Isle of Man Government

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Isle of Man Eye Care Strategy For Consultation

Department of Health and Social Care

Rheynn Slaynt as Kiarail y Theay

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Contents

MINISTERIAL FOREWORD

Eye health is important and loss of sight or visual impairment is a significant cause of disability and affects an individual's wellbeing across so many areas of their life. As we age we are at a greater risk of suffering sight loss and as, our population ages, this will become an ever increasing problem.

My Department already spends more per head of population on eye health services than the NHS in England and it is worrying that we are not achieving the outcomes we should be for that spend. People are waiting too long for initial appointments and too many people with macular and retinal conditions still have to travel off-Island for treatment. When people are seen at Noble's Hospital they usually receive a good service but, in view of the financial challenges we face, we have to do better in terms of productivity and throughput to make sure people are seen in a timely manner and wherever possible are seen on Island. It is not acceptable that people's sight can deteriorate whilst they are waiting many months for an initial appointment. We also should be providing a structured annual screening service for diabetic retinopathy.

The proposed strategy therefore identifies the need to redesign the service provided by Ophthalmology staff at Noble's Hospital, improving what can be offered on-Island and, as a consequence, avoiding patients having to travel across to the UK.

This may be accomplished either through extending the skills within the hospital Ophthalmology Department or, if this proves impossible, through the development of partnership arrangements with an off-Island provider, similar to that provided to patients receiving treatment for Age-Related Macular Degeneration on-Island by staff from Aintree.

In addition, we have a highly trained workforce working in high-street Opticians and we have identified that they should be able to manage the ongoing treatment of people with a range of eye conditions, taking pressure from Noble's Hospital and enabling the staff there to improve access and see patients with a wider range of conditions that require specialist diagnosis or treatment.

We are fortunate in having a number of committed and expert organisations in the voluntary sector who work to promote eye health and support people who experience sight loss to make adjustments to their lives. They have played a full role in the development of this strategy, and indeed, requested of my predecessor that the Department develop this strategy. We want to hear the views of everyone involved in eye health about what we are proposing. There is an easy read version of the strategy and a podcast version. There are a number of questions throughout the document which have been grouped for response at the end. But please don't limit yourself to these, we want to hear your views about all elements of the services, what we're currently doing well and what we could do better.

EXECUTIVE SUMMARY

1. Eye health is important. Eye health problems are a major cause of disability and impact negatively on quality of life. Problems increase with age. It is important that problems are identified early and that people are aware of the importance of eye health. The main determinants of an individual's eye health are familial and lifestyle factors.

2. The Department of Health and Social Care spends more per head of population on eye health services than NHS commissioners in England. Some of the higher spend is due to the need for people with rare conditions to travel off Island for treatment.

3. Despite current levels of funding, waiting times for out-patient appointments and in-patient admission are unacceptably long.

4. There is a need to reallocate resource to meet current needs. This will enable more people to be treated on Island (right care in the right place) and achieve a reduction in waiting times.

5. Services need to be evidence based. Currently the Department is funding sight tests at more frequent intervals than recommended by the College of Optometrists. The strategy recommends that, where clinically appropriate, sight test intervals should be increased to two years.

6. The Ophthalmology Department at Nobles Hospital is very busy providing more than 12,000 appointments per year. It provides good quality care and outcomes, but is struggling to cope with existing demand, and with an ageing population the need and demand for services will increase. In recent years, there has been little change in skill mix.

7. The Ophthalmology Department at Noble's does not provide many of the new services that have been developed elsewhere, particularly for people with retinal or macular problems. Whilst the ARMD service provided on the Island by Aintree has meant that more than 100 people have not had to travel regularly to Liverpool, there are still large numbers of people, most of them aged over 60, who have to travel to Liverpool because services are not provided here.

8. There is a need for a service redesign of the Ophthalmology Department. This will enable more care to be provided on the Island, either directly by staff employed at Noble's or by the extension of partnership arrangements with an off Island provider. As well as expansion of the ARMD service, this will include greater productivity in cataract surgery, minor vitreous conditions and the introduction of a diabetic retinopathy screening service.

9. As well as expanding the skill mix at Noble's, pressure will be taken off the Ophthalmology Department by commissioning high street optometrists to provide a number of services for people with minor eye conditions. This is likely to more than offset any reduction in income as a result of the changes in frequency of sight tests.

10. The Island is fortunate in having a number of active voluntary sector organisations which support people with low or no vision. There is a need to make sure that health services and other agencies refer people at the right time to make sure support is available when needed.

11. Financially, the impact of this strategy will be to reduce expenditure on treatments provided in the UK and the associated travel costs; to provide realistic funding for the expanded range of services provided at Noble's that will enable more people to receive care on Island; and to improve access to services and to fund an expansion of services provided in the community by Optometrists. Overall spend will reduce to within reasonable tolerances of UK benchmarks, whilst recognising the additional needs of an older population. Once the redesign project is complete, realistic budgets will be set.

12. This is a strategy for consultation. It sets out a direction of travel that we believe will provide better services for local people. It does not yet have all of the answers.

INTRODUCTION

Eye sight problems are life changing conditions. People with sight loss have an increased risk of losing their independence, and often have lower wellbeing, higher levels of anxiety and depression and poorer satisfaction with their life overall. People with little or no sight are more likely to have early admission to long term care, especially where multiple health conditions in combination with vision loss compromise functional capacity.

The Isle of Man population is ageing, and is projected to continue to age over the next few decades, with the fastest population increases in the numbers of those aged 85 and over. This is the age group most at risk of eye disorders causing vision impairment.

However some important causes of vision impairment, such as glaucoma, are treatable if detected early. Ophthalmic services in the Isle of Man are well resourced. However, the model of care provided has not substantially changed as new treatments have developed, meaning that waiting times for services at the hospital are unacceptably high, and too many patients are being referred off Island. Other than eye tests, community optometrists are not commissioned to provide any services in the community.

The Department of Health and Social Care's Five Year Strategy has five strategic goals:

- for people to take greater responsibility for their own health;
- to help people stay well in their own homes and communities, avoiding hospital or residential care whenever possible;
- to improve services for people who really do need care in hospital;
- to provide safeguards for people who cannot protect themselves; and
- to ensure that people receive good value health and social care.

All these strategic goals apply to eye health. As well as improving preventative and treatment services, it is important that services are in place to support people who have low or no vision, and that the Island is able to provide an environment where people with sight problems are still able to live as good a life as possible. The Island is fortunate in having strong and committed voluntary sector organisations.

This strategy proposes the development of whole system pathways which offer timely and optimal care, streamline processes, improve access and convenience for patients, which are cost-effective and deliver high-quality, measurable outcomes at population and individual levels. Better use of capacity and resources will result in more timely care and reduce avoidable sight loss.

The Department has been working with colleagues from the third sector to develop this strategy over the past year and is making the following commitments:

Commitment 1 DHSC will work with the voluntary sector and with the community to raise awareness of the importance of eye health with the aim that everyone in the Isle of Man looks after their eyes and their sight, is aware of risks to their eyesight and the early signs and symptoms of disease and knows where to go for support.

Commitment 2	Everyone with an eye condition receives timely treatment and, if permanent sight loss occurs, early and appropriate services and support are available and accessible to all.
Commitment 3	DHSC will reconfigure services to ensure that services are providing value for money based on the evidence of effectiveness and benchmarked information. Processes will be streamlined.
Commitment 4	Services will be provided locally wherever possible. More services will be provided in primary care by optometrists. Services will be developed at Noble's to remove the need to leave the Island for treatment except when clinically necessary. In developing local services, DHSC will build on the success of the ARMD Clinic.
Commitment 5	The Isle of Man will be a society in which people with sight loss can fully participate.

This strategy largely utilises data, mainly from the UK, to provide an overview of the eye health needs and support required for the visually impaired. Accurate local data is limited, there is no coding of outpatient activity at Noble's and information routinely provided of care in UK hospitals is recorded at Point of Delivery, rather than HRG codes. There has not been the capacity within the Public Health team to produce a full JSNA and British sources of data exclude the Isle of Man. One of the priorities going forward must be to improve Business Intelligence to support the planning of services. This strategy has been developed by a multi-agency and multi-professional Eye Care Strategy Group, members of the group are shown in Appendix 1.

The aim of the strategy was to encompass all age groups. It has not been possible, at this stage, to consider in any detail the needs of children for services and the pathways of care. This will be in scope for the service redesign work covered later in this strategy.

UNDERSTANDING EYE HEALTH AND SIGHT LOSS

Manx Blind Welfare has 585 people registered with the organisation which is a higher figure than the combined total of the Blind and partially sighted registers, which has 198 people registered as blind (of whom 20 are living in the UK) and 191 registered as partially sighted. The difference between the numbers is thought to be partly the result of some people feeling that being officially registered could be stigmatising.

In the UK, the number of people living with sight loss was predicted to increase by 22 per cent between 2015 and 2020. The increase can be attributed chiefly to an ageing population; over 80 per cent of sight loss occurs in people aged over 60 years. The prevalence of sight loss increases with age. One in five people aged 75 and over and one in two people aged 90 and over are living with sight loss in the UK. If we extrapolate these figures it suggests that in the Isle of Man there are 1500 over 75s with some form of sight loss.

Resident Population 2016	Number	%
50-54	6681	8.02
55-59	5887	7.07
60-64	5170	6.21
65-69	5441	6.53
70-74	4212	5.06
75-79	3155	3.79
80-84	2129	2.56
85 +	2268	2.72

Population aged 50+	34943
% of population	41.94
Total Population	83314

Source: Isle of Man Census 2016

There is some data available from the Public Health Outcome Framework (PHOF)

		IoM	North West Region	England
PHOF 4.12i	Rate of certified sight loss due to age related macular degeneration (AMD) in those aged 65+	93.4	118.7	118.1
PHOF 4.12ii	Rate of certified sight loss due to Glaucoma in those aged 40+	2.2 *	14.8	12.8
PHOF 4.12iii	Rate of certified sight loss due to diabetic eye disease in those aged 12+	4.1 *	2.7	3.2
PHOF 4.12iv	rate of sight loss certifications	47.3	45.7	42.4

all figures are per 100,000 population

* very small numbers in the sample means there are wide confidence intervals

In the UK, the Local Optical Committee Support Unit has produced a National Eye Health Epidemiological model which outlines the expected prevalence of the main eye conditions. For illustrative purposes, the expected prevalence of these conditions in the North West of England is shown below, with numbers for how many people we would expect on the Isle of Man to have this particular condition if the prevalence was exactly matched, which of course it isn't and, as previously outlined, incidences increase with age and is also affected by other determinants, including ethnicity and lifestyle. The numbers are higher than the previous table because these figures will include people with the condition who are being treated and who have not experienced sight loss sufficient for a CVI (Certificate of Visual Impairment).

