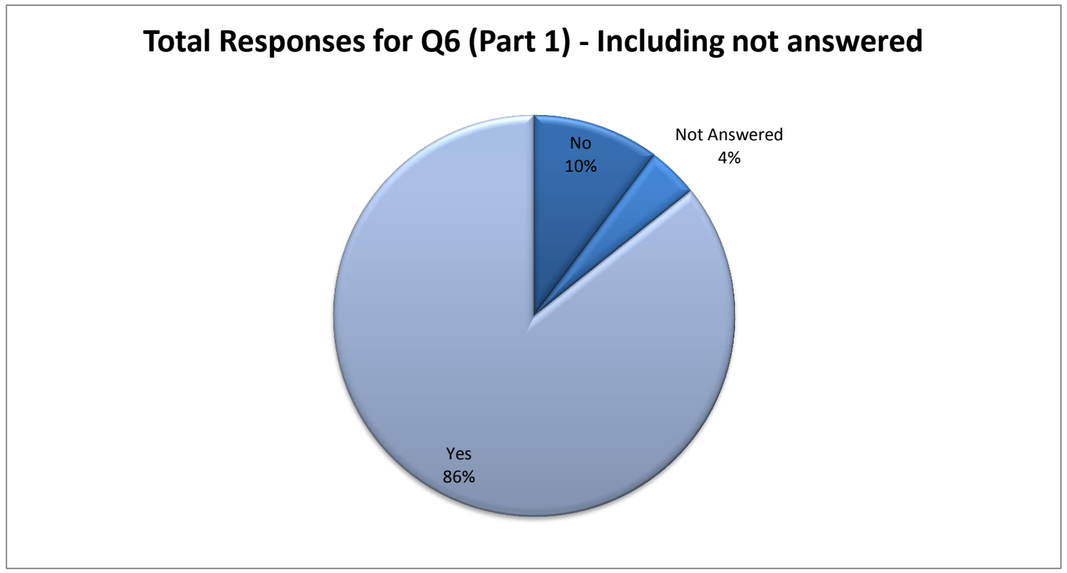
- Given the costs of the procedues and of travel then unless there are good reasons for attending a clinic off the Island as outlined in the document then there should be no reason as to why the procedure should not be self funded.
- Yes

Q6 - Should the Department be providing annual diabetic retinopathy screening?

Yes/No Responses

No. & % Answered	47	96%	of all respondents
Yes	**42**	89%	of those that answered
No	5	11%	of those that answered

Not Answered	2



Text Responses

33	Gave a text response	67% of possible respondents	70% of those that answered Q6 yes/no
16 (including 1 "Don't Know")	Gave no text response	33% of possible respondents	

General Consensus;

- Yes - Annual diabetic retinopathy screening should be provided. This may aid in early diagnosis and effective management of the condition
- Some concerns over cost and suggestions of providing more support for provisions within the community

Text Responses	No of Responses
No	**5**
I think it should be down to the individual to report any changes in their eyes to their GPs who can then refer them to Nobles if necessary.	1
It is expensive and there is evidence that patients do not always attend these appointments (DNA rates are high).	1
Most Opticians will pick up on these and send the patient to hospital.	1
Support the optometrists to provide this service in the community. This works if annual tests are retained. Require some quality assessment to be undertaken and patient record sharing. If the scheme trusts these highly qualified optometrists to provide incommunity service than why not this service too?	1
You've already said you don't know how many diabetics are getting a retinal photograph done annually as part of the eye test with an optician. It makes sense to annual screening but why would you take on work already being done elsewhere, especially when you don't know how much. If screening can be done effectively by opticians why not work with them. As a patient I don't think I'd have any issue with them sharing information with the hospital team. Is it possible it could all be done and leave the department to focus on higher value work for its specialists.	1
Yes	**42**
Evidenced based practise leading to reduced future costs for late diagnosis.	1
Absolutely essential for early diagnosis and long-term cost saving!	1

Diabetes is a killer so early detection is vital.	1
Early detection is vital and in the long run could save the department significant costs.	1
Eye screening is often not carried out when a person is attending an annual diabetic appointment.	1
Funding dependent, and looking at the risk plus any broader requirements.	1
I am very surprised that this is not already happening! Prevention is cheaper than missing it and supporting someone with sight loss	1
If sight issues can be detected early this is good for the patient as well as reducing the long term costs associated with blindness.	1
I'm amazed that we don't provide it	1
It is a no brainer.	1
It just seems obvious.	1
It saves further costs down the line if helped sooner.	1
It should be FUNDED by the Department, although Nobles is not the best place. Retinopathy should be made a mandatory part of the eye test, along with OHT screening, and peripheral vision field tests. If Department funding is to be transferred to Optometrists, then service level definitions and quality assurance are essential in any case.	1
It's essential	1
Might prevent more expensive treatments	1
No brainer!	1
Selfish really as one with an eye problem	1
The later costs of not catching and treating diabetic problems now are huge.	1
The reasons are clear for this as stated above	1
This is a critical requirement.	1
This is an at risk group and therefore this should be provided. However, if the diabetes is a result of severe overweight due to overconsumption, then the individual should be made to pay for themselves as they have got themselves into this predicament. The tax payer should not be funding stupid, but rather fund the services for those that unfortunately have had medical detriment to them through no fault of their own.	1
This is an important service and may help provide support for those in need at an early stage thus bringing maximum benefit.	1
This is essential	1
This repeatable screening should be provided by opticians in the community who could be trained appropriately	1
to ensure any change in condition is recognized	1
Without a doubt screening should be provided annually.	1
Yes, but not necessarily in Nobles. Depending on historical prevalence, specialist centres could be set up in say Douglas, Ramsey, Peel and Port St. Mary and community eye care providers could perform the service to an agreed specification and the retinopathy image placed in the patient's EMIS file or a central repository given the images are taken in RAW format and can be quite large.	1
(blank)	15
Not Answered	**2**
Only for those whose diabetes is not self inflicted so if obese, need to be undertaking a wellness programme addressing healthy eating and exercise	1
Don't know	1
Total	**49**

Paper Responses

- RNIB would support the recommendations for an annual diabetic eye-screening programme. Diabetic eye screening had been available in the UK over the last decade as recommended by the UK National Screening Committee. We do not have a fixed view on the model of delivery but we would anticipate that a new screening service would be developed to best meet the needs of the Isle of Man and be delivered in a way that best facilities the attendants of the widest number of people referred for diabetic screening. Some considerations may include location of service, hours of operations and related costs. RNIB is aware of discussions across the UK around the recommended screening period for diabetic retinopathy and would recommend that the Department take any future decision of the UK National Screening Committee regarding screening periods into account.

