

Sunderland Eye Health Needs Assessment

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Glossary of terms

A&E.....	accident and emergency (hospital department)
AMD.....	age-related macular degeneration
BME.....	black or minority ethnic
CCG.....	Clinical Commissioning Group (an organisation that purchases local health care services)
CVI.....	Certificate of Visual Impairment
DDES.....	Durham, Darlington, Easington and Sedgefield
DNA.....	did not attend (used as a term to classify those health care appointments where the service user did not attend)
ECLO.....	eye clinic liaison officer
GOS.....	General Ophthalmic Services contract
GP.....	general practitioner
HSCIC.....	Health and Social Care Information Centre
IAPB.....	International Association for the Prevention of Blindness
MECS.....	minor eye conditions service
NHS.....	National Health Service
OCT.....	optical coherence tomography
PbR.....	Payment by Results – the payment system in England under which commissioners pay healthcare providers for each patient seen or treated
PEARS.....	primary eyecare assessment and referral service
PHSE.....	personal, social, health and economic (a subject within the school curriculum)
R3A.....	active proliferative retinopathy
RNIB.....	Royal National Institute for the Blind
SEI.....	Sunderland Eye Infirmary
SENCO.....	special educational needs coordinator
SHAPE.....	Strategic Health Asset Planning and Evaluation (a web application developed by the Department of Health)

SSDESPSunderland and South Tyneside Diabetic Eye Screening Programme

VDUvisual display unit

WHOWorld Health Organisation

Sunderland Eye Health Needs Assessment 2016

1. Executive Summary

Among the population of Sunderland, around 1,000 people are severely visually impaired or blind. Another 7,000 people are living with sight loss that has a significant impact on their daily living. Also, many of us visit the opticians for a sight test, both to see whether our sight needs correcting with glasses or contact lenses, but also to have our sight checked for early signs of eye conditions such as cataract or glaucoma. If we have been diagnosed with an eye condition it is likely we will visit an eye hospital for treatment. And sometimes we may need to visit an eye casualty department, for any urgent sight threatening conditions or if we have injured our eyes during work or leisure activities. This eye health needs assessment considers the need for services that can prevent sight loss and treat diagnosed eye conditions and eye trauma among the population of Sunderland. It also considers the wider needs for emotional and practical support among those who have experienced sight loss and the ease with which they can integrate into society by seeking employment, doing routine daily tasks such as shopping, or accessing leisure services.

To inform its findings, information was drawn from a number of different sources:

- Information about the number and characteristics of people with sight loss living in Sunderland, and the number of people accessing eye health care services, both now and in the future
- The views of Sunderland residents who have experienced sight loss and who use eye health services, via an online survey and an engagement event
- The views of people who provide or purchase eye health care services for the Sunderland population

The study has been undertaken by the public health team within Sunderland City Council with support from the Cumbria and North East Local Eye Health Network.

This study has reached a number of important conclusions:

- Evidence-based screening services for children 4-5 years and people with diabetes are available in Sunderland and uptake is good, but there is scope for more eye health prevention activity, particularly within the school Personal, Health, Social and Economic curriculum and aimed at older people. The rate of uptake of routine sight tests in Sunderland is below regional and national averages. Prevention activity could help to increase uptake of routine sight tests. This will reduce undetected sight loss and identify early-stage sight-threatening eye conditions. Early diagnosis and treatment of some eye conditions can avoid sight loss.
- The volume of hospital eye care activity has risen faster than population projections have predicted. Forward planning of these services will need to take this upward trend in activity into account both in terms of clinic capacity and workforce planning.

- Direct referral by community optometrists into secondary care can speed up the referral process, but there needs to be parallel electronic notification to both the service user's chosen eye hospital and their registered GP Practice. In this way, the GP Practice can add information on comorbidities and prescribed medications in parallel during forwarding the referral on to the eye hospital, without slowing down the referral process. Direct referral is not currently widely used in Sunderland.
- The delivery of locally commissioned enhanced services by community optometrists has the potential to reduce demand on hospital eye care services and offer the provision of these services closer to the service user's home. Some services are currently being commissioned in Sunderland (glaucoma / intra-ocular pressure referral refinement, cataract choice and children's eye screening). There is a desire to offer uniform provision across Sunderland but some services are not currently available in all of the five Sunderland localities. There are other enhanced services (minor eye conditions service or MECS, learning disability community eye care pathway and adult low vision pathway) that are available in other areas in the North East but are not currently commissioned in Sunderland. A Healthy Living scheme has worked well in Dudley, in the West Midlands, that involves both pharmacies and optical practices.
- Some people living with a visual impairment in Sunderland experience an unmet need for emotional support in the community in the years following diagnosis with a long-term eye condition. There are talking therapy services available by referral from a GP and there are counselling and peer support services available through local voluntary sector organisations, but awareness of these services may be low. Further work is needed to understand why people are not accessing existing services.