This data is largely useful in giving an indication of the need and explain why numbers being treated in the UK and at Noble's continue to increase.

Condition	NW prevalence	Numbers in the Isle of Man if NW prevalence applies
AMD	2.4%	2000
Wet-AMD Cases	1.69%	1408
Dry AMD Cases	0.84%	700
- Drusen cases	11.05%	9206
Mean estimated glaucoma cases	1.43%	1191
Cataract high estimate	6.75%	5591

Impaired vision	3.97%	3308
Low vision	3.38%	2816
Severe sight impairment	058%	483

At Risk Groups

There is a high prevalence rate of sight loss amongst people with learning disabilities. In the UK, nearly one in ten adults with learning disabilities is blind or partially sighted. People with learning disabilities are 10 times more likely to be blind or partially sighted than the general population. Although, not large populations on the Isle of Man, there are minority ethnic groups with a raised level of risk of eye disease. The risk of developing glaucoma is higher in African and African-Caribbean populations. People from South-East Asia and China are at higher risk of angle-closure glaucoma. Evidence shows that people from the Asian population are at a higher risk of developing cataracts. African, African-Caribbean and Asian populations are at a higher risk of developing diabetic eye disease.

Consultation Question 1: Are the needs of at risk groups currently being met?

Eye conditions

This section provides a definition of the leading causes of blindness and refers to particular issues which may need to be taken into further consideration. The prevention of sight loss is crucial as over 50 per cent of sight loss can be avoided.

Age-related macular degeneration (AMD)

This condition commonly affects people over the age of 50 and is the leading cause of blindness in people over the age of 65.

There are two main types of AMD: (NV) neovascular or exudative AMD commonly known as wet AMD; and atrophic commonly known as dry AMD.

- **Wet AMD** can develop quickly affecting central vision in a short period of time. Early identification and treatment of wet AMD is vital. Treatment can halt the further development of scarring but lost sight cannot be restored.
- **Dry AMD** can develop slowly and take a long time to progress. There is currently no treatment for dry AMD. People with early and moderate stages of dry AMD are not eligible for registration, but it does have an impact upon a person daily life, for example they may have to stop driving.

In it its final stage, known as geographic atrophy, a person then can become eligible for registration.

Drusen, are tiny yellow or white accumulations of extracellular material that build up in the eye. The presence of a few small ("hard") drusen is normal with advancing age, and most people over 40 have some hard drusen. However, the presence of larger and more numerous drusen in the macula is a common early sign of age-related macular degeneration (AMD).

Glaucoma

This is a group of eye conditions in which the optic nerve is damaged commonly, but not always, due to changes in eye pressure. Damage to sight can usually be minimised by early diagnosis in conjunction with careful regular observation and treatment.

Many glaucoma patients will attend regular appointments and take eye drops for the rest of their lives to prevent deterioration of vision. Some forms of glaucoma can be treated with laser surgery.

Cataracts

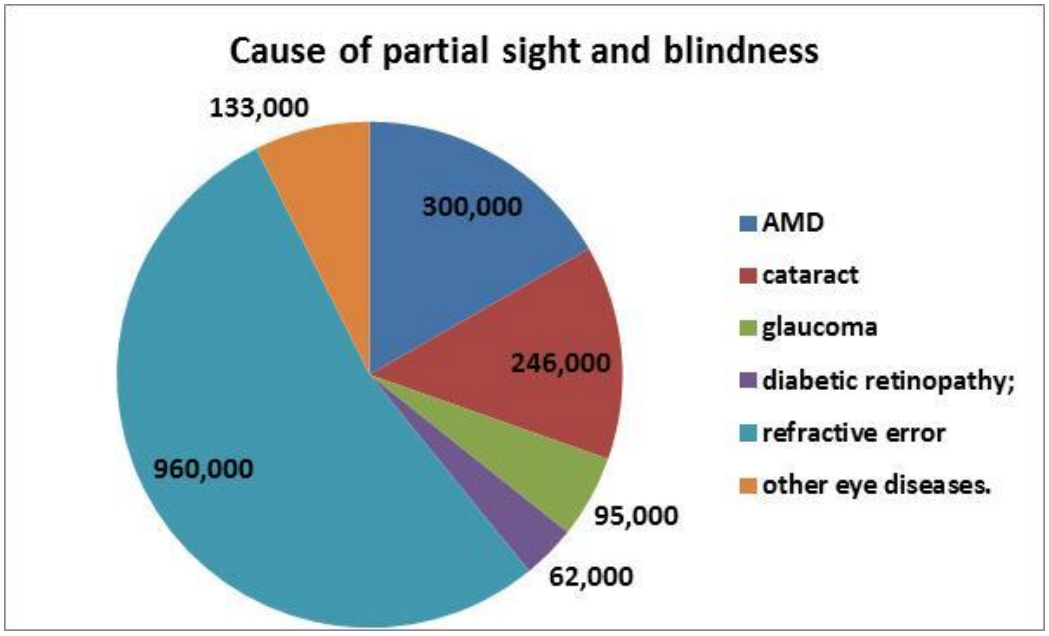
This is a common eye condition that is prevalent in older people. The lens becomes less transparent and turns misty or cloudy. Cataracts over time can get worse and impact upon vision. A straightforward operation replaces the lens with an artificial one.

Diabetic retinopathy

This can lead to permanent sight loss, therefore screening and early diagnosis with appropriate intervention is essential.

Low vision

This refers to people who have some useful vision which can often be improved with low vision aids and adaptations.



Causes of sight loss in the UK

Source: RNIB / FSUK

Health determinants

The impact of sight loss, both from uncorrected refractive error and eye conditions, coupled with other health determinants can dramatically increase risk of ill health from falls, depression and the complications of co-morbidities. The links between sight loss and other health determinants include:

Smoking

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

Research has shown that cessation programmes which link sight loss and smoking provide a motivation for people to reduce or give up smoking

Obesity

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

Alcohol

Heavy alcohol consumption is associated with an increased risk of early age-related macular degeneration.

Stroke prevention

Damage resulting from stroke can impact on the visual pathway of the eyes which can result in visual field loss, blurry vision, double vision and moving images. In addition there may be inability to read (alexia) or to write (agraphia).

Around 60 per cent of stroke survivors have some sort of visual dysfunction following stroke. The most common condition is homonymous hemianopia, a loss of half a person's visual field, which occurs in 30 per cent of all stroke survivors.

Blood pressure/hypertension

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

Sun

Looking at the sun directly can cause irreversible damage to eyesight. Several studies also suggest sunlight exposure is a risk factor for cataracts.

Dementia

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

Impact of Sight Loss on Health and Society

Falls

A recent review of evidence on the link between falls and sight loss found that almost half (47 per cent) of all falls sustained by blind and partially sighted people were directly attributable to their sight loss.

On average, the estimated medical cost of falls in the UK is £269 million in a population of 85 million people. Of the total cost of treating all accidental falls in the UK, 21 per cent was spent on the population with visual impairment.

Depression

Older people with sight loss are almost three times more likely to experience depression than people with good vision.

Employment

In the UK, 66 per cent of registered blind and partially sighted people of working age are not in paid employment. No comparable figures exist for the Isle of Man. People registered as blind or partially sighted are nearly five times more likely to have been not in paid employment for five years or more than the general population.

Age, additional disability or health problems, severity of sight loss, educational level and ethnicity are all factors that influence the employment status of blind and partially sighted people of working age.

Eye Health Promotion

Most general lifestyle health promotion interventions apply to eye health. Therefore, for good eye health the following are important:

- healthy diet and regular exercise
- sun protection, protecting your eyes from sun
- not smoking
- sensible levels of alcohol consumption

Up to date advice with reference to evidence is available at www.visionmatters.org.uk/looking-after-your-eyes/looking-after-your-eyes

In addition, regular eye examinations are important.

THE CASE FOR CHANGE

Programme budgeting is a term used by the NHS in England to describe the process of capturing costs related to discrete areas of activity or service and then benchmarking the results against published capitation figures to identify outliers for management action. It is useful for identifying areas where commissioning action should be taken to either drive better value for money or improve allocative efficiency, (i.e. making the right choices about how to allocate or spend a limited budget on services and activities that produce the best possible set of outcomes).

The figures shown below compare spend on eye health compared to commissioning organisations in England. As such, the table excludes the Department's commissioning of services from the voluntary sector to support people with low or no vision. Whilst it is inevitable that the data will not be 100% accurate, it demonstrates that the Department of Health and Social Care is spending considerably **more** than the average for England, and as the subsequent tables show is not providing adequate access to cataract operations or managing waiting times.

Expenditure On Eye Care - Isle Of Man			
	IOM 15/16 Actuals £'000	IOM Spend per 100,000 population	NHS England 2013/2014 £'000
Primary Care (1) Primary Prescribing	332	393	230
Unscheduled Care Non-elective Admission A&E Emergency Transport			 68 92 7
Scheduled Care (2) Elective Outpatient Attendances Outpatient Procedures Outpatient Diagnostic Imaging	3,701	4,380	**(4)** 797 1,232 0 8
Unbundled/High Cost Critical Care Drugs & Devices			 2 362
Other Health Care Services (3)	1,666	1,972	81
Running Costs		6,745	2,878
Gross Expenditure	**5,699**		

1. Includes GP & Outpatient Prescribing

2. All included in elective, costs no split, includes UK referrals

3. Includes Primary Care Ophthalmic Services & Patient Transport

4. Includes all outpatients not split in 13-14

There are a number of areas identified for review:

- Expenditure on sight tests
- Prescribing costs
- Cost of delivering services in Noble's
- Costs of treating people in the UK, including travel costs.