Q6 - Should this be provided in a hospital or community setting?

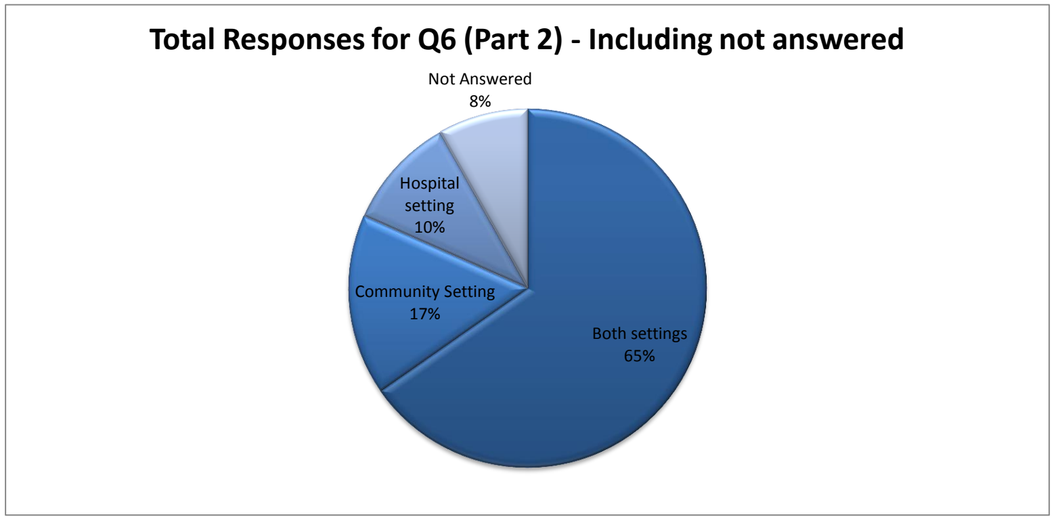
Yes/No Responses

No. & % Answered	45	90%	of all respondents
Both	**32**	71%	of those that answered
Hospital	5	11%	of those that answered
Community	8	18%	of those that answered

Not Answered	4

Text Responses

28	Gave a text response	57% of possible respondents	62% of those that answered Q6 yes/no
21 (including 1 "Don't Know")	Gave no text response	43% of possible respondents	



General Consensus;

- Both Setting

Text Responses	No. of Response
Both settings	32
As above.	1
As previously stated a skilled workforce and well equipped environment are prerequisites for screening.	1
Diabetics may need more bespoke screenings/advice than a high street optician can provide.	1
Due to the nature of the condition it is known that some diabetics especially those who have poor control of the diabetes may fail to attend appointments. If screening may occur in both settings then there is a higher chance of catching the retinopathy earlier saving time, money and sight in the long run. Pathways to quick access to treatment must exist otherwise the screening is of little benefit	1
Ease of access. Some may be patients or need assistance with a transfer to either setting anyway.	1
Easier access should improve numbers screened.	1
If someone can reasonably avail in the community that makes sense. If someone is already hospitalised, or undergoing other treatments it similarly makes sense to receive it in hospital also.	1
Inpatients may need the service as part of other eye investigations. Keeping services are close to the patient as possible reduces the pressure on Nobles, but there are occasions where some tests that are carried out in the community may need to repeated in a hospital setting.	1

It doesn’t matter but it needs to be bench marked. Lilly to be cheaper in community setting	1
It would give greater flexibility for GPs or others to make referrals and ease pressure on the hospital a stress times like TT - There would no reason why this could not be done a GP practice or Community centre say once a month or more regularly if the need was identified	1
It's not always easy for an elderly or disabled person to travel to Noble's.	1
Locally if the optician is trained to undertake this work, much easier for the patient	1
Options needed depending on the patient.	1
Provided that the photography is compared year on year to determine any loss of vision and propose remedial action.	1
Reasons above. Difficulty of travelling to Douglas.	1
Some can get to hospital, some could have this done in clinic. Some cannot get to hospital so need community visits.	1
Whatever setting is easiest and most practical	1
Where the patient is most comfortable and confident	1
(blank)	14
Community Setting	8
Assuming 'community setting' means local high-street optomotrists.	1
If it is only screening then this does not need to be at hospital.	1
Is this not something an optician could do?	1
More convenient for patients not to have to travel to Noble's.	1
See previous response	1
(blank)	3
Hospital setting	5
If the community setting is in the GP practice under medical supervision and subject to immediate on site medical verification then this could be useful.	1
Keep in one place to avoid staff having to travel between sites - it is not difficult, or expensive for patients to travel but while staff are travelling they are not working	1
Stop outsourcing to inexperienced people.	1
(blank)	2
Not Answered	4
Don't know	1
Wherever it's most affective	1
which ever offers best access for patients and value for money.	1
(blank)	1
Total	**49**

Paper Responses

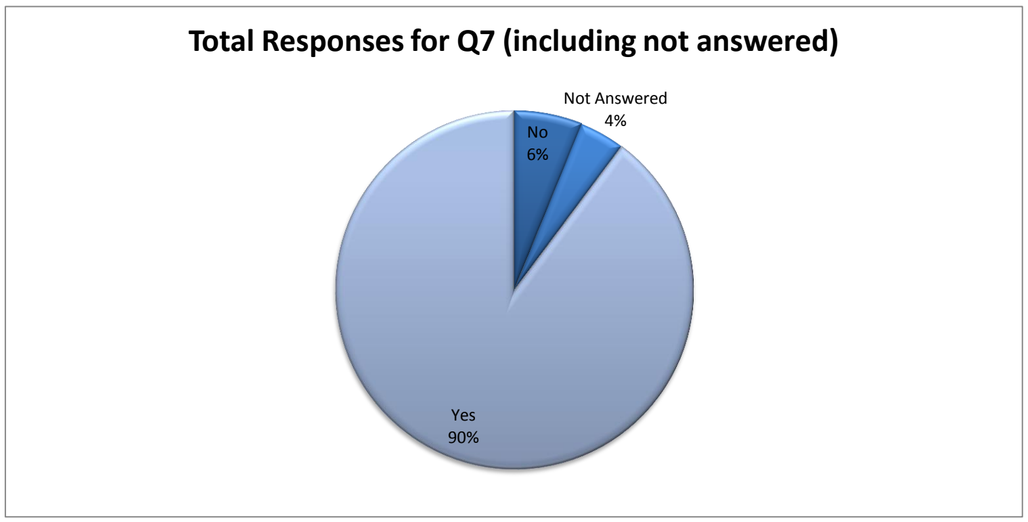
- That the first part of this question is best practice and is currently not being provided then the only part of the question that needs answering is whether Annual Diabetic Retinopathy Screening should be provided in either a Community of Hospital Setting. We would suggest that a community setting is far better and more convenient for the patient, though a hospital setting is preferable compared to the present non-system. Proper funding is one of the critical points.
- Yes - hospital as it presumably has all the necessary equipment and qualified staff

Q7 - Should the Department seek to adopt the Certificate of Visual Impairment?