To address these findings it makes the following recommendations:

Prevention and screening

- Summary results from the children's eye screening programme at 4 to 5 years of age (uptake and number and rate of referrals), for Sunderland as a whole, should be fed back to stakeholders, e.g. commissioners and school head teachers, at the end of each academic year. This will help to engage stakeholders and inform them of the benefits of the programme. It will also provide information that could be included in a news item in a school newsletter to parents and carers, highlighting the importance of vision screening.
- Elements of the school Personal, Social, Health and Economic (PSHE) curriculum that highlight the health risks of smoking should include the increased risk of sight loss arising from smoking. Similarly literature available to people accessing NHS Stop Smoking Services should highlight the reduced risk of sight loss arising from giving up smoking.
- elements of the school PSHE curriculum that relate to healthy lifestyles should include content highlighting measures that can reduce the risk of poor eye health in

later life such as regular eye tests, advice on a healthy “visual diet”, wearing sunglasses in bright sunlight and wearing protective goggles when playing some sports.

Hospital eye care

- A limited study of patterns of attendance at eye care A&E at Sunderland Eye Infirmary / Sunderland City Hospitals should be undertaken. This is a gap in the analysis within this needs assessment. In particular, the work should seek to identify the number and proportion of attendances that could have been managed more effectively in primary care and should consider how these attendances can be reduced
- Eye care makes up a substantial proportion (around 10%) of inpatient hospital admissions. Also, patterns of eye care admissions are changing, due to advances in effective treatments, and due to the aging population. There should be debate at a national level to consider the value of monitoring a headline indicator of eye care hospital activity e.g. age-standardised rate of hospital admissions due to age-related macular degeneration per 100,000 people aged 65 years and over, for all CCG populations.
- Once its review of offsite provision and any subsequent changes to services are complete, Sunderland Eye Infirmary should consider undertaking a travel survey among service users. The survey should seek to identify groups within the population that find it most difficult to travel to eye care appointments. A parallel study of the likelihood that service users do not attend appointments could also be undertaken to establish if there is any correlation between ease or difficulty of travel to appointment and the risk of “did not attend” (DNA) among different population groups. Such a study has the potential to provide a greater understanding of the needs of people who find it difficult to access hospital eye care, but also, with a suitable action plan, it has the potential to reduce DNA rates.
- The information provided to eye care patients when visiting the eye clinic liaison officer (ECLO) at Sunderland Eye Infirmary should be reviewed to ensure that it includes information about all available community support services for people with a visual impairment offered either by GP Practices, optometric practices or local voluntary sector organisations.

Community eye care

- Enhanced community care pathways have the potential to reduce demand on secondary care services. Ophthalmologists and optometrists, through the Local Optical Committee and Local Eye Health Network, should meet to discuss the desirability and challenges of expanding existing community care pathways and introducing new pathways. Any barriers such as suitably trained workforce capacity issues should be identified and actions to remove these barriers taken forward. Variations in current provision of enhanced community optometric / optical services

across Sunderland, and variations in need between local communities, should inform these discussions.

Support services

- Some additional engagement work is undertaken to speak to people living with a visual impairment in Sunderland. This work should seek to understand whether the unmet need for emotional support identified within this study is due to a low awareness of existing services, barriers to accessing these services or whether the existing services are different from those that people would like to access.

Eye health services working together

- Sunderland Eye Infirmary collaborates with ophthalmology colleagues in other NHS Trusts and the Cumbria and North East Local Eye Health Network, to participate in a planned region wide audit of feedback of clinical findings from secondary care to community optometrists.
- Ophthalmologists and optometrists, through the Local Optical Committee, should discuss practical ways in which i) referrals from community to secondary care can be streamlined without reducing the quality of referrals, and ii) feedback to optometrists can be improved.

What is needed going forward is a process by which an action plan can be developed to address the recommendations within this needs assessment, the identified actions can be taken forward and new challenges can be addressed as they emerge. With continuing collaboration between different parts of the health care system there is the potential to make the eye health care system in Sunderland work even more effectively, further improve standards of care and reduce the number of people experiencing sight loss in the future.