The additional spend might be justified if the Department was providing additional access to services than populations elsewhere. Unfortunately that is not the case, and Ophthalmology is one of the specialties with the highest waiting times.

Ophthalmology Hospital Waiting Times At 31 December 2016							
		Months	Waiting	At	Noble's		
	Total waiting	0-2	3-5	6-11	12-17	18-23	24+
Outpatient 1st appointment	1127	568	207	180	115	47	10
Inpatient treatment	256	147	53	30	18	8	0

The Department of Health and Social Care is aiming for all first appointments to be within 3 months of referral and all in-patient treatment to be provided within a further 6 months (patients will still be prioritised on the basis of clinical need). This is an interim target before the Department is able to measure the times between referral and first definitive treatment (known as the RTT target). These long waiting times are in spite of Noble's being well resourced in comparison with English hospitals (accepting that bigger departments are able to benefit from economies of scale).

The Ophthalmology Department at Noble's is one of the busiest Departments of the hospital. It manages a range of eye conditions from emergency presentations to stable long-term conditions, but is still largely trying to meet demand with traditional models of service delivery, but is failing to meet demand for services. Increasingly, the challenge that the growing patient population presents will lead to increased waiting times, unless new ways of working are adopted.

Since 2008 there has been a 24% increase in patients attending eye outpatient appointments at Noble's. 12% of all outpatient attendees are to the Eye department. Cataract surgery accounts for 6% of all surgery. New treatments have been introduced for Age Related Macular Disease and Retinal Vascular Disease. Patients are either travelling to the UK for these treatments, or services are being provided by Aintree NHS Trust as a visiting service. With increases in the numbers of people living with diabetes who have a greater risk of eye disease than the general population and the ageing of the population, services as they are currently provided are not sustainable.

The Royal College of Ophthalmologists estimates that the projected demographic changes will produce a 25% growth in cataract numbers over the next 10 years. For a department currently running at full capacity to cope with existing demand, changes are going to be required to avoid progressive under-provision and the need for waiting list initiatives or recruitment of outside help.

There are no targets for follow-up patients and no systematic recording of delays, or the impact on eye health. Services are almost exclusively based at Noble's and the current skill mix and capacity, or how that capacity is organised, means large numbers of patients are travelling to the UK, often for relatively minor follow-up appointments.

Weakness in Current Service

Services have evolved and, with the notable exception of ARMD, there has been no conscious planning to determine which services should be provided on Island and which at specialist services in England. Other barriers to service improvement include the lack of integrated IT systems, poor communication between primary, secondary and tertiary providers. There is a paucity of outcome data or published quality standards across all aspects of eye care. There is a rudimentary understanding of how much the Island spends on eye care, but no accurate costing of services. At Noble's there is a shortage of trained specialist nurses to support the doctors, little opportunity for continuing professional development or career development. There is an overreliance on long-term locums or staff visiting from the UK.

The rate of cataract procedures is within the normal range for a population of the size of the Isle of Man, but as the programme budget indicates, the hospital service is significantly more expensive than benchmarks in the UK. It also has unacceptably high waiting lists and times, both for in-patients and out-patients.

A process mapping exercise highlighted a number of areas where processes could be improved:

- Management of referrals through a single waiting list (the Consultants currently take it in turns to take referrals and the lists are operated separately)
- One stop shop for certain conditions
- Increase the number of people discharged
- Review of clinic templates
- Reduce dependency on relatively high cost temporary staffing
- Increase the number of specialist nurses and allied healthcare professionals in ophthalmology i.e. optometrists or orthoptists.

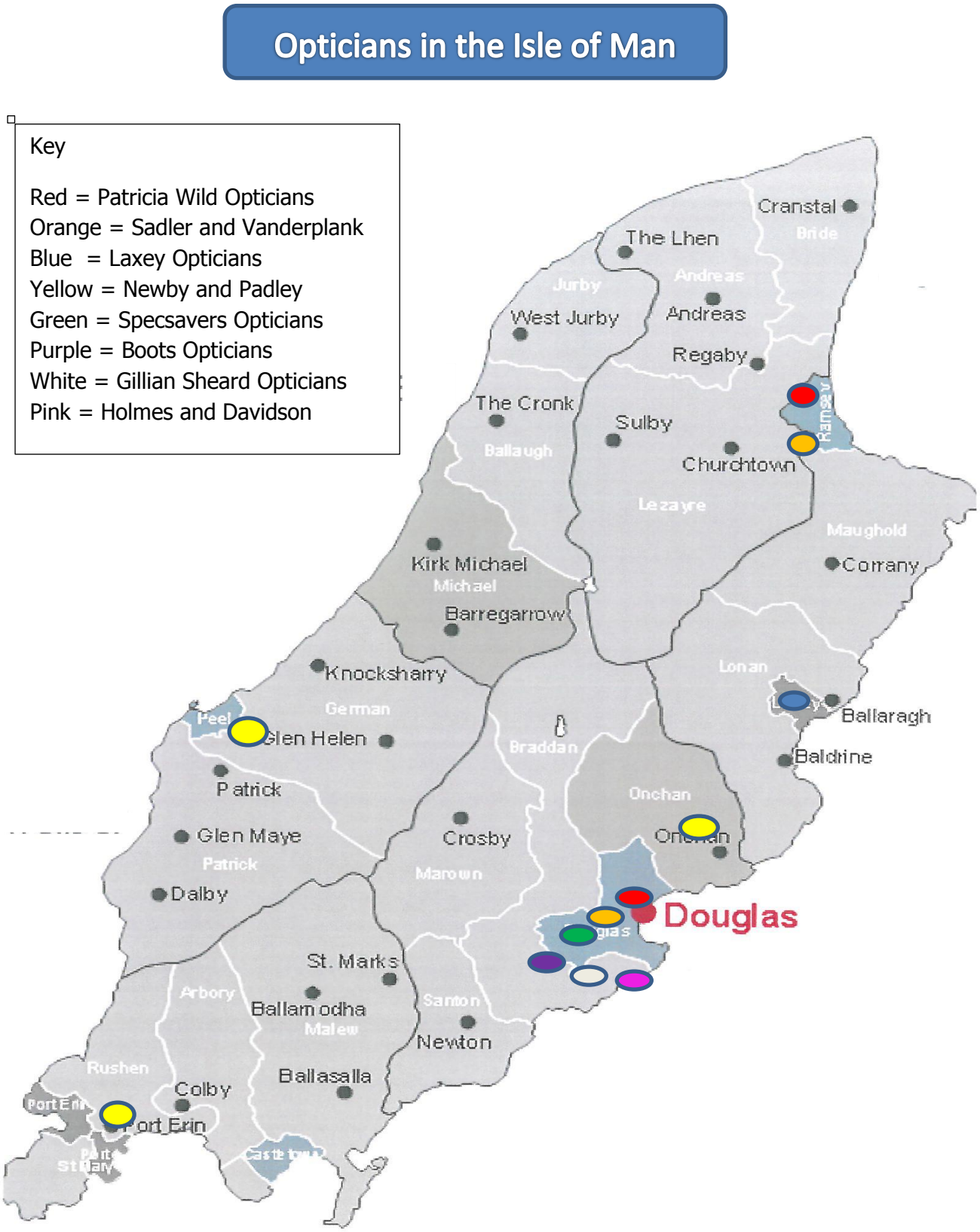
This indicates the need for clear pathways which offer timely and optimal care, streamlining of processes, improved access and convenience for patients, which are cost-effective and deliver high-quality, and finally measurable outcomes at population and individual levels.

Dedicated resources have been identified for a Service Redesign Project which will seek to:

- Reduce overall spend closer to England averages recognising the effect of a larger older population and the challenges of providing a service to a small island based population
- Reallocate spending from services provided within UK hospitals to services provided at Noble's
- Increase funding in primary care to reflect more patients being seen in primary care
- Fund a diabetic eye screening programme

The Service Redesign Project will assess whether the shifts in spending can be achieved by reconfiguration of existing services with required changes to skill mix and overall staffing OR whether the Department needs to commission an inreach service from a provider, either in the UK or elsewhere.

CURRENT POSITION – PRIMARY CARE OPTOMETRY SERVICE



There is reasonable coverage of the main centres of population by high street opticians. Opticians are private companies with a contract with the Department for the provision of NHS sight tests. They employ Optometrists. Optometrists are primary health care specialists trained to examine the eyes to detect defects in vision, signs of injury, ocular diseases or abnormality and problems with general health. They make a health assessment, offer clinical advice, prescribe spectacles or contact lenses and refer patients for further treatment, when necessary.

There are currently eight optical businesses in the Island with contracts with the Department, with thirteen premises. There are 22 optometrists on the Department's performers' list.

Optometrists study at university for three years and must participate in a period of assessed clinical training in practice, before being deemed to have the knowledge and skills needed to be registered. Once registered, they have the opportunity to take further qualifications and develop their interests in specialist areas of practice.

Although Optometrists have had more specialist training in managing eye conditions than General Medical Practitioners, currently if they detect a problem which requires further investigation they have to refer to the GP or advise the patient to attend the Accident and Emergency Department to be seen as an emergency. In the UK, most areas have recognised that by requiring patients to be referred by a GP adds an extra bureaucratic step in the process that adds delay, creates additional work for GPs and adds no value to the patient. They have therefore introduced pathways where optometrists can refer directly, with a copy sent to the GP for inclusion in the patient's medical record.

Consultation Question 2: Should optometrists be able to refer directly to Noble's?

Current services in primary care

Opticians are contracted to provide sight tests and can claim for domiciliary visits to test the sight of people who are housebound.