Yes/No Responses

No. & % Answered	47	96%	of all respondents
Yes	**44**	94%	of those that answered
No	3	6%	of those that answered

Not Answered	2



Text Responses

20	Gave a text response	41% of possible respondents	43% of those that answered Q6 yes/no
29 (including 1 "Don't Know")	Gave no text response	59% of possible respondents	

General Consensus;

• Yes - Adoption of CVI would be beneficial as BD8 is "out of date"

Text Responses	**No of Responses**
No	**3**
Why the black and white answers. If the change doesn't cost anything then do it otherwise no - you need to save cash!	1
Don't know	2
Yes	**44**
Increase patient choice and involvement	1
As it is current "best practice", and means IOM patients are being treated in the same way as patients in England	1
As noted the BD8 is out dated and does not always clearly identify consent.	1
But there needs to be someone who knows what the form is, what it does, what the issues might be and how it affects the patient. And they must be available 1-2-1 to discuss this. not a part-time person with 3 minutes per patient.	1
Clearer purpose and more detailed document.	1
delaying in diagnoses over a weekend and therefore delay in getting the UK has left a family member partially sighted - this could have easily been prevented if Nobles had reacted earlier.	1
For consistency and adoption of best practice.	1
I am not able to state reasons other than reading the above it seems to make sense to do so	1
If the existing process is out of date , of course.	1

In general, the Isle of Man should stop feigning independence, and focus instead on following UK best practice in a TIMELY manner. In healthcare matters in particular, this should ideally happen without the interference of Tynwald.	1
It is in line with good practice and approaches to registration.	1
It makes sense to review your forms on a regular basis to make sure they're fit for purpose. Also, there is greater awareness of the need to use plain english for ease of understanding by patients and greater cultural diversity. It's curious you don't have a question about using a product that's not approved for AMD though	1
It seems more relevant to current times.	1
It sounds like it will benefit patients	1
My son struggles with his vision, but support and information is not there for him especially for school etc. It's a case of yes you need glasses here is your prescription, bye.	1
Our current system seems out of date.	1
The BD8 is now massively out-dated.	1
The Certificate of Visual Impairment is successful in the UK and provides better understanding to those being registered.	1
Why continue with an outmoded process that fails to provide all necessary information and is generally not fit for purpose in today's climate? The adoption of the CVI form would provide a better understanding and give a clearer picture of patients' needs.	1
(blank)	25
Not Answered	**2**
(blank)	2
Total	**49**

Paper Responses

- Certificate of Visual Impairment which would be both best practice and lead to better services for those people who require such certification then it can only be to the good. We also feel that the current mode of certification requiring Ophthalmological opinion should be looked at and perhaps the skills of community optometrists be used here as well.
- Yes
- The Department should adopt a mechanism to capture epidemiological data about the nature of sight loss on the Isle of Man population. These are different forms for certifying sight loss and capturing epidemiological data in England and Wales, Scotland and Northern Ireland. We recommend the Department considers the arrangements in each UK nation to help identify the best approach for the Isle of Man. It is widely recognised in optometry departments across the UK that an Eye Clinic Liaison Officer can effectively support the process of certification. BNIB would be happy to discuss the introduction of a revised CVI form for the Isle of Man with the Department.

Q8 - Is there sufficient support for people where permanent sight loss occurs, in terms of emotional support and rehabilitation?

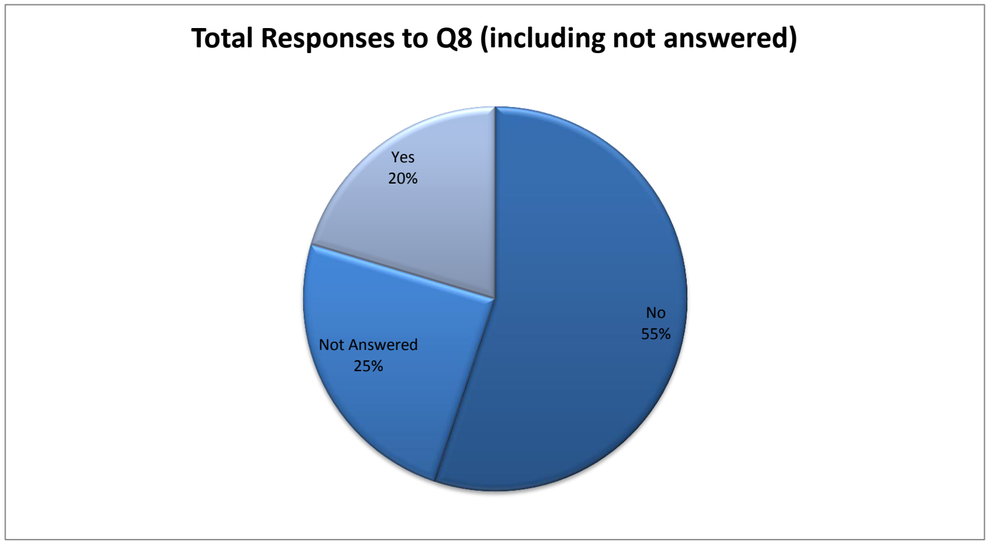
Yes/No Responses

No. & % Answered	37	76%	of all respondents
Yes	10	27%	of those that answered
No	**27**	73%	of those that answered

Not Answered	12

Text Responses

19	Gave a text response	39% of possible respondents	51% of those that answered Q6 yes/no
28 (including 8 "Unsure")	Gave no text response	57% of possible respondents	



General Consensus;

- No - There is insufficient support/information and lack of communication between services
- Where sufficient support is provided it seems disjointed