2. Introduction

It is estimated that 3% of the Sunderland population – around 8,000 people – are living with sight loss that has a significant impact on their daily living¹. Of these people, 1,000 are living with severe sight loss or blindness. Sight loss can affect us at any time in our lives, from birth through to old age, but the risk of experiencing sight loss increases with age. Both in Sunderland and across England, a range of factors including better health care and healthier lifestyles, are contributing towards people living longer. Because of this ‘aging’ population, but also because new procedures and treatments are being developed which are widening the range of conditions that can be effectively treated, demand for eye health care services is rising.

This eye health needs assessment is timely because it offers a chance to consider by how much demand for eye health care services will increase over the next five to ten years. This, in turn, will provide health care commissioners with the information they need to plan services effectively to meet that demand. But the focus of this study is wider than simply eye health care. It considers local rehabilitation and support services which help people come to terms with a newly diagnosed eye condition and maintain their independence wherever possible. It also looks at some wider issues that affect how people who have a visual impairment can integrate into society and maintain their independence, such as travelling about within their community. The needs assessment has also offered an opportunity for a range of stakeholders – people with a visual impairment, their carers, friends and family, health and care service providers and service commissioners – to voice their views and opinions in relation to local eye care services and other issues which affect people whose sight is impaired.

We shouldn’t forget that around 50% of sight loss is thought to be avoidable, through education about prevention, encouraging regular sight tests and screening for and early detection of diabetic retinopathy. This needs assessment is also a chance to consider how much eye health prevention activity is taking place in Sunderland, how frequently people are accessing sight tests, and what proportion of people with diabetes are taking up routine eye screening. By improving the effectiveness of prevention and screening activity we have the potential to reduce the proportion of people who will experience sight loss in the future.

3. Background

Rising life expectancy in the UK – the ‘aging population’ – and the growth in the total size of the population has undoubtedly led to a focus on the likely increase in future demand for eye care services. This has a driving factor behind a number of key policy developments.

¹ Royal National Institute for the Blind (2014) “RNIB Sight Loss Data Tool version 2.2 – Local Authority Report” available at <http://www.rnib.org.uk/knowledge-and-research-hub-key-information-and-statistics/sight-loss-data-tool> (last accessed 6th January 2016)

3.1. The Vision 2020 Strategy

Vision 2020 was established in 2002 as the UK's response to the Vision 2020 initiative of the World Health Organisation (WHO) and the International Association for the Prevention of Blindness (IAPB). The WHO's Vision 2020 mission is to create a world in which no one is needlessly blind and those that experience unavoidable sight loss can reach their full potential. It is a partnership organisation that brings together the eye health and sight loss communities. Its 2015-2018 strategy highlights three key outcomes:

- i) Prevention – everyone in the UK looks after their eyes and sight
- ii) Treatment – 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
- iii) Inclusion – a society in which people with sight loss can fully participate

It also references four key documents which guide its work:

- i) The Adult UK Eye Health and Sight Loss Pathway²
- ii) The Children's Eye Health and Sight Loss Pathway³
These pathways provide a process map to deliver seamless transition from diagnosis and clinical interventions, through emotional support, information, reablement (visual impairment rehabilitation), maximising residual vision, and other social care supports, to full autonomy, independence, health and wellbeing.
- iii) The Sight Loss and Vision Priority Setting Partnership Report⁴, which sets priorities for eye research
- iv) Seeing it My Way Outcomes⁵ - Seeing it My Way is an initiative to ensure that every blind and partially sighted person, regardless of age, ethnicity, extent of sight loss, other disabilities, or location across the UK, has access to the same range of information and support.

3.2. The Public Health Outcomes Framework

Indicator 4.12 of the Public Health Outcomes Framework measures the rate at which people are certified as either severely sight-impaired or sight-impaired and have lost their sight from one of the three major causes of preventable sight loss: glaucoma, age-related macular degeneration and diabetic retinopathy. In many cases sight loss from these eye conditions can be prevented, or the progress of the disease can be slowed down, if

² Vision 2020 (2015) "Adult UK eye health and sight loss pathway revised January 2015" available at <http://www.vision2020uk.org.uk/adult-uk-eye-health-and-sight-loss-pathway-revised-january-2015/> (last accessed 7th January 2016)