Sight Tests (Adults and Children)

	2014-2015	**2015-2016**	**2016-2017**
Total Number of Sight Tests Completed	35,803	36,472	36,409
Cost of Sight Tests Completed	£748,283	£777,218	£775,876
Total Number of Domiciliary Visits Completed	275	168	167
Cost of Domiciliary Visits Completed	£18,251	£6248	£6273

Vouchers/Repairs

	2014-2015	2015-2016	2016-2017
Number of Vouchers Issued	3200	3742	3280
Cost of Vouchers Issued	£133,799	£152,839	£134,140
Number of Repair Vouchers Issued	447	454	461
Cost of Repair Vouchers Issued	£10,355	£10,039	£9,600

There is no specification in the Isle of Man of what should be included within the sight test. Whilst opticians will always test visual acuity, some optometrists will provide a number of other assessments, including retinal photography and visual field tests to see whether the patient has existing or latent eye disease. These tests are not funded by the NHS, and are either provided free of charge to the patient, or the Optician charges the patient privately.

Sight Tests

Regular eye tests are important because most eye disease is asymptomatic in its early stages. A sight test is a vital health check that can pick up early signs of eye conditions before there is awareness of any symptoms – many of which can be treated if found early enough. A sight test will show spectacles or contact lenses are needed for the first time or to change the current prescription.

Currently any resident of the Island is entitled to a free NHS sight test every 12 months. If, in the optician's clinical opinion, a sight test is required more frequently, this can be performed under the NHS. It is unclear as to when and why the 12 month time period was decided.

The optician receives a fee from the Department of £21.31 for each sight test undertaken.

The Cost and provision of sight tests over the last five years is set out below			
Year	Number of sight tests provided	Cost of individual sight test	Total cost of providing sight tests
12-13	33,407	£20.70	£691,525
13-14	36,344	£20.90	£759,590
14-15	35,803	£20.90	£748,283
15-16	36,472	£21.10	£777,218
16-17	36,409	£21.31	£775,876

HOW THE ISLE OF MAN CURRENTLY DIFFERS FROM ENGLAND

In comparing spend with England, it is necessary to highlight that the Isle of Man unlike England provides free sight tests for all under the NHS. In England NHS sight tests are only provided free of charge, every two years to certain categories of patients, i.e. on the basis of their clinical condition, if they are over 60 or if they are in receipt of social security benefits. Patients in England with certain clinical conditions are able to obtain NHS sight tests more frequently than the usual two year timescale. For example, a child wearing glasses, a diabetic, a patient who is age 40 or over with a family history of glaucoma or a patient aged over 70 would all be recommended to have a sight test annually. Wales and Northern Ireland do not provide universal free sight tests, but Scotland has reintroduced them. There has been some analysis of the economic benefits of the reintroduction, but because it makes a number of assumptions, it is not regarded as strong evidence.

College of Optometrists Recommendations

The professional body recommends that patients should be examined at the most appropriate intervals, depending on their clinical needs:

Patient age and/or condition	**Recommended minimum re-examination interval**
Up to 16, absence of binocular vision anomaly or refractive error	1 year
under 7 years, with binocular vision anomaly or corrected refractive error	6 months
7-15 years, with binocular vision anomaly or rapidly progressing myopia	6 months
16 years and over	2 years
with diabetes who are part of diabetic retinopathy monitoring scheme	2 years
with diabetes who are not part of diabetic retinopathy monitoring scheme	1 year

Contact lens patients may need more frequent appointments for aftercare but are not entitled to more frequent NHS sight tests simply because they wear contact lenses unless provided to meet a medical need.

It is difficult to see how providing routine sight tests more frequently than the recommended intervals can either improve health or represent value for money.

The Department is constantly reviewing the charges it makes for services. This is necessary both to address its overall financial position and to enable investment in new services. Within the National Health and Care Service Scheme that will be laid before Tynwald after consultation, the Department will outline its intentions for charging.

Any changes recommended in the Scheme will be subject to separate consultation, but in addition to any changes therein recommended it is proposed that the interval for sight tests becomes **every two years** rather than every year, unless the patient is in an identified category requiring more regular sight tests for clinical reasons. There is evidence that a number of the sight tests are currently being undertaken annually, or certainly less than every two years. In addition, Opticians Practices on the Island actively request patients to attend annually.

Consultation Question 3: What should be included in the specification of a sight test?

Development of services in the Community

Optical Practitioners are an under-utilised source of expertise within the Isle of Man health service. In the UK, pathways have been introduced for accredited Optometrists to provide a range of services under contract that take some of the pressure from secondary care services and make them more able to focus on specialist treatment and more complex conditions.

For instance the LOC Support Unit reports that minor eye conditions services manage 70 – 80% of their patients without onward referral with the impact of a 14 – 18% reduction in new appointments in hospitals. Community Eye Services have high levels of patient satisfaction and service provided more cheaply than in secondary care. Accreditation and proper commissioning means there are robust clinical governance frameworks and performance monitoring in place for these services.

Services that the Department suggests should be commissioned from high street optometrists include:

- Glaucoma repeat readings and OHT monitoring
- Pre/post operative Cataract Pathway
- Children's vision (post screening)
- Low vision services
- Services for people with learning disability
- Urgent care - fast track to Ophthalmology where patient triage and appointments offered based on clinical need urgent (24 hours) or routine (2 days) for the management of:
    - Red eye or eyelids
    - Dry eye, gritty and uncomfortable eyes
    - Irritation and inflammation of the eye
    - Significant sticky discharge from eye or watery eye
    - Recently occurring or sudden increase of flashes and floaters
    - Painful eye
    - In-growing eyelashes

- Recent and sudden reduced vision

- Provision of specialist contact lenses

The Clinical Council for Eye Health Commissioning has produced accredited pathways for all these services. It is proposed to adopt the pathways on the Isle of Man and commission services using an Any Qualified Provider Model.

It is proposed to develop detailed specifications for these services and to transfer the budget from Noble's to primary care commissioning for these services to be provided in the community from 1 April 2018. These will be commissioned on an Any Qualified Provider basis with a fixed tariff for service.

There will be a need to consider how Opticians can be supported to purchase any additional equipment required and look at how to join up IT systems to support information sharing.

Consultation Question 4: Are there any reasons why these services should not be provided within primary care?

SERVICES AT NOBLE'S HOSPITAL

Ophthalmology is one of the busiest specialties at Noble's. With the exception of cataract surgery, which accounts for over 95% of eye care surgical procedures performed on Island, most of the activity is in Outpatient clinics. As the table indicates, the ratio of new to follow-up patients is greater than 1:3. Through commissioning additional services from community optical practices, the case mix of patients seen at Noble's will change. It is not appropriate to set out arbitrary targets for new: follow up ratios, and as services are remodelled clinician templates will be next based on best practice and evidence from the Royal College of Ophthalmologists.

Ophthalmology Outpatient Appointments 16/17								
			Attended			Did Not Attend		
Clinic	**Day**	**Time**	**New**	**FUp**	**Total**	**New**	**FUp**	**Total**
Eye Review	Monday	am	63	378	441	9	59	68
Eye Review	Monday	pm	4	267	271	1	43	44
EYE REVIEW	Monday	pm	36	113	149	2	6	8
Locum	Monday Friday	pm	278	584	862	21	82	103
Locum	Monday Wednesday	am	291	697	988	21	95	116
1 DAY POST OP NURSE CLINIC	Tuesday		0	64	64	0	0	0
EYE CLINIC	Tuesday	am	39	91	130	3	13	16
Eye Clinic	Tuesday	am	45	331	376	4	46	50
EXTRA EYE CLINIC	Tuesday	am	147	353	500	8	41	49
Cataract	Tuesday	am	70	502	572	9	23	32
Laser Patients	Tuesday	pm	1	146	147	0	4	4
Cataract	Tuesday	pm	47	402	449	3	20	23
Minor Ops Clinic	Wednesday		0	74	74	0	7	7
CHO	Wednesday	am	41	85	126	3	9	12
Eye Clinic	Wednesday	am	53	326	379	6	54	60
RDCH OPHTHALMOLOGY	Wednesday	am	4	128	132	0	4	4
Assessment	Wednesday	pm	111	19	130	21	1	22
Laser Clinic	Wednesday	pm	1	67	68	0	4	4
Thurs Assessment Clinic	Thursday		93	45	138	13	2	15
1 DAY POST OP NURSE CLINIC	Thursday		0	81	81	0	0	0
Eye Review	Thursday	am	77	490	567	11	64	75
Cataract	Thursday	am	64	468	532	5	15	20
Minor Ops	Thursday	pm	0	84	84	0	6	6
Locum	Thursday	pm	135	270	405	21	34	55
EYE CLINIC	Friday	am	40	96	136	2	3	5
Eye Clinic	Friday	am	34	354	388	2	61	63
Cataract	Friday	am	81	550	631	6	12	18
LOCUM EXTRA	Friday	am	139	362	501	19	33	52
Emergency Ophthalmology			356	271	627	2	2	4
LOCUM EXTRA			178	199	377	20	24	44
One Stop Cataract			49	0	49	0	0	0
LOCUM DIABETIC EYE CLINIC			156	55	211	36	4	40
OPHTHALMIC NURSE VISUAL FIELD			4	291	295	0	58	58
RDCH VISUAL FIELDS CLINIC			4	79	83	0	2	2
Total			2641	8322	10963	248	831	1079

This section of the strategy examines the major Ophthalmic pathways. The Royal College of Ophthalmologists has recognised that the increasing demand for hospital eye services (HES) is not being met and continues to grow and has commissioned a series of papers under the title "The Way Forward" to identify current methods of working and schemes devised by ophthalmology departments in the UK to help meet the increasing demand in ophthalmic services.

Because, as has been outlined, the prevalence of eye conditions increases with age, large numbers of older people are leaving the Island for eye care appointments. Under this strategy the intention is to redeploy the resource freed up by routine conditions being managed in primary care to develop a range of new services at Noble's which will prevent significant numbers of people having to travel off Island for eye care. It is important that patients have confidence in the service and there will need to be investment in medical,

nursing and allied health professional staff to make sure that there is the right skill mix to deliver the wider range of services.