Row Labels	**No of Responses**
No	**27**
Absolutely not, with a somewhat cavalier attitude to life changing diagnosis given without any support . Whilst this may be an everyday situation for staff it is NOT for the person receiving diagnosis	1
Clear pathway with use if voluntary sector is required	1
For people who lose their sight over a period of time there is no obvious point at which to offer services. People may not ask through pride or lack of awareness. People will struggle on as they don't want to make a fuss. There needs to be regular follow ups.	1
From experience with caring for others people are not given appropriate information about support in any form.	1
Its hard enough getting support for other chronic conditions so I would imagine not	1
My 83-year-old mother has found the Low Vision Unit at Corrin Court to be very helpful. However, as her live-in carer, I've had to do most of the practical stuff, and also take time off work to escort her to Aintree for ARMD assessment and treatment.	1
My main area is people who lose sight due to a stroke it is sudden and traumatic and there is little available within the community to help them either return to work or adapt to their disability outside of the first few weeks post discharge. Emotionally it is very isolating and the stigma surrounding it needs changing. emotional support should not be related to the disability or visual loss only but to all areas of a persons health and life.	1
My son hasn't received any !	1
Physical environment	1

There is excellent support for adults on the island although this is not always publicised at the point of care. Younger adults and children in particular have less support. Communication between services is a major issue.	1
There probably isn't but this will come down to budget pressure. Ultimately, people need to be informed as to how these things will effect their lives, and indeed be assisted with adapting to what might be a new life style	1
Too much money is spend elsewhere on government vanity projects where it should be diverted to services such as these.	1
VIPs need clearer understanding of which services are available and more pertinent to them. Better liaison between clinicians and support services, direct referrals by Optometrists, clear readily available literature provided are all 'must haves'	1
How can I answer this question yes / no if I have no experience of using the service? who the hell writes these surveys?	1
I am not sure as this is outside of my experience.	1
(blank)	12
Yes	**10**
The agencies and networks are there but silo mentality and working practices do not fully support this. optometrist referring to 3rd sector will not remove this and they may be a further barrier and (as yet unidentified) a costly option.	1
Every area of discrimination need looking at as the government is currently doing	1
Stronger voluntary sector than UK?	1
The Manx Blind Welfare do a brilliant job.	1
The resources are there, they just need to be publicised better, utilised effectively and in conjunction with each other.	1
There appears to sufficient support but it depends on how it is being delivered and whether those that suffer sight loss experience tangible benefits.	1
(blank)	4
Not Answered	**12**
Don't know	2
I am not sure if there is sufficient support.	1
No idea	1
Thankfully I don't know.	1
Unable to answer questions 8 & 9 due to insufficient knowledge	1
(blank)	6
Total	**49**

Paper Responses

- In respect of support services for persons with low/no vision and those for whom permanent sight loss has occurred, whilst the Association may have some anecdotal stories, it does not have any direct information or experience to comment on the performance of such support mechanisms that may exist, nor does it have any direct evidence regarding barriers that may or may not exist for persons with permanent sight loss living on Island
- I don't think so. Are these services advertised and public made aware?
- RNIB employs 2 full time Rehabilitation Officers and a part time Eye Clinic Liaison Officer to provide such services under contract with the Department, and with this resource we can currently meet the needs of the island residents. However, RNIB recommends that every newly diagnosed patient should be automatically referred to the ECLO who can provide the much needed emotional support at a very difficult time in a patients sight loss journey and can provide information on eye care conditions and signpost patients for help with other services. We recognise that an increase in referral to ECLO may necessitate and increase in ECLO hours at Nobles Hospital.

Q9 - What are the current barriers for people with low or no visions in education, employment and other areas of living on the Island?

Education

19	Gave a text response	39% of possible respondents
30 (of which 9 where answered unsure)	Gave no text response	61% of possible respondents

Employment

20	Gave a text response	41% of possible respondents
29 (of which 7 where answered unsure)	Gave no text response	59% of possible respondents

Other Barriers

18	Gave a text response	37% of possible respondents
31 (of which 5 where answered unsure)	Gave no text response	63% of possible respondents

Text Responses - What are the current barriers in education for people with low or no visions living on the Island?	**No. of Responses**
?	1
again not sure of the barriers	1
Ask them	1
Books in braille format. Lack of audible books.	1
Don't know.	1
I don't believe we are an equality driven society yet, a long way off.	1
I have no idea	2
Insufficient number of qualified partially sighted or blind specialists in schools and colleges. General ignorance and lack of understanding. We need to be disability wiser to appreciate the problems encountered by VIPs.	1
It would appear to lack of funds and the number specially trained staff within the education system	1
Lack of access/ability to use computers. Mobility.	1
Lack of awareness within schools especially teaching staff, not understanding what the child can actually see.	1
Limited specialist teaching support and funding available.	1
Little understanding or specialism amongst staff	1
Need more support staff	1
No access to eqipement that may assist them within work and at home. Children educated in SENCO needs classrooms due to visual problems which does not give mainstream education and can reduce options for essential education and skills development. Lack of link for services to provide assistance dogs.	1
No experience yet.	1
No idea	1
No idea	1
No real allowance made in classes	1
Not known.	1
Physical environment	1
Small numbers	1
social isolation	1
stigmatization, bullying, lack of facilities for visually impaired persons	1

Transport and a general lack of service provision.	1
understanding of unusual visual impairment, difficult to access courses without prearranged support.	1
Unsure	1
(blank)	21
Total	**49**

Row Labels - What are the current barrier in employment for people with low or no vision living on the Island?	**No. of Responses**
?	1
again not sure of the barriers	1
Any job requirement sight, as well as companies attempting to cater for partially sighted people. The cost could be high.	1
as above	2
As above	1
As above. Adequate provision made for VIPs in employment. Recognising vulnerability and flash points.	1
ask them	1
Don't know.	1
Equipment, transport,	1
few work opportunities for those who have low or no vision	1
Health and Safety Risk Assesment has to be compiled for a partial eyesight.	1
I don't believe we are an equality driven society yet, a long way off	1
I have no idea	1
If I was an employer, I would only employ blind/ partially sighted individuals, if compelled to do so	1
Knowledge about and cost of supportive technologies.	1
Lack of access/ability to use computers. Mobility. Self sufficiency. Employers aren't geared up for this type of disability in the workplace.	1
No idea	1
Not known.	1
Physical environment	1
reduced opportunities for those with a visual impairment particularly if it if not total sight loss. Access to employment transport etc is also challenging.	1
reduction of choices of employment	1
Support with career for those with sever sight loss to enable job progression	1
The government support that is available to jobseekers with a disability lacks drive, determination and passion. The service would benefit from being redesigned and then freshly rolled out and adhered to. A holistic approach could be adopted.	1
The number of Employers who fully understand the needs of a visually impaired or blind person , and a willingness to to make changes within the workplace to accommodate the fore mentioned group	1
Unsure	1
Unwillingness for employers to consider how they can employ, rather than why they can't	1
(blank)	22
Total	**49**