³ Vision 2020 (2014) "Guidelines and Pathway for putting the UK Vision Strategy into Action for Children and Young People (0 to 25 years) with Vision Impairment, and their Families" available at <http://www.vision2020uk.org.uk/guidelines-and-pathway-for-putting-the-uk-vision-strategy-into-action-for-children-and-young-people-0-to-25-years-with-vision-impairment-and-their-families-2/> (last accessed 19th January 2016)

⁴ Sight Loss Priority Setting Partnership (2013) "Setting Priorities for Eye Research, Final Report" available at <http://www.sightlosspsp.org.uk/> (last accessed 11th January 2016)

⁵ Royal National Institute for the Blind (2015) "Seeing It My Way" available at <http://www.rnib.org.uk/about-rnib-what-we-do-uk-vision-strategy/seeing-it-my-way> (last accessed 11th January 2016)

detected and treated earlier. The inclusion of this indicator confirms a commitment which mirrors the Vision 2020 UK aim of avoiding preventable blindness.

3.3. Local context

This needs assessment aims to provide a sound strategic evidence base to inform future commissioning of locally determined vision services, based on need, the best available evidence and current service mapping. Undertaking an eye health needs assessment is also in line with the recommendation from the NHS Commissioning Board in their report “Securing excellence in commissioning primary care”⁶ that Local Eye Health Networks should work with local stakeholders to develop a rapid eye health needs assessment approach to support the development of Joint Strategic Needs Assessments.

4. Methods

4.1. Needs assessment process

Health needs assessment may be described as “a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities.”⁷ It should include a mapping of current service provision so that gaps in services or areas where current services are not the most cost-effective can be identified. It should also include engagement with a wide range of stakeholders, including health and care service users, their families and carers, service providers, service commissioners and interested voluntary sector organisations representing people affected by the health or care issue.

The Public Health team within Sunderland City Council, supported by the Cumbria and North East Local Eye Health Network, invited a range of stakeholders to an engagement event in March 2015, held at Sunderland Civic Centre. Those attending included people with a visual impairment, providers of eye health services in hospital and community settings, commissioners (people who plan and purchase eye health services), members and staff from organisations that represent people who are visually impaired and public health practitioners. The aims of the event were to raise awareness of the Sunderland eye health needs assessment and capture views about:

- the experiences of people living with a visual impairment in Sunderland
- prevention i.e. health messages and interventions that could reduce the number of people experiencing avoidable long-term eye conditions
- local eye health services in community and hospital settings
- things that make it more difficult for people with a visual impairment to integrate into society and achieve their full potential

A summary of the key points raised at the event are included as an Annex to this report.

Sunderland City Council also published four separate questionnaires on its website aimed at: i) people with a visual impairment, their family or carers and people without a visual

⁶ NHS Commissioning Board (2012) “Securing excellence in commissioning primary care” available at <https://www.england.nhs.uk/wp-content/uploads/2012/06/ex-comm-pc.pdf> (last accessed 7th January 2016)

⁷ National Institute of Health and Care Excellence (2005) “Health Needs Assessment; a practical guide”

impairment who use local preventative eye health services, ii) GPs, iii) optometrists and iv) ophthalmologists (eye doctors working in a hospital setting). The questionnaires were open for a four week period in July and August 2015 and the optometrist questionnaire was extended for a further two week period to get responses from a wider number of providers. The Council received 230 responses from service users and members of the public, 10 responses from GPs, 9 responses from optometrists and 6 responses from ophthalmologists. Staff from the public health team also met with key commissioners and service providers in one-to-one meetings and via telephone conversations to get a more detailed picture of current service provision.

On completion of the draft needs assessment, this was shared with a small group of key stakeholders to get initial feedback on the scope, findings and recommendations, but also to ensure that no important issues had been overlooked.

4.2. Population

The population that is the focus of this needs assessment is the population of all ages that are resident within the local authority boundaries of Sunderland. In some sections of the needs assessment there is a particular focus on the community of people living in Sunderland who experience visual impairment either following diagnosis with a long-term eye condition or as a result of trauma.

Estimates of how the Sunderland population, and particularly the size of the older population, will change in future years have been taken from 2012-based subnational population projections published by the Office for National Statistics⁸.

4.3. Estimates of the prevalence of eye disease

Estimates of the prevalence of key long-term eye conditions, both now and in the future, have been taken from the Royal National Institute for the Blind's (RNIB) Sight Loss Data Tool⁹. Projections go forward to 2020 and are based on the National Eye Health Epidemiological Model¹⁰ and 2010-based subnational population projections¹¹. Numbers who are registered as visually impaired or severely visually impaired have been taken from data collected from local authorities by the Health and Social Care Information Centre¹².