Noble's is starting a redesign project to review all ophthalmic pathways and scope the skill mix and staffing required to manage the majority of conditions on Island and better use the funding provided to UK Trust and travel costs for care on Island.

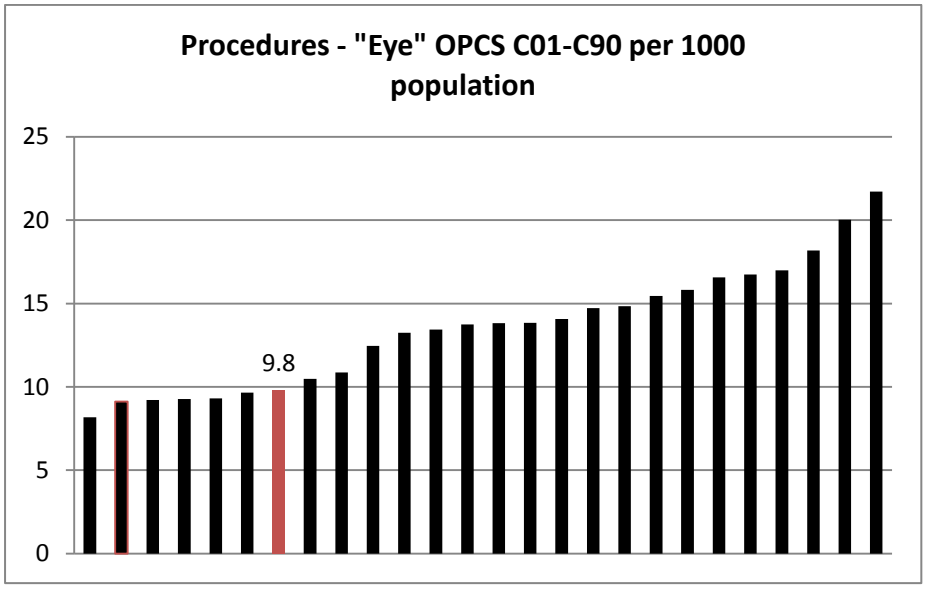
Sending patients to the UK for treatment is expensive. For a patient who needs to be accompanied by an escort, the costs are in excess of £300 before the Department has been charged for the health care intervention by the UK hospital. This accounts for a significant amount of the higher than average expenditure on eye health.

The Department wishes to ensure that patients are only travelling to the UK for treatment when there is a need for them to do so. Most of these appointments are relatively routine, but necessary because Noble's does not have the staff able to manage the conditions on Island. The redesign proposal will identify within a reduced financial envelope how services can change at Noble's. It will explore whether it is best from a clinical and a financial perspective for the Department to employ staff working in Ophthalmology or whether it should commission a strategic partnership to provide an inreach Ophthalmology service at Noble's. This will enable a substantial proportion of the resource spent on treatment in the UK to be deployed to provide treatment on Island. There will be a requirement for investment in capital equipment. This will be included within the redesign project.

Cataract Surgery

The main surgical procedure undertaken by the Ophthalmic Department at Noble's is cataract operations.

Procedures provided in IoM per 1000 population compared to NHS England Area Teams



Isle of Man is shown in red

There are no reported concerns about the quality of treatment or outcomes achieved by patients. However, as the programme budget indicates, Noble's is well resourced in the Ophthalmology Department and because the Department has not introduced new ways of

working it is now not able to demonstrate optimum levels of productivity. This contributes to the long waiting lists. There is evidence from a systematic review that patients who wait more than 6 months for cataract surgery may experience negative outcomes during the wait period, including vision loss, a reduced quality of life and an increased rate of falls.

Pathways and processes

Currently 4-5 cataract operations are undertaken in each session at Noble's. The most productive units in the UK are managing 12-14 operations per session. Recently, topical anaesthesia has started to be used in some cataract operations at Noble's which consists of numbing eye drops to the surface of the eye which can be applied by the surgeon. This has already reduced cost. However, the current lower productivity is inevitable because the skill mix within the Department is substantially different than that of the best performing units in the UK. A complete review of operating procedures and changes to staffing and skill mix to increase operational productivity will be undertaken. One of the changes that will be required is that referrals will be implemented through a pooled waiting list managed by an ophthalmic coordinator.

Within the proposal for an extension of the role of the optometrist, patients will attend the optometrist rather than being referred to Noble's for a pre-operative assessment. If the need for cataract surgery is agreed in line with the threshold criteria to be developed, the optometrist will contact the hospital. It is proposed that within the redesigned service patients will be able to choose the date for surgery within 18 weeks of referral. Following surgery, for patients who require a second cataract to be done, they will be assessed before leaving the hospital and given an appointment for between 6 and 13 weeks for the second surgery. Patients will no longer attend clinic immediately post-surgery, unless there are complications and patients will have a final follow up appointment 6 weeks after surgery with the optometrist.

Alongside pathway redesign there is a need to ensure that the patients who can most benefit from the surgery are prioritised. It is proposed that this will be managed through the introduction of thresholds for surgery.

Thresholds for Surgery

The Department of Health and Social Care is reviewing its clinical policies to ensure that it uses its limited resources in the most effective way and that services are provided in ways that those with the greatest need will benefit. As part of this review, it is recommended that cataract surgery should only be provided on the NHS for:

i) patients with a best corrected visual acuity of 6/12 or worse in the affected eye (threshold applies for both first and second eye surgery), AND have impairment in lifestyle such as substantial effect on activities of daily living, leisure activities, and risk of falls

ii) Surgery is indicated for management of ocular comorbidities such as control of glaucoma, view of diabetic retinopathy etc.

iii) Patients with cataract having visual acuity better than 6/12 does not imply automatic exclusion. In this circumstance, where there is a clear clinical indication or symptoms affecting lifestyle, surgery should still be considered and approval sought through the Individual Funding Requests Panel outlining how it is expected that the individual will receive exceptional benefit. For example, a patient with 6/6 symptomatic posterior subcapsular cataract, affecting activities of daily living and driving.

The acuity criterion is included as it represents a quantifiable indicator of vision that can be routinely audited (for referrals and surgical intervention), whereas symptoms are more challenging to audit in practice in the absence of pragmatic and standardised tools to measure them.

SERVICES PROVIDED IN THE UK

The majority of patients seen in the UK for eye conditions are treated at the Royal Liverpool and Broadgreen University Hospitals or at Aintree. A small number of patients attend Warrington for Oculoplastics.

As the figures below show very few of the patients are admitted for procedures, with the costs of inpatient procedures representing not much more than 10% of the payments made to UK Trusts for treatment.

IoM admitted patients care in UK Contracted Trusts April 2015 to March 2016

HRG code	OPHTHALMOLOGY	Aintree		RL&BUH		Total	
		Activity	Cost	Activity	Cost	**Activity**	**Cost**
BZ01Z	Enhanced Cataract Surgery			4	£ 4,023	**4**	**£ 4,023**
BZ02Z	Phacoemulsification Cataract Extraction and Lens Implant	2	£ 1,492	7	£ 5,238	**9**	**£ 6,730**
BZ03Z	Phacoemulsification Cataract Surgery			1	£ 949	**1**	**£ 949**
BZ05Z	Major Oculoplastics Procedures	2	£ 2,528	2	£ 2,537	**4**	**£ 5,065**
BZ06A	Intermediate Oculoplastics Procedures, 19 years and over	4	£ 3,511			**4**	**£ 3,511**
BZ07A	Minor Oculoplastics Procedures, 19 years and over	1	£ 609	4	£ 2,443	**5**	**£ 3,052**
BZ09A	Intermediate Orbits or Lacrimal Procedures, 19 years and over	1	£ 2,044			**1**	**£ 2,044**
BZ11Z	Major Cornea or Sclera Procedures			1	£ 2,032	**1**	**£ 2,032**
BZ12Z	Intermediate Cornea or Sclera Procedures	1	£ 1,533	7	£ 10,768	**8**	**£ 12,301**
BZ13Z	Minor Cornea or Sclera Procedures			4	£ 3,444	**4**	**£ 3,444**
BZ14A	Major Ocular Motility Procedures, 19 years and over	2	£ 2,507			**2**	**£ 2,507**
BZ15A	Intermediate Ocular Motility Procedures, 19 years and over	5	£ 5,614	1	£ 1,127	**6**	**£ 6,741**
BZ15B	Intermediate Ocular Motility Procedures, 18 years and under	3	£ 3,446			**3**	**£ 3,446**
BZ16A	Minor Ocular Motility Procedures, 19 years and over	4	£ 4,329			**4**	**£ 4,329**
BZ16B	Minor Ocular Motility Procedures, 18 years and under			1	£ 1,054	**1**	**£ 1,054**
BZ17Z	Major Glaucoma Procedures			16	£ 21,712	**16**	**£ 21,712**
BZ18Z	Intermediate Glaucoma Procedures			2	£ 1,968	**2**	**£ 1,968**
BZ20Z	Complex Vitreous Retinal Procedures			7	£ 12,840	**7**	**£ 12,840**
BZ21Z	Major Vitreous Retinal Procedures			17	£ 24,504	**17**	**£ 24,504**
BZ22Z	Intermediate Vitreous Retinal Procedures	1	£ 1,188	5	£ 5,962	**6**	**£ 7,150**
BZ23Z	Minor Vitreous Retinal Procedures	22	£ 7,930	17	£ 6,148	**39**	**£ 14,078**
BZ24A	Non-Surgical Ophthalmology with length of stay 2 days or more			1	£ 2,755	**1**	**£ 2,755**
BZ24C	Non-Surgical Ophthalmology with length of stay 1 day or less			2	£ 646	**2**	**£ 646**
WA14A	Procedure not carried out for clinical or patient reasons			2	£ 909	**2**	**£ 909**
WA14B	Procedure not carried out for other or unspecified reason			1	£ 455	**1**	**£ 455**
	TOTAL	**48**	**£ 36,731**	**102**	**£111,514**	**150**	**£148,245**

Out-patient activity in the UK is not coded, so there is no information systematically provided to the Department of why people are being seen in out-patient appointments in the UK, which as shown overleaf accounts for the majority of the spend.