Text Reponses - Are there any other barriers for people with low or no vision living on the island?	No. of Responses
?	1
Again I have no idea as I am not amongst this group nor do I know anyone who is	1
as above	2
Clearer signs, more braille	1
Despite Equalities legislation, public authorities on the IOM consistently ignore the basic rules for signage to be clearly legible, especially for people with low vision. For example, recent finger-post and tourism signs in Douglas comprise blue/green lettering on a similar colour background. Government signs are cluttered with logos and fancy images, in contrast to the clear signage within Nobles hospital.	1
Don't know	1
Especially for those whose sight has deteriorated suddenly, there is the need for sighted people to read out materials and complete forms, etc.	1
I don't believe we are an equality driven society yet, a long way off	1
Lack of access to specialist equipment to enable visually impaired parents to parent.	1
lack of management and planning (thought) by politicians for what may be the most vulnerable group of patients on the island but seem to get the least consideration when it comes to social planning	1
Lack of public transport in some areas. For example, bus service from Castletown to Peel has just been removed. No bus service from the West to Onchan. Lack of knowledge of DDA by service providers.	1
mobility, lack of amenities, poor understanding by the 'sighted' population, guide dogs being attacked or not allowed into shops, pubs etc.	1
Mobility. Self sufficiency. People are housebound as they may also be elderly/infirm. Reliance on other people for shopping/daily needs. Depression and loneliness are a factor.	1
No idea	1
Physical barriers e.g. Street furniture	1
Physical environment	1
Simple measures i.e chairs which are the same colour as the floor being used so there is no contrast making them harder to see. lower level lighting prevent independence (try the hospital car park at night).	1
The general public need better educating in the needs and requirements of visually impaired / blind people to remove any ignorance and prejudice they have , you have to remember most people will never understand or totally experience what is like to loose ones sight and education is always the way forward	1
To actually walk around Douglas presents huge problems for the visually impaired. The pavements are neglected and dangerous in many areas. Every day I see broken glass, discarded road signs, re-cycling containers, chained up bikes, paving stones simply broken, curb-stones broken - all massive hazards for us with limited eyesight.	1
Understanding that the numbers of people who use Braille is quite low, I am always surprised by the number of ramps for the equally small number of wheelchair users, but the comparative lack of braille in signing and buttons.	1
Unsure	1
Vulnerability and isolation in areas involving sport, travel, communication, leisure	1
(blank)	26
Total	**49**

Paper Responses

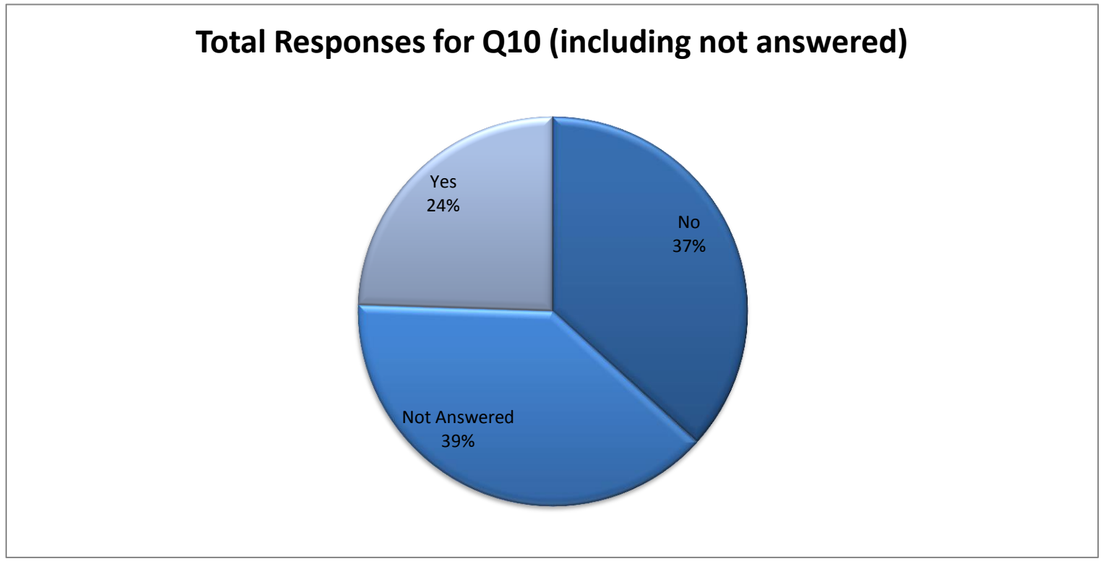
- I have not enough info to comment
- We are content that the current barriers are reflected at page 42 of the strategy document.

Q10 - Are these services meeting people's needs? - Disability Services

Yes/No Responses

No. & % Answered	30	61%	of all respondents
Yes	12	40%	of those that answered
No	**18**	60%	of those that answered

Not Answered	19



Text Responses

15	Gave a text response	31% of possible respondents	50% of those that answered Q6 yes/no
34 (including 9 "Unsure")	Gave no text response	69% of possible respondents	

General Consensus;

- No, services - Not enough money invested in such services & service skills not sufficient to meet needs. Not enough awareness of the services offered
- There are dedicated staff but services not cohesive
- **To improve services** we could improve skills within services, raise more awareness of services offered and ensure a cohesive service is offered

Text Response - Are these services meeting people's needs?	**No of Responses**
No	**14**
Many of the issues mentioned above can apply to people experiencing permanent or temporary difficulties for many clinical and social conditions. There could be further flexibility from statutory services to meet these needs but there is a refusal to allocate sufficient and appropriate funding to provide these services at present outside of trying to develop 'cheaper' options. The continual focus on this option only denies imaginative and more productive methods to meet patients needs.	1
Again, too much money is spend on Government vanity projects and not enough money spent on services such as these.	1
as a healthcare professional who works with people who have sudden sight loss I am unaware of the sight loss rehabilitation and support service.	1
Good as far as they go - but it's the day-to-day living that is made so much more difficult by sudden sight loss. People who have previously coped on their own may be reluctant to move into sheltered accommodation or similar.	1
If the gov thinks they aren't then they must be very bad.	1
Low Vision Service needs to be extended to all fully qualified Opticians.	1
Low Vision Services via Specsavers: Despite being customers of Specsavers, am totally unaware of the existence and scope of such services. Also, Specsavers appear to have stopped stocking dark glasses with light-excluding frames recommended for AMD sufferers. Very difficult to find such frames on the IOM.	1