⁸ Office for National Statistics (2014) "2012-based subnational population projections" available at <http://www.ons.gov.uk/ons/rel/snpp/sub-national-population-projections/2012-based-projections/index.html> (last accessed 25th January 2016)

⁹ Royal National Institute for the Blind (2015) "Sight Loss Data Tool (version 2.2)" available at <http://www.rnib.org.uk/knowledge-and-research-hub-key-information-and-statistics/sight-loss-data-tool> (last accessed 25th January 2015)

¹⁰ Public Health Action Support Team (2013) "National Eye Health Epidemiological Model", Local Optical Committee Support Unit available at <http://www.eyehalthmodel.org/#> (last accessed at 25th January 2016)

¹¹ Office for National Statistics (2012) "Subnational Population Projections, 2010-based projections" available at <http://www.ons.gov.uk/ons/rel/snpp/sub-national-population-projections/2010-based-projections/index.html> (last accessed 25th January 2016)

¹² Health and Social Care Information Centre (2014) "Registered Blind and Partially Sighted People – Year Ending 31 March 2014, England" available at <http://www.hscic.gov.uk/catalogue/PUB14798> (last accessed 25th January 2016)

5. Major eye conditions

This section provides an overview of low vision and the four most common conditions that lead to visual impairment in the UK – cataract, glaucoma, macular degeneration and diabetic retinopathy.

5.1. Low vision

Low vision is any impairment of visual function which cannot be corrected by spectacles, contact lenses or medical intervention and which limits everyday activities. It can be caused by a variety of congenital or age-related conditions, or may be caused by trauma. Low vision can also be the result of other medical conditions (co-morbidities) such as stroke, or can be related to a learning disability. The three most common causes of low vision in the UK are age-related macular degeneration, diabetic retinopathy and glaucoma. Although cataracts are common, vision returns close to normal following surgery to remove a cataract, where there is no other affecting ocular co-morbidity.

In the UK nearly 2 million people experience low vision or sight loss. That is approximately one person in 30. It is estimated¹³ that 1 in 5 people (20%) 75 years of age or more and 1 in 2 people (50%) over the age of 90 are living with low vision but there is no definitive data source. Adults with a learning disability are 10 times more likely to be blind or partially sighted than the general population¹⁴.

In 2014 290,000 people in England were registered as either blind or visually impaired¹⁵. This represents a 3% fall compared to the number registered in 2011. Of these people, 63% or just under two thirds are 75 years of age or over. The true total number of people with low vision will be higher. Many who are eligible do not register, for a variety of reasons, but some people with low vision will also have eyesight that is only slightly better than the threshold below which people are eligible for registration.

5.2. Age-related macular degeneration

Macular degeneration is a group of conditions affecting the macula lutea of the eye, leading to loss of central vision. Age-related macular degeneration (AMD) is the most common cause of blindness among older people. Two types are recognised – atrophic or dry AMD and wet AMD. With late dry AMD, atrophy affects the centre of the macula whereas with late wet AMD, abnormal blood vessels grow into the macula and leak blood or fluid. Late dry AMD progresses slowly whereas wet AMD can develop quickly, causing sudden sight loss. Of these types, only wet AMD is currently controllable in the main and anti-VEGF (vascular endothelial growth factor) therapy by intravitreal injection is currently the preferred treatment.

¹³ Royal National Institute for the Blind (2015) “Key information and statistics” available at <http://www.rnib.org.uk/knowledge-and-research-hub/key-information-and-statistics> (last accessed 11th January 2016)

¹⁴ Ibid.

¹⁵ Health and Social Care Information Centre (2014) “Registered Blind and Partially Sighted People – Year Ending 31 March 2014, England”, available at <http://www.hscic.gov.uk/catalogue/PUB14798> (last accessed 12th January 2016)

Commissioning guidelines produced by the College of Optometrists and the Royal College of Ophthalmologists¹⁶ recommend that service users presenting to community optometrists with suspected wet AMD should be referred directly and urgently to a specialist macular clinic where imaging and treatment facilities are available. Treatment of confirmed wet AMD should commence within two weeks of diagnosis and should be followed by regular review and re-treatment appointments.