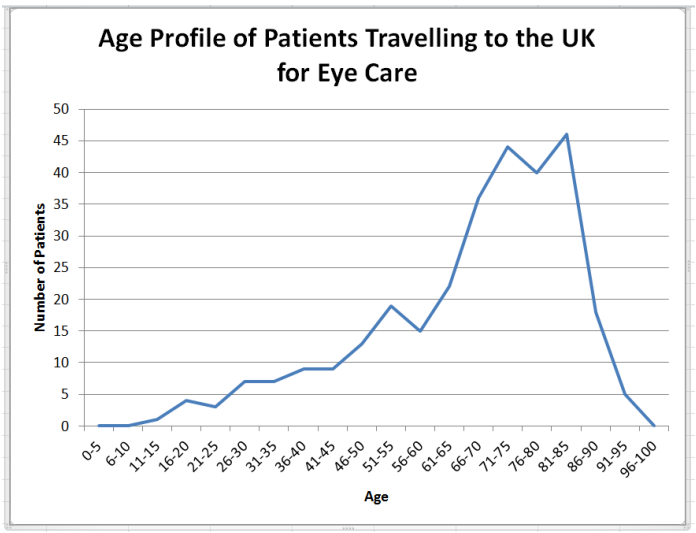
Activity provided by UK Trusts to IoM patients 2016/17

Sum of activity	**Trust**							
Point of Delivery	Aintree	Central Manchester	Liverpool Women's	Royal Liverpool	St. Helens	Wirral	Walton	Total
1st Outpatient attendance	75	5	3	117	1	1	9	211
Assessment only ARMD appointments	142			22				164
ARMD Drugs	120			56				176
ARMD full pathway appts	129			56				185
ARMD service		1						1
ARMD treatment appts	668							668
Chemotherapy				2				2
Day cases	43			90	1			134
Drugs excluded From Tariff	70			6				76
Elective excess Bed days	17							17
Elective inpatient spells	5	1		33				39
Follow-up Outpatient appts	431	19	7	740		5	3	1205
Non-elective Inpatient spells	1							1
Outpatient procedures	780			222				1002

Cost of activity provided by UK Trusts to IoM patients 2016/17

Sum of activity	**Trust**							
Point of Delivery	Aintree £	Central Manchester £	Liverpool Women's £	Royal Liverpool £	St. Helens £	Wirral £	Walton £	Total £
1st Outpatient attendance	8,890	593	353	13,779	118	117	1,058	24,909
Assessment only ARMD appointments	67,747			8,526				76,273
ARMD Drugs	253,840			31,248				285,088
ARMD full pathway appts	111,278			30,261				141,539
ARMD service		10,630						10,630
ARMD treatment appts	502,837							502,837
Chemotherapy				2,622				2,622
Day cases	35,027			119,852	762			155,642
Drugs excluded From Tariff	108,070			4,453				112,523
Elective excess Bed days	4,273							4,273
Elective inpatient spells	5,016	1,027		51,628				57,672
Follow-up Outpatient appts	28,828	2,351	466	49,472		332	200	81,649
Non-elective Inpatient spells	5,682							5,682
Outpatient procedures	90,559			27,128				117,687
Total	1,222,047	14,600	819	338,970	880	450	1,258	1,579,024

An audit of the Patient Transport system data shows 299 patients travelling to either the Royal Liverpool or Aintree for eye conditions. The majority of these are older people. From the data, the majority of patients were originally referred for problems of the retina and macular, with a smaller number of patients referred for corneal problems or glaucoma.



Analysis of more detailed activity at Aintree shows that aside from ARMD the most common condition treated is Minor Vitreous retinal procedures. The level of the data does not provide us with sufficient information about what procedure is being done and whether if there were additional sessions of a retinal specialist on Island, whether all or most of these procedures could be provided on the Island. Providing the procedures, which includes bringing all ARMD appointments to the Island and single professional follow-ups, would save more than 1,000 patient journeys a year (at an estimate cost per journey of £300 equates to an annual saving of £300,000).

Ophthalmology Activity at Aintree April - February 2017		
HRG Description	Activity	Actual Price
Adhoc - ARMD Drugs		230,658
Adhoc - Branch Retinal Vein Occlusion		16,899
Adhoc - Central Retinal Vein Occlusion		4,739
Adhoc - Central Serous Retinopathy		1,573
Adhoc - Clinically Significant Macular Oedema		19,550
Adhoc - Diabetic Macular Oedema		20,556
Adhoc - Diabetic Maculopathy		7,984
Adhoc - Diabetic Retinopathy		6,906
Adhoc - Subfoveal Choroidal Neovascularisation		8,994
Adhoc - Torsion Dystonias		350
Adhoc - Venous Occlusions		5,220
ARMD Assesment	117	55,820
ARMD FULL	116	100,064
ARMD Treatment Only	611	459,930
Electrical and Other Invasive Therapy Level 2	6	679
Enhanced Cataract Surgery	1	1,020
First Attendance - Multi Professional	7	909
First Attendance - Single Professional	61	7,160
Follow Up Attendance - Multi Professional	7	683
Follow Up Attendance - Single Professional	386	25,661
Intermediate Nose Procedures, 19 years and over without C	1	117
Intermediate Ocular Motility Procedures, 18 years and under	5	5,848
Intermediate Ocular Motility Procedures, 19 years and over	2	2,285
Intermediate Oculoplastics Procedures, 19 years and over	3	2,680
Intermediate Orbits or Lacrimal Procedures, 19 years and ov	1	1,433
Intermediate Vitreous Retinal Procedures	76	15,099
Major Oculoplastics Procedures	1	1,287
Major Skin Procedures Category 1, with Major CC	1	5,682
Minor Ocular Motility Procedures, 18 years and under	2	2,138
Minor Ocular Motility Procedures, 19 years and over	5	5,505
Minor Oculoplastics Procedures, 19 years and over	12	4,400
Minor Orbits or Lacrimal Procedures, 19 years and over	2	739
Minor Vitreous Retinal Procedures	638	73,502
Non-Admitted Non Face to Face Attendance - Follow-up	1	24
Non-Phacoemulsification Cataract Surgery	1	963
Non-Surgical Ophthalmology with length of stay 1 day or less	1	327
Phacoemulsification Cataract Extraction and Lens Implant	5	3,797
Vascular Access except for Renal Replacement Therapy, with	1	221
Grand Total	2070	1,101,402

Very few of these conditions are acute emergencies and a key element of the redesign project will be to assess what service developments are required to provide the appropriate skill mix and specialist equipment so that the majority of these patients could have this care on Island. It will be important that clinicians would be seeing sufficient cases to maintain their specialist skills and that local provision is financially viable. However, the starting point is to assume that it is possible to provide most services on Island, recognising that this may need a range of visiting Consultants.

Confidence in local services is important. The Department is not able to afford a properly resourced modern Hospital Eye Department and fund treatment and travel for large numbers of patients to UK hospitals. Some patients who could be seen at Noble's have indicated a preference to be seen at UK hospitals.

Consultation Question 5: 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?

DIABETIC EYE SCREENING

Diabetic Eye Screening is a key part of diabetes care. People with diabetes are at risk of damage from diabetic retinopathy, which is one of the most common causes of sight loss amongst people of working age. Because it doesn't usually cause noticeable symptoms in its early stages, screening for the disease is essential if it is to be detected before it has become advanced, and is difficult or impossible to treat.

In all areas of the UK, local diabetic eye screening services provide comprehensive annual screening programmes operating call and recall systems, which is also quality assured as a national NHS Diabetic Screening programme.

On the Isle of Man about 1000 diabetic patients a year attend the Diabetic centre for an annual retinal photograph. These are patients either under the care of the Diabetic Team or who have been discharged back to primary care by the Diabetic Team. The photographs are currently reviewed by one of the locum speciality doctors. The 2014 JSNA reported diabetic percentages of 4.11% based on information records with GP practice clinician registers. The England study reported prevalence is 5%. This means that there are around 3200 people recorded with diabetes on the Island, and fewer than a third are receiving an annual retinal photograph at Noble's

Patients who have their diabetes managed with primary care are advised to have a retinal photograph taken by their optometrists as part of a sight test. There is no specification for sight tests so some optometrists may not provide retinal photography routinely. There is also no data to show how many diabetics have had an annual retinal photograph. Moreover, optometrists, whilst working to professional standards, are not part of a systematic quality assurance process.

The experience of other international diabetic retinopathy screening programmes has shown that of the population screened and treated, six per cent are prevented from going blind within a year of treatment and 34 per cent within 10 years of treatment. The eligible population that should be invited for screening are aged 12 and older, diagnosed with diabetes and excluding those who do not have perception of light in both eyes. There are a number of steps that make up the complex process that is diabetic retinopathy screening. Each aspect of the screening process must be fully quality assured. Quality assurance is process driven, and specific steps help define and achieve screening goals.

The Department approved a business case to introduce an annual diabetic eye screening service a number of years ago, but has never identified the funding to implement the service. As part of the reconfiguration of services, it is intended that this service will be commissioned to start in April 2018 and options for a service model which will meet quality assurance standards will be developed as part of the implementation plan.

Consultation Question 6: Should the Department be providing annual diabetic retinopathy screening? Should this be provided in the hospital or in a community setting?

AGE RELATED MACULAR DEGENERATION

Effective treatment for Age Related Macular Degeneration has only been available over the last decade. Since the discovery of the effectiveness of injections with anti-VEGF drugs, patients with possible neovascular AMD (nAMD) require urgent new appointments and follow ups must not be deferred. This means that recurrent assessment and treatment are required, and the demands for the service are increasing rapidly.

Since April 2015, because of an arrangement negotiated with Aintree NHS Trust, most patients who had been travelling for their injections have had their treatment provided on Island. In the past year, 114 patients have received their care at Noble's and 66 patients still at Aintree. There is a smaller cohort still being seen at the Royal Liverpool Eye Clinic. Originally Aintree was providing the whole clinical team, but following the training of local staff, is only now supplying the service with the Consultant Ophthalmologist.