Only MBW has offered my blind relative any form of service and this has been reactive rather then proactive. No one gets in touch to offer any help. Laughably all her eye clinic appointments come through by letter.	1
Other areas have poor support for chronic conditions, I don't believe VIPs are any different.	1
Proper liaison between all services provision on Island and ensure that skills sets match needs in all areas via robust training. Removal of professional barriers concerning needs of VIPs.	1
Staff do not have skills in the area and find it difficult to identify employment.	1
Again not having used these services how can I possibly answer yes or no	1
I am unable to really comment as, again, it isoutside of my experience.	1
I have no experience of this area and do not feel I can comment appropriately as there is no "Don't know' box!	1
(blank)	4
Yes	**4**
However better joint working would improve the current offer	1
I have stated yes only because I know the people involved are caring other than that as not a service user I do not know	1
I'd like to say yes, but in all honesty I do not know. If really depends on what those needs are.	1
The disability employment service has very dedicated staff.	1
(blank)	8
Not Answered	**6**
?	1
Don't know	1
Don't know.	1
No experience yet.	1
Unable to answer due to insufficient knowledge	1
Unable to comment	1
(blank)	13
Total	**49**

Text Response - How could these services change?	**No of Responses**
Build services around the needs of the patients and the issue of clinical responsibility - enhance trust and integrity in the services by openness, honesty and much improved communications to engage with staff and patients more effectively.	1
?	1
A thorough overhaul and open feedback from VIPs and their carers.	1
As above.	1
as mentioned above breaking down the silo mentalities would be a good start - how about training practitioners who can 'span' the professions who are intent on only working vertically and not horizontally as well? Creating personnel who can cover say 80% of what 2 or 3 different service workers currently do and leave the remaining 20% to the specialists.	1
Don’t know enough to comment on this	1
ideally we need more information about what they are, who they serve etc. stakeholder (current and future) need to be engaged to assess need before changes can be implemented.	1

Improved skills, employing adults with disabilities in the roles so they can understand impact of disabilities. Change the culture of the service. Introduce more incentives for employing people with disabilities.	1
Long-term, the setting up of a retirement 'village' specialising in those with low or no vision.	1
More proactive contact. A phonecall once a year to talk through how the patient is coping, the services available, tools and support on offer. Back up any letters with a phonecall to raise awareness of key information. Draw awareness to any support getting to and from appointments.	1
Raise awareness of what services are available.	1
RNIB could be better resourced. Other referral routes into Low Vision Service could be introduced.	1
See above	1
To find an initiative to bring all of the angencies together , sharing of information within these agencies is essential so nobody slips through the net	1
Use more AI in computer systems	1
Without experience I cannot answer	1
(blank)	33
Total	**49**

Paper Responses

- Don’t have enough info.
- RNIB recommends that the task and finish group is established by the Department to explore this question with service users.

Are there any other comment you have about the eye care strategy?

27	Gave a text response	55% of possible respondents
22	Gave no text response	45% of possible respondents

Text Responses	No. of Responses
No service users on the group	1
After a recent cataract operation I was impressed with the professional slickness of the operation with all staff involved working as a well-oiled machine. Although vastly overworked, staff at the Eye Clinic are caring, approachable, unfailingly polite and reassuring. A pleasant experience all round.	1
Anything to cut downs on trips to Liverpool would be welcome. Getting up at 4.30am for a 15 minute appointment is no fun, particularly in our later years! Use of telemedicine in some of cases perhaps? In better economic times of course more staff including a further consultant. Whatever government can do to reduce the waiting lists which can only get longer with our ageing population.	1
Appointments for checks are currently timed to meet administrative restrictions, ignoring clinical requirements - for instance I saw Mr Khan on 3rd August 2017 and he said he would see me again in 3 months - when the letter came the appointment was for SECOND APRIL 2018 !! I called and eventually they found an appointment in December, confirmed that Mr Khan had said 3 months but admitted they set appointments on the basis of "next available" rather than referring to clinical needs. The above situation is not unusual - in the past, "3 months or 6 months" has usually been extended to 4/5 or 7/8 months.	1
Childrens services are poor. You have to wait a while to be seen, then on another list for consultant, and if ref to alderhey another wait. Then you are given appointments for optometrists in Liverpool which could be done locally. You end up having to have time off work to get a very early morning flight, and spend the day with a distressed and tired child who probably wont cooperate anyway, rather than having a) local optometry services, or b) go with child and see consultant and optometrist on the same time. Money is being wasted on several appointments!	1
Clear processes and guidelines need to be in place for any outsourced services. Patients must always have a line of recourse if they are not happy with the service.	1
Everything could be improved if we looked at - the one thing that is overlooked is education, leaflets could be sent to the "at risk" groups & placed in public buildings and the GP clinics and opticians and perhaps the use of social media and on the Manx.net home page which many people visit daily	1
Existing opticans are not being used fully to deliver a full eye care plan and provision of new equipment is not provided by NHS.	1
Eye care is important and can identify early on certain ill health conditions which if left untreated can be expensive to the tax payer in the long run to treat. However, there is a danger of not giving people autonomy in making their own health care choices. The services should be there, easy to access and if the public want to use them more frequently than is professionally recommended by the various Royal Colleges and evidence based medicine, then should pay for them at 'cost' but not at 'cost plus' where the 'plus' is function of abnormal profit or unregulated consultant private fees.	1
Good that you are trying to improve things but you need to keep the option open to still use Liverpool for the complex cases. For the general stuff - keep it at nobles where the professionals are. Don't outsource any more and don't let kids on the high street make decisions about my eye healthcare.	1
I caught an eye infection a few months back. I went to my optometrist. They checked and confirmed it was an infection. They sent me straight to A&E. At A&E, I waited in the lounge for almost 4 hours. It's a good thing I had my Kindle with me otherwise I would have gone nuts. When a doctor saw me, the examination took 5 minutes and he gave me some eye cream. Why can't an optometrist be given this level of diagnosis and treatment trust? Let an optometrist in the high street dispense an eye care treatment. Going to the hospital for this and waiting for 4 hours for a 5 minute exam is crazy. It wastes NHS resources.	1
I find ophthalmology impossible to communicate with and have had a complaint upheld but not noticed any improvement in service. When I had a vitrectomy across I had to go across for 3 follow up appointments. As I could not fly I was away from home for 40 hours each time although seen each time for less than 30 minutes. When I went to Noble's afterwards they did exactly the same tests. Could these follow up appointments not be done locally with an urgent referral across if any problem is identified?	1