The commissioning guidelines note that treating AMD service users on time became more challenging in 2013 after NICE approved ranibizumab to treat diabetic macular oedema and retinal vein occlusion, thus increasing the demand for intravitreal injections. This has increased the importance of adopting innovative service models which improve detection and initial referral times. Examples are:

- Electronic referrals which improve the speed and quality of referrals
- Optometrists and GPs, particularly locums, receiving regular training to recognise the signs and symptoms of wet AMD and are familiar with local processes for urgent referrals
- Direct referral from community optometrist to AMD clinic without going through a GP, including the ability to share fundus photographs or optical coherence tomography (OCT) scans with hospital clinicians
- Increased use of OCT instruments within community optometric practices, where accredited and trained community optometrists review service users then refer those who need treatment or advanced investigation to the hospital

5.3. Diabetic retinopathy

Diabetic retinopathy is a disorder of the retina, due to damage of the blood vessels of the retina occurring as a complication of longstanding diabetes. It can be detected by careful eye examination before it causes any deterioration in vision, and for this reason there is a structured screening programme run within the NHS in England¹⁷. All diabetics are invited for an annual eye examination following the diagnosis of diabetes. Patients with signs of disease are referred to a hospital clinic as either urgent (with sight threatening active proliferative retinopathy or R3A) or routine. The aim is for service users with R3A screening results to be notified within 2 weeks of screening and to be seen in clinic within 2 weeks of notification. The aim for routine referrals is to be seen in clinic within 13 weeks

¹⁶ College of Optometrists and Royal College of Ophthalmologists (2013) "Commissioning better eye care: Age-related macular degeneration Version 1" available at http://www.college-optometrists.org/filemanager/root/site_assets/guidance/amd_guidance_25_11_13.pdf (last accessed 15th January 2016)

¹⁷ Public Health England (2014) "Diabetic eye screening: programme overview" available at <https://www.gov.uk/guidance/diabetic-eye-screening-programme-overview> (last accessed 15th January 2016)

of notification¹⁸. Modifiable risk factors for diabetic retinopathy include glycaemic (blood sugar) control, blood pressure, body mass index, pregnancy and smoking¹⁹.

5.4. Cataract

Cataract is defined as any opacity in the lens of the eye that results in blurred vision. Cataracts may be congenital or the result of metabolic disease such as diabetes, direct or indirect injury to the lens or prolonged exposure of the eye to infra-red rays. However, they are most commonly the result of age. Treatment, where appropriate, is by removal of the affected lens and, in modern practice, through insertion of an intraocular lens implant inside the eye²⁰. Risk factors include age (most cataracts occur in people over 60 years of age), gender (cataracts are more common among women than men), diabetes, sunlight, nutrition and socio-economic status, smoking and alcohol²¹.

5.5. Glaucoma

Glaucoma is a group of diseases in which progressive damage to the optic nerve leads to loss of vision and, in a small proportion of people, blindness. It is caused by raised intraocular pressure. It is described in four main ways according to:

- Age of onset: congenital, infantile, juvenile or adult
- Rate of onset: acute or chronic
- Cause: primary (no known cause) or secondary, with a known cause such as a disease, drug or developmental condition
- Mechanism: angle closure glaucoma or open angle glaucoma

Risk factors for the development of glaucoma include:

- Raised intraocular pressure
- Age
- Family history
- Ethnicity – it is more common in people of black African origin compared to people of white ethnicity
- Steroids
- Myopia
- Diabetes

¹⁸ NHS Diabetic Eye Screening Programme (2014) "Interim quality standards and performance objectives for Diabetic Eye Screening Programmes pending a full standards review" available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/406180/Interim_QA_Standards_v1_11_final_issue_1_.pdf (last accessed 19th January 2016)

¹⁹ Royal College of Ophthalmologists (2012) "Diabetic Retinopathy Guidelines" available at <https://www.rcophth.ac.uk/wp-content/uploads/2014/12/2013-SCI-301-FINAL-DR-GUIDELINES-DEC-2012-updated-July-2013.pdf> (last accessed 15th January 2016)

²⁰ National Institute for Health and Care Excellence (2015) "Clinical knowledge summaries: Cataracts" available at <http://cks.nice.org.uk/cataracts#!topicsummary> (last accessed 25th January 2016)

²¹ Royal College of Ophthalmologists (2010) "Cataract surgery guidelines" available at <https://www.rcophth.ac.uk/wp-content/uploads/2014/12/2010-SCI-069-Cataract-Surgery-Guidelines-2010-SEPTEMBER-2010.pdf> (last accessed 25th January 2016)