Currently most patients still have to travel to Aintree for diagnostic appointments, and more complex patients, including those with co-morbidities, are still being seen at Aintree. The existing service has been very successful, but is now under extreme pressure and needs an increase in capacity to be able to meet demand. The service needs to be reconfigured if it is to significantly increase the proportion of patients who can have all their treatment managed on Island which was the original aim of the service. This will require changes to the contractual arrangement with Aintree.

This is a significant element of the service redesign, which will include the following components of new ways of working identified by the Royal College's commissioned work:

Referral Management

- Suspected nAMD requires fast track referrals and rapid access for immediate assessment and imaging
- How direct electronic referral can be used to facilitate this
- How new patient triage using clinical assessment and imaging may be performed by trained non-medical healthcare professionals (HCPs) or ophthalmologists
- The decision that rapid treatment or no treatment is required should be made and delivered with the most efficient use of time and personnel.

Virtual Clinics in AMD

- Royal College of Ophthalmology reports that 63% of eye departments reported using virtual clinics
- Reliance on imaging has made these more acceptable
- These can be delivered in the Hospital or at peripheral sites, including mobile units or via telemedicine to provide more space. They do not need to be provided at Noble's.
- Decisions about treatment are made by the consultant at a virtual reporting session or by the HCPs directly where trained for this case mix
- Different levels of decision making are being developed.

One Stop Clinics

Clinics where patients are both assessed and treated at the same time have been successful in reducing the number of hospital appointments for patients. These can be used for new or returning patients, but are reported as being more common for review patients (53%) than new referrals (30%). The advantages are not fully known and attempts to get the best of both worlds with injection lists running alongside assessment clinics have also developed, i.e. start with booked patients for injection and leave space for those being assessed. The option of using telemedicine will also be explored.

Skill Mix

When anti-VEGF injections were introduced it was solely the preserve of Consultant Ophthalmologists. However, other Health Care Professionals (HCPs) are now injecting patients. The Moorfield Eye Hospital has 40 nurse injectors and in Sunderland 90% of IVT injections are performed by nurses. The redesign will explore the use of HCPs under clinical supervision of the Consultant for services on Island.

ARMD Drugs

When Lucentis (ranibizumab) was licenced in 2006, the new macular degeneration drug was celebrated as a major medical breakthrough. But some eye doctors argue that a drug closely related to Lucentis, known as Avastin (bevacizumab), also has been shown to be a highly effective and far cheaper alternative for individuals with advanced AMD. The problem is that Avastin is approved only for treatment of colon and other cancers, but not for macular degeneration. As both drugs are licenced by the same company, there is no incentive for the company to apply for a licence for the cheaper drug. As an alternative, many eye doctors have been using Avastin as an unlicensed treatment. Aintree has indicated that its doctors would not be prepared to use Avastin.

The Clinical Recommendations Committee will assess the benefits and risks of using Avastin, and make a recommendation to the Department. An initial analysis of potential savings is included below:

The Anti-VEGF drugs used for ARMD treatment are expensive. However, there are costed treatment options for ARMD

1. Cost for EYLEA (Aflibercept) 40mg/1ml Drug Tariff price £816.00

Current charge to Noble's is £437.00 per syringe via discount scheme

Cost per year treatment: 8 vials per year £3,496.00
Based on one injection per month for first three months, then every two months.

2. Cost for Lucentis (Ramibizumab) 10mg/1ml Drug Tariff price :£742.00

Current charge to Noble's is £445.20 per syringe via discount scheme

Cost per year treatment is 8 vials per year £3,561.00
Based on one injection per month for first three months, then every two months

3. Cost for Avastin (Bevacizumab) 25mg/ml (4mls vial) in November 2014 for a Bevacizumab 5mg syringe made by Hospira (Short expiry date) – Drug Tariff price: £242.40

Current charge to Nobles is £24.00 per syringe based on ordering 5. One syringe allows a dose of 1.25mg to be administered to one patient.

Cost per year: £288.00 per year
Based on one syringe (1.25mg) per month
*unlicensed and increased risk when product is re-packaged for administration of the smaller dose.

Usage for 2015-16:

In the year 01 April 2015 to 30 March 2016 the number of syringes used is:

Eylea – 180 syringes – Total cost exc. VAT - £78660.00

Lucentis – 204 syringes – Total cost exc. VAT - £90820.80

Costs correct at time of preparation: 12th July 2016.

Switching to Avastin would present a £70,000 saving opportunity.

SUPPORT SERVICES AVAILABLE TO BLIND AND VISUALLY IMPAIRED PEOPLE LIVING IN THE ISLE OF MAN

A wide range of support services are available to people living with the challenges of sight loss in the Isle of Man; those services are provided mainly from public and third sector agencies.

Specialised support is provided locally by three third sector organisations: Manx Blind Welfare Society (MBWS), RNIB and the local Macular Society support group. Department of Health and Social Care provision is predominantly Occupational Therapists, Medical staff and Health visitors and others.

UK based Third Sector organisations working with blind people such as Guide Dogs and Blind Veterans make occasional visits to the Island often working in liaison with MBWS and/or RNIB in the provision of further specialised assistance to blind people.

Referrals to the local third sector agencies come from various sources including GPs, Optometrists, Noble's Hospital Eye Clinic Liaison Officer and on occasion directly from other areas of the hospital. Referrals are also made by Allied Health or Social Care Professionals, Educationalists, family and friends and/directly by people who have sight loss or problems with their vision.

An oversight of the local service provision is taken by the Isle of Man Vision Impairment Partnership.

<u>Manx Blind Welfare Society</u>

Manx Blind Welfare Society operates free from public sector funding, grants or contracts. Significant aspects of its services are operated through its extensive network of volunteers. Services are provided without charge. The service operates with 7 FTE and 5 PTE and in excess of 250 volunteers.

Some of the services provided

- Manx recorded news service
- Social, leisure, entertainment and recreational activities (including annual escorted holiday)
- Emotional Support
- Independent living support (including buddy allocation when appropriate)
- Social Advocacy, Intervention and Representation
- Financial Assistance (Special circumstances)
- Free issue Assistive Technologies including IT and communication equipment (Home and Workplace)
- Home and hospital visiting service
- Free Audio Lending Library (4000+ titles)
- Braille and Audio transcription service

- Weekly Luncheon and Entertainment club.

The Macular Society Support Group

The Macular Society Support Group provides a range of services to those living with the challenges of Macular degeneration. Importantly this group are able to provide more information helping people to gain a fuller understanding of their condition and the group encourage people to live their lives to the full.

Some of the services provided

- Regular meetings with informative speakers (includes updates on treatments and the latest technologies)
- Helpline (National)
- Personal peer to peer emotional support (helping to learn to live with and overcome some the challenges faced by macular patients)
- Advice and Information (can include signposting on to other public or third sector support providers)
- Events and Outings (providing a chance to form new friendships and meet with similar people enduring the problems of vision reduction or sight loss)

RNIB Isle of Man

RNIB Isle of Man is an Manx registered charity and works under contract with the Department of Health and Social Care.

Referrals to RNIB come from a number of health professionals, GPs, Optometrists, Noble's Hospital Eye Care Liaison Officer (ECLO) or from other areas of the hospital.

There are also referrals from other allied health or social care professionals, Education Department, family and friends and/or directly from people who have problems with their sight.

Under contract with the Department of Health and Social Care, RNIB provides services to people living with sight loss. There are two full time Rehabilitation Officers (Senior Rehabilitation Officer manages all of the services). The recently qualified second Rehabilitation Officer also has the title of Low Vision Therapist having qualified for this role 3 years ago.

The Eye Care Liaison Officer (ECLO) – based at Noble's Hospital Eye Clinic

The ECLO works closely with medical and nursing staff in the eye clinic, as well as colleagues in social services and voluntary organisations, to connect patients with the practical and emotional support they need to help understand their diagnosis, deal with their sight loss and maintain their independence. The ECLO is available, not only at the point of diagnosis to help an individual understand their eye condition, but at all other times a patient is present within the eye clinic.

Rehabilitation Service

Two Rehabilitation Officers are available to identify, deliver and evaluate professional rehabilitation interventions to visually impaired people to enhance their skills and confidence

to maximize their independence. This is done through service-user-led assessment of need/aspirations to help promote independent living.

Rehabilitation may include, but is not restricted to:

- Daily living skills – home management, employment and leisure
- Communication skills – includes all forms of access to communication, including Braille, Moon, audio description, telephones, Deaf/blind manual and block alphabet
- Mobility training – helping to develop independence in indoor and outdoor mobility environments – including training in guiding skills, pre-cane, long cane, orientation and route planning techniques

Low Vision Service

The Isle of Man Low Vision service was developed 6 years ago. RNIB are responsible for the management and administration of this service. Funding is currently provided through the Department's Commissioning Division which meets the cost of low vision aids provided to individuals using the service. A clinical examination room is proved by MBWS and funding for the diagnostic equipment was provided using funds donated to MBWS by the now disbanded Isle of Man Federation of the Blind.

The service is supported by a local Optometrist and operates a monthly clinic.

Also providing support is a Low Vision Therapist and Rehabilitation Officer.

Following a low vision assessment, further domiciliary assistance is provided by the Low Vision Therapist who will advise on lighting levels, will help individuals to get the most out of their remaining vision by offering reading strategies and ensure that correct use is made of any low vision aids provided.

Register

RNIB hold a copy of the register for blind and partially sighted people. This is maintained locally.

Record of examination to certify a person as blind or partially sighted

Detailed guidance for Ophthalmologists is included on form BD8 to enable them to "decide whether to certify a person as blind or partially sighted".

The current BD8 uses a slightly amended version of the 1920 definition of "blindness"

> "So blind as to be unable to perform any work for which eyesight is essential" (Blind Person's Act 1920)

There is no equivalent legal definition of partial sight but guidelines include the wording, "substantially and permanently handicapped by defective vision caused by congenital defect or illness or injury".