I understand the preoccupation with saving money but I would have liked to see more on information sharing to deliver services. I was shocked to see that scans of my retina were not readily available to each new consultant as I moved from one hospital to another, even if they did need new images. However, no amount of new systems will help if you cannot get efficient working practices in place and the right level of professional staff. I am worried that in the haste to save we see a decline in quality especially for non-routine conditions. And I think that as a small regional hospital we may never be able to offer all services locally or attract the necessary medical staff.	1
I was VERY disappointed i couldn't comment on the use of Avastin over more expensive drugs. Like your item said its not licensed for use as such and needs thorough research to prove effectiveness. Cheaper is not always best although government always takes that option. We are not a poor society or a 3rd world country, we can and should pay for the best treatment to those who need it and taxes should be raised to enable this to happen.	1
I would like to comment on how difficult it is to get your eye test results paperwork from the opticians! Its never 'refused' but they hang on to it for dear life to make you purchase from them. Maybe you dont have the funds available or you feel pressurised to choose something you dont actually like. It should be written in somewhere that you should receive your eye test result before you leave the optician, no messing about. And no pressure and no 'delays'. either that or it should be posted to you within a month. Or emailed to you.	1
It is currently woefully inadequate and my elderly father's experiences have been traumatic at best and he has received callous treatment from a Manx consultant	1
It is of huge concern to me that this is a cost cutting exercise without due consideration given to the quality of care. Generally I would say that the existing service and care by permanent consultants is excellent but this is in total contrast to the care received from locums which is dangerous and well below satisfactory. I would also say that the administration and secretariat function is appalling so much so that it is causing risk to patients - surely this should be addressed urgently?	1
My experience as an OHT patient since 2015 has been 1. Referral via a GP caused no significant delay, but direct referal would have been better. 2. Retinograph camera at Nobles was inferior to my own optometrist. 3. This was a waste of Nobles clinic time, as I was already being monitored. Ditto peripheral vision field test. Further proof that placing these services out in primary care would be a more efficient use of resources. 4. My condition is well controlled, and should be monitored in primary care. 5. But this would mean annual eye tests!	1
Only that my optician was brilliant in referring me to Nobles for a consultation. I was able to be seen privately quite quickly, however, I just wondered how long I would have had to wait for a first initial appointment and how long it would have taken if I hadn't gone to UK privately for my surgery.	1
Promote the idea of people buying glasses "on line" to avoid the Island Opticians high profit margins	1
Publicly funded sight tests for all are a luxury we cannot afford and private sector opticians are active reminding at 6 month intervals for children and 12 months for adults with no good evidence paid for by the public purse. Their potential loss of income in removing free sight tests for all and decreasing the frequency can be made up by offering services currently done in hospital.. pressure checks for glaucoma for example. For this to work there needs to be a clear open pathway for communication between community optometrists and the ophthalmology Department	1
The 'accepted' method of dealing with conditions such as mine is to refer you to Liverpool	1
The number of patients receiving eye treatment across does not appear to include children being seen over at Alder Hey for eye care - this often includes those with special needs, nystagmus or tumours.	1
The service has an excellent visiting orthoptist who's knowledge and skills need to be tapped into. I am disappointed to see that she was not part of the team developing this. The service could do better if it functioned as a team. personal agendas and reliance on locums makes it difficult to improve or engage with.	1

Travelling to Liverpool is exhausting and stressful. However, at Liverpool St Pauls the patient is treated as an active participant in the diagnostic and treatment processes. At each stage, the patient is asked about their changes and concerns, and these details are added to their file notes. Most consultants show and discuss scans and test results with their patients. Holistic treatment for multiple eye conditions is co-ordinated between the various consultants, and follow-up appointments are specified and booked at intervals governed by clinical need. At Nobles, the patient is treated as a passive recipient, and there is a reluctance to discuss test results and eye-pressure readings with patients. The doctors advise as to the interval to the next appointment in accordance with clinical need, and appointment letters are then received indicating a substantial delay (eg 7 months instead of 3 months). If treatment were to be transferred from UK to Nobles, it is absolutely vital that staff and resources will be consistently maintained in the long term to ensure comprehensive and timely treatment. eg. AMD injections cannot be deferred. Liverpool St Pauls appear to prefer use of Eyelea to Lucentis, as this can permit longer intervals between injections. From personal experience, they are prepared to use Avastin in emergency. We strongly support any moves by the NHS to get Avastin licenced for use for AMD.	1
Whilst my 83-year-old mother and I are very grateful for the Aintree treatment, having to travel is taking its toll on her general health. Local provision would be so much better.	1
You could do with monitoring you senior staff better, as my recent experience shows!	1
(blank)	22
Total	**49**

Paper Responses

• We note that nearly all the statistics quoted come from NHS England, given that in respect of eye care services that are now now effectively four different schemes in the UK, the question has to be asked as to why no consideration of statistics from other parts of the UK. From the optometric point of view the system in Scotland would be a better model to look at, yet it is dismissed in a few lines. One has to question if there is an institutional bias in the Department to view the England NHS as the only model worthy of consideration for the Isle of Man. One major failing in the current method of delivery of eye care in the Isle of Man is the lack of reciprocal communication between the Secondary Care and Primary Care (optometrists). Currently patients are referred into Secondary care by optometrists, usually via the GP, but occasionally directly via A&E, but it is very rare that the optometrist receives any feedback whatsoever. What feedback that the optometrist gets is via the patient who is surprised to that we have not been informed of the results of our referrals and more importantly, from the point of view improving referrals they do not often correctly relay the diagnosis. This is something that must change if improvement in the service is to take place. One item that was briefly discussed at a meeting of the Group was Visual Standards in Driving, we realise that this is in the purview of the Department of Infrastructure. However, we feel that the D.H.S.C should make representations to the D.O.I regarding the implementation of the more up to date standards adopted by the UK, given recent events with visually impaired drivers causing accidents in England and the obvious knock on effects to health spending. Given the requirements for the negotiation required for implementation of the pathways, taking into account any additional training for the participating optometrists as well as the appropriate remuneration the time scale for implementation may be somewhat optimistic. The Strategy does not mention the remuneration levels for the schemes, and this should be expected as they will be subject to negotiation. The Department should be aware, however, if remuneration levels are commensurate to the current level of the NHS Sight Test, then it is very unlikely that any of these schemes involving community optometrists will take place.