5.6. Urgent eye care

An urgent eye condition is any eye condition that is of recent onset and is distressing or is believed by the patient, carer or referring health professional to present an imminent threat to vision or general health. Many eye conditions classified as urgent by this definition can be managed in one or two consultations without recourse to complex diagnostic or treatment facilities. Urgent eye care commissioning guidelines²², published jointly by the College of Optometrists and the Royal College of Ophthalmologists in 2013, draw the following conclusions, based on the experiences of hospital eye care departments across England:

- Many patients treated by the urgent eye care service have non-urgent conditions, particularly patients who self-refer to eye casualty.
- The incidence of presentations to eye casualty services has been estimated at 20-30 per 1000 per year. Most hospital urgent eye care services report that they struggle to keep pace with demand and that a significant proportion of patients seen in these services have conditions which could be diagnosed and managed in a primary care setting by optometrists.

The guidelines cite research that suggests that 90% of 'eye emergencies' seen within eye casualty A&E departments are self-referrals. 50% to 65% of all attendances are likely to be related to trauma and it is estimated that a further 10% to 25% will be related to infection or inflammation.

6. Population profile, health status and lifestyle behaviours

6.1. Population change

Sunderland has an estimated population of 276,000 in 2015²³, of which 52,000 (19%) are aged 65 years and over, and 2,100 (2%) are aged 85 years and over. Across England 18% and 2% of the population are aged 65 years and over and 85 years and over respectively. The risk of experiencing visual impairment increases with age, so the size of the population aged 65 years and over, and the rate at which this population is changing, are indicators of the level of demand for eye health services and how demand for these services will change in the future.

Between 2015 and 2020 it is estimated that the whole population of Sunderland will grow by 0.5% compared to a 4% growth across England. However, it is likely that the population 65 years and over will grow by 9% (10% across England) and the population 85 years and over will grow by 24% (18% across England). Over the next 10 years, by 2025, the growth of the population 65 years and over in Sunderland is likely to be 21% (21% across England) and the population 85 years and over will likely increase by 49% (42% across

²² College of Optometrists and Royal College of Ophthalmologists (2013) "Commissioning Better Eye Care: Urgent Eye Care, Version 1" available at http://www.college-optometrists.org/filemanager/root/site_assets/guidance/urgent_eye_care_template_25_11_13.pdf (last accessed 26th January 2016)

²³ Office for National Statistics (2014) "2012-based subnational population projections" available at <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcn%3A77-335242> (last accessed 11th January 2016)

England). The predicted rapid rise in the size of the oldest population groups is likely to have the effect of increasing the demand for eye health services and thus there will be an increased need for ophthalmists and ophthalmic nursing staff. The likely future increase in demand for eye health care services is considered in more detail in section 7.3 on p19.

6.2. Age

Age is a key risk factor for age-related macular degeneration (AMD), cataracts and glaucoma. The proportion of the population aged 65 years and over (19%) in Sunderland is very similar to the national average (18%), but this age group will be disproportionately represented among eye health care service users and so accessibility of services is a key concern for two reasons. Firstly, mobility decreases with age. Older people will, on average, have more difficulty travelling to and attending health care appointments. Secondly, a smaller proportion of older people will drive or have access to a car in which to travel to health care appointments. Availability and accessibility of public transport becomes more important among this age group, as does the availability of NHS and voluntary sector patient transport services.

6.3. Social and economic disadvantage

The population of Sunderland experiences above average levels of social and economic disadvantage, with 38% of the population living in the 20% of areas across England that are most disadvantaged according to the 2015 index of multiple deprivation²⁴. This indicator is measured across seven domains: income, employment, education, health, crime, barriers to housing and the living environment. There is strong evidence that some unhealthy lifestyle behaviours and related health outcomes are more prevalent within disadvantaged communities, particularly smoking²⁵ and obesity²⁶. These factors increase the risk of experiencing some long-term eye conditions such as age-related macular degeneration or diabetic retinopathy. Consequently we would expect a greater proportion of people to experience visual impairment in Sunderland compared to the national average. A further implication of high levels of social and economic disadvantage is that a smaller proportion of households will have a car within disadvantaged communities and so people will find it more difficult to access health care services. The difficulties of using public transport are compounded for people with a visual impairment.