The guidance on the BD8 defines the various levels of vision below which people will qualify for registration as blind or partially sighted and this is determined by measuring the person's visual acuity, assessing the person's visual fiends and finally, the Ophthalmologist's professional judgement.

Ophthalmologists are advised to consider two additional factors when deciding about certification which are the speed and age of onset of visual disability.

The form BD8 has been used for many years on the Isle of Man and in 2003 the UK began changing the certificate and now use the CVI form (Certificate of Visual Impairment). This has been in place and in use in the UK since 2005.

Voluntary sector colleagues have expressed concern that the BD8 form used on the Island of Man is largely out of date, the consents are ambiguous and the information that is required to be provided by the Ophthalmologist minimalistic and not fit for purpose.

The CVI form immediately focuses on the patient consent part of the form whereas the BD8 contains a much shortened version…"the patient agrees to a copy of this form being sent to the Director of Social Services, the General Practitioner named in Part 1, to the RNIB (who are providing services on the island) and the Manx Blind Welfare Society".

The CVI form explains in more detail what the purpose of the form is, who will receive a copy and why and what a patient can do if they do not wish for this information to be shared.

The BD8 merely states, "the patient understands what this form is for and how it will be used".

Unfortunately, it has been suggested, that in some cases, the patient is told that they are going to be registered with little explanation about this procedure. The patient is largely unaware that the whole process of registration is entirely voluntary and the BD8 does not make this clear.

It is recommended that the Department explores the process for discontinuation of the form BD8 and the adoption of the CVI form. The patient will have much more detailed information regarding their eyesight and any practitioners working with a patient will have a better understanding of how the patient's visual performance is and can design suitable working practises based on that individual's needs.

Consultation Question 7: Should the Department seek to adopt the Certificate of Visual Impairment?

Department of Health and Social Care

The Department of Health and Social Care contract the following services

- Rehabilitation provision – daily living skills, communication skills and orientation and mobility training in various settings.
- Occupational Therapy (home visits to provide additional special enabling equipment).
- Acute and respite healthcare (staff at Noble's and Ramsey, some of whom are trained in basic vision awareness).
- Social workers (working with VIPs during hospitalisation, discharge planning and in the development of public or private care packages).
- Re-ablement service (officers focus on assessing people's ability to live independently and/or discussing and agreeing how that might be enabled).
- Domiciliary support staff (Staff who can assist people in a range of different ways all geared to helping people live independently).

There are others who make a significant contribution to providing support to blind and visually impaired people including the Visual Impairment Support Service (VISS) which supports a number of students in mainstream education.

Improvements

Current Barriers for people with low or no vision in education, employment and other services that prevent people from having full opportunities because of their sight loss.

There is strong evidence to suggest that our public to third sector referral system has room for improvement. We all recognise that some people are left confused about the services that are available to them immediately following diagnosis and in some cases patients don't present to, or are not referred to support agencies in a timely manner. Areas for addressing include:

- Ensuring the ECLO service is fully utilised by Clinicians
- Regular cross sector publication of the services available to VIPs
- Improved "who to contact" guidance
- As optometrists take on an expanded role ensure that they also make referrals directly to the third sector support services
- Be confident that the referrals pathway for suspected urgent cases is working

The Equality Act legislation places additional requirements on employers and it is expected that there will be more opportunity for people seeking employment who fall under the protected characteristics of the new law.

In advance of the passage of Equality Act detailed regulations in the interim significant effort has been exerted by the IOM Government Multi Agency Forum (a DHSC sponsored group comprised of representatives from the Public, Private and Third Sectors) which has introduced the Tiered Award Scheme designed to encourage each sector to become more "disability smart" in their approach to issues of accessibility. It encourages service providers and employers to make reasonable adjustments to how they operate, not just in terms of the services they provide but in how they engage staff. This award is the single biggest contribution to changing attitudes and awareness, the actions taken by participants after initial assessment often lead to organisations gaining a higher award level in recognition of the changes they have adopted.

Consultation Question 8: Is there sufficient support for people where permanent sight loss occurs in terms of emotional support and rehabilitation?

Consultation Question 9: What are the current barriers for people with low/no vision in education, employment and other areas of living on the Island?

The IOM Government Disability Employment Service is constantly engaged in the process of assisting people with a range of disabilities including sight loss into employment and advising and encouraging employers sometimes with assistance from other support agencies (public and third sector) to employ people with a range of impairments or life challenges.

There remain individuals or groups of individuals across the Island who are living with little support in terms of maintaining their independence or living fully inclusive lives. There needs to be a concerted joined-up effort to address issues of isolation, inclusion and independence.

- There is a need break down professional boundaries and silo mentality working tirelessly to provide, or at least offer our services to the whole VIP audience
- Ensure that regular and appropriate contact is made with VIPs living alone and particularly those with complex needs
- We need to up-skill all sector service providers who may now or at any future period be delivering support in domiciliary care settings. Much of that training can be provided at no cost via either from MBWS or RNIB or both in combination.
- Recognising that blind and deaf/blind individuals are particularly vulnerable at certain crucial times in their lives such as at discharge from hospital or respite care. We should regularly review the safety of discharge procedures for this vulnerable group.

Commissioned services

Adult Social Care Division of the DHSC oversees two significant contracted areas in relation to visual impairment:

- Sight loss rehabilitation and support
- Low Vision Service through Specsavers

The sight loss, rehabilitation and support service is commissioned by adult services from RNIB.

The low vision service is commissioned by Adult Social Care from a local opticians

Consultation Question 10: Are these services meeting people's needs? How could these services change?

Conclusion

The Department is committed to improving eye care services and wishes to receive the views of the public, professionals and, most importantly, service users on the proposed changes contained within this strategy.

INDICATIVE TIMESCALE FOR NEXT STEPS

July 2017	Departmental consideration of Strategy for consultation
July– December 2017	Redesign project commencement
October – December 2017	Strategy consultation

January 2018	Budget development showing proposed increase in primary care optical services, changes to Noble's budget, decrease in tertiary budget, funding of diabetic annual screening. This will show an overall reduced spend on eye care over three years, bringing the Isle of Man closer to England averages adjusted for change.
January 2018-March 2018	Complete procurements for primary care services
March 2018	Mobilisation
April 2018	Commencement of new services

APPENDIX 1 - MEMBERS OF THE EYE CARE STRATEGY GROUP

Members:

Tim Mansfield	Director of Commissioning
Mushtaq Khan	Clinical Lead Ophthalmology
Nigel Malpass	Macular Society
Patricia Wild	Macular Society
Ian Hodgson	Isle of Man Association of Optometrists & Registered Opticians
Ian Cooil	Manx Blind Welfare
Dr Henrietta Ewart	Director of Public Health
Cath Hayhow	Director of Adult Social Care
Mairead Doyle	Registered Nurse – Noble's Hospital
Oliver Radford	Divisional Manager – Noble's Hospital
Julie Lee	Royal National Institute for the Blind
Jacqueline Weatherall	Royal National Institute for the Blind
Linda McCauley	HSCC representative
Annmarie Cubbon	Head of Externally Contracted Services
Dr Jugnu Mahajan	Medical Director
Michelle Dutton	Regional Manager, Macular Society

Other Attendees

Ian Marsh	Clinical Director, Aintree NHS Trust
Maria Dengler-Harles	Service Manager, Aintree NHS Trust
Dr Iain Kewley	Director of Primary Care (now retired)
Jillian Patchett	Royal National Institute for the Blind

APPENDIX 2 – GLOSSARY

ARMD AMD	Age-Related Macular Degeneration
Aintree	Aintree University Hospital NHS Foundation Trust
Liverpool	Aintree and Royal University Hospitals Liverpool and Broadgreen Trust
Optician	Technician trained to design, verify and fit eyeglass lenses and frames, contact lenses, and other devices to correct eyesight
Optometrist	Healthcare Professional who provides primary vision care ranging from sight testing and correction to the diagnosis, treatment, and management of vision changes
Ophthalmolgist	Medical Doctor who specializes in eye and vision care
Orthoptist	Allied Healthcare Professional involved in the assessment, diagnosis, and management of disorders of the eyes, extra-ocular muscles and vision
DHSC Department	Department of Health and Social Care
HRG Codes	Health care Resource Groups used to provide average cost in England of particular treatment
JSNA	Joint Strategic Needs Assessment
PHOF	Public Health Outcome Framework
LOC Support Unit	Local Optical Committee Support Unit
CVI	Certificate of Visual Impairment
RTT	Referral To Treatment
Any Qualified Provider Model	A model where any provider able to demonstrate that it can deliver a specified service with appropriate qualifications and experience is able to be contracted to provide the service.
HES	Hospital Eye Services
Eye OPCS CO1-C90	Clinical coding of surgical procedures in Ophthalmology
HCP	Healthcare Professional
Anti-VGEF	Anti-VEGF stands for 'anti vascular endothelial growth factor'. These drugs work by stopping a protein called vascular endothelial growth factor (VEGF) produced by cells in the retina from working. New blood vessel growth is a major problem which occurs in a number of eye conditions.
IVT	Intravitreal injection
MBWS	Manx Blind Welfare Society
FTE / PTE	Full-Time Equivalent / Part-Time Equivalent
ECLO	The Eye Care Liaison Officer
RDCH	Ramsey & District Cottage Hospital
VIP	Visually Impaired Person
VISS	Visual Impairment Support Service
FD8 Compliant	Complies with Isle of Man Government procurement regulations.

APPENDIX 3 - CONSULTATION QUESTIONS

1. ***Are the needs of at risk groups currently being met?***

2. ***Should optometrists be able to refer directly to Noble's***

3. ***What should be included in the specification of a sight test?***

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

5. ***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?***

6. ***Should the Department be providing annual diabetic retinopathy screening? Should this be provided in the hospital or in a community setting?***

7. ***Should the Department seek to adopt the Certificate of Visual Impairment?***

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

9. ***What are the current barriers for people with low/no vision in education, employment and other areas of living on the Island?***

10. ***Are these services meeting people's needs? How could these services change?***

11. ***Are there any other comments you have about the Eye Care Strategy? Is there anything not here that you think we should have included?***

Please submit comments to:

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