• **Collaboration with community and voluntary sector** - There is a need for meaningful collaboration with the community and voluntary sector. To achieve this we would recommend the formation of a steering group to link officials leading policy developments that affect the lives of people with eye conditions and sight loss with the community and voluntary sector and disabled people. RNIB is particular interested in developing a partnership relationship with Isle of Man government departments with the aim that we should work together to improve the life experience of everyone affected by sight loss on the Isle of Man. It would be important that any such steering group is led by a senior official with responsibility for taking forward the 5 commitments made by the Department in this strategy. **Data Collection** - The Strategy notes that the data cited is mainly from the UK and states that it is a priority going forwards to improve business intelligence. we fully support that this has been identified as a priority. Data collection is important in terms of developing or planning services and for measuring impact/outcomes. RNIB is keen to work with the Department to establish specific data gaps particularly in relation to sight loss. **Waiting Times** - The Strategy recommends a target of people receiving first appointments within 3 months or referral. We would ask the Department to clarify how this target was determined. RNIB agrees with the strategy in terms of the growing ageing patient population presenting for a first appointment. Therefore, we would recommend that specific targets should be set for macular patients. In March 2016, the Royal College of Ophthalmologists released preliminary findings from a national study indicating that at least 20 patients per month suffer severe and unnecessary sight loss due to appointment delays. Having shorter waiting times not only avoids unnecessary sight loss, but helps the Department save money. Health and Social Care costs avoided are more than 3 times the cost of delivering services. **Accessible Information Standard** - RNIB has raised this issue during the development of this strategy and we refer the Depertment to the accessible information standard introduced in the UK. Currently, "reasonable adjustments" in relation to health information are not being made for people with sight loss - many receiving information or appointments not in thier preferred formats. Patients cannot read appointment letters and often miss hospital appointments as a result affecting waiting times even more. This is unacceptable. **Strategy Implantation** - RNIB also thinks it is important for the Department to establish a steering group to verse the implementation of the Strategy. We would recommend Government, medical professionals and voluntary organisations are represented in a steering group. In Northern Ireland the situation with regard to waiting lists was similar to other parts of the UK in that urgent action was required so that preventable sight loss could be avoided and people did not come to harm whilst waiting to be seen. In 2010 the then Department of Health, Social Services and Public Safety developed the Developing Eyecare Partnership Strategy in response to the increasing pressures on hospital eye services. The document set out a 5 year strategic plan to improve the commissioning and provision of eyecare services in Northern Ireland. The basis of the strategy centred on developing an improved integration of care between primary/community care and secondary case so that patients could more readily receive the treatment they require at the right time. The strategy centred on four aims: **1.** identify potential sight-threatening problems at a much earlier stage. **2.** Contribute to the independence of adults and maintaining them well in the community for as long as possible by improving access to current Health and Social Care treatment for acute and/or long term eye conditions. **3.** Contribute to the improvement of life chances for children, including those children living with disabilities, through improving access to eyecare services and treatment for acute and long term conditions. **4.** Maximise use of Health and Social Care resources in both primary and secondary care services. Whilst the comprehensive eyecare strategy had been developed in Northern Ireland, the resourcing and pace if its implementation had been a major issue. The changes envisaged within the strategy have not been resourced sufficiently and as a result, the pace of change has been too slow to avoid lengthening waiting times and the risks they pose. We would recommend that Department ensures that the changes proposed in this strategy are effectively resourced and implemented within a reasonable timeframe so that people receive timely treatment and avoidable sight loss is prevented.

Is there anything not here that you think should have been included?

16	Gave a text response	33% of possible respondents
33	Gave no text response	67% of possible respondents

Row Labels	No. of Responses
Amount of time consultants spend on private patients and appropriate charging to consultant for use of room, nurse, equipment, secretary etc. Charging for services used by non residents, tighter restrictions on registering with primary care Introduction of immigration health service charge Better signage around Nobles - even sighted people can't find the right department. Why not consider conducting basic sight and hearing tests in school and child screening for weight, scoliosis etc. Start community health early.	1
As a strategy it is lacking in that there are not the following steps built in: dates for reviews, who by and what criteria to be used. baseline of current services costs by cost centre Anticipated costs year on year of all planned developments (staffing, training, transport, consultations, meetings, new appointments, upgrades to staff equipments, new contracts etc) Goals or aims in financial terms of what the strategy seeks to achieve (save) over the coming years.	1
Before going to consultation would it have helped to do more research and filled in some of the declared gaps in knowledge?	1
Given that most of private sector eye care providers used to only get around 30% of their income from NHS patients eye tests, the bulk of the remaining 70% coming from selling lenses / contact lenses and spectacle frames. While this consultation is suggesting that more services are being considered to be placed in the community, what it has not explored is whether, when a patient who is diagnosed in the community would be prepared to pay non NHS prices for some of the "solutions" these organisations might wish to offer that would not be offered if the service was provided in an NHS setting. Hearing aids is an example of where the private sector prices can be in excess of £6k for something that the NHS can offer for around £600. Thus the appetite for private sector prices by NHS patients might have been an interesting question to ask.	1
Given you say the majority of people impacted are elderly do you not think a 19 page consultation survey is wholly inappropriate?	1
I am not sure as I think most things were covered	1
If you have to go across for treatment, you need to be given clear information about what's happening and why, and who you are going to see. We ended up in Liverpool with absolutely no idea why we were there and what the treatment might involve. This isn't an unusual situation, it is the result of a lack of experienced IOM staff who know what they are doing. And buck passing. Very unprofessional and creates anxiety where there should be none.	1
Is full use being made of eg younger retired professionals on the Island with the specialist eye care skills which could be updated and used?	1
Modest charge for eye tests?	1
No	2

Not that I can immediately think of.	1
Option to close iom nobles eye department with transfer of some treatments to opticians and the rest treated in the uk where quality of care is priority not cost	1
The very real problem of recruiting sufficient well skilled opthalmic surgeons and nursing staff to replace retiring experts on island. Getting rid of the stigma and negative image unfortunately attached to Nobles Hospital as 'the chocolate box without any chocolates' so that qualified professionals want to come and work here.	1
Yes - the regularity of appointments for individuals with a known problem, as referred to above	1
Yes room to comment on drug treatments for macular degeneration.	1
(blank)	33
Total	**49**