6.4. Ethnicity

People of African or Afro-Caribbean ethnicity are four times more likely to develop glaucoma compared to the white population²⁷. Asian populations are at higher risk of

²⁴ Department for Communities and Local Government (2015) "English indices of deprivation 2015" available at <https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015> (last accessed 11th January 2016)

²⁵ Health and Social Care Information Centre (2015) "Statistics on smoking, England – 2015" Table 2.2, available at <http://www.hscic.gov.uk/article/2021/Website-Search?productid=17945> (last accessed 11th January 2016)

²⁶ Health and Social Care Information Centre (2015) "Health Survey for England 2014" Table 9.5 available at <http://www.hscic.gov.uk/article/2021/Website-Search?productid=19585> (last accessed 11th January 2016)

²⁷ Wormald RP, Basauri E et al (1994) "The African Caribbean Eye Survey: risk factors for glaucoma in a sample of African Caribbean people living in London", *Eye (London)*. 1994;8 (Pt 3):315-20, abstract available at <http://www.ncbi.nlm.nih.gov/pubmed/7958037>

cataracts²⁸. Both populations are at a higher risk of diabetic eye disease²⁹. At the 2011 Census³⁰ 3% of the Sunderland population were of Asian or Asian British ethnicity (7,300 people) and 0.5% were of Black or Black British ethnicity (1,300 people). The areas with the highest proportion of people from black or minority ethnic (BME) communities in Sunderland are to be found in the Hendon and Millfield wards within the Sunderland East locality.

6.5. Health Outcomes

Health outcomes are generally poorer in Sunderland compared to average outcomes across England. Life expectancy at birth is two years less³¹. There are also 24% more early deaths (deaths under the age of 75 years) due to heart disease and stroke³², and 24% more early deaths due to all types of cancer³³. However, the following health outcomes are more closely linked to the risk of experiencing visual impairment.

People diagnosed with diabetes have a risk of developing diabetic retinopathy and all diabetics aged 12 years and over in the UK are invited to have their eyes screened annually. Diabetic retinopathy is the most common cause of sight loss among people of working age. 6.6% of adults 17 years and over have been diagnosed with diabetes in Sunderland compared to 6.4% across England³⁴.

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 survivors³⁵. In Sunderland, 1.8% of people of all ages have been diagnosed with stroke, compared to 1.7% across England³⁶.

²⁸ Rauf A, Malik R et al (2013) "The British Asian Community Eye Study: Outline of results on the prevalence of eye disease in British Asians with origins from the Asian subcontinent", *Indian J Ophthalmol.* 2013 Feb; 61(2): 53–58, abstract available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3638326/> (last accessed 11th January 2016)

²⁹ NHS Choices (2016) "Diabetic retinopathy", available at <http://www.nhs.uk/Conditions/Diabetic-retinopathy/Pages/Introduction.aspx#risk> (last accessed 17th April 2016)

³⁰ NOMIS (2014) "2011 Census data – table DC2101EW – Ethnic group by sex and age" available at www.nomisweb.co.uk (last accessed 11th January 2016)

³¹ Office for National Statistics (2015) "Life expectancy at birth and at age 65 by local areas in England and Wales, 2012 to 2014" available at <http://www.ons.gov.uk/ons/rel/subnational-health4/life-expectancy-at-birth-and-at-age-65-by-local-areas-in-england-and-wales/2012-14/stb-life-2012-14.html> (last accessed 13th January 2016)

³² Health and Social Care Information Centre (2015) "Mortality from all all circulatory disease: indirectly standardised ratio (SMR), <75 years, 3-year average, MFP, 2012-2014" available at <https://indicators.ic.nhs.uk> (last accessed 13th January 2016)

³³ Health and Social Care Information Centre (2015) "Mortality from all cancers: indirectly standardised ratio (SMR), <75 years, 3-year average, MFP, 2012-2014" available at <https://indicators.ic.nhs.uk> (last accessed 13th January 2016)

³⁴ Health and Social Care Information Centre (2016) "Quality and Outcomes Framework (QOF) – 2014-15" available at <http://www.hscic.gov.uk/catalogue/PUB18887> (last accessed 13th January 2016)

³⁵ Stroke Association (2012) "Visual problems after stroke" available at <http://www.stroke.org.uk/factsheet/visual-problems-after-stroke> (last accessed 13th January 2016)

³⁶ Health and Social Care Information Centre (2016) "Quality and Outcomes Framework (QOF) – 2014-15" available at <http://www.hscic.gov.uk/catalogue/PUB18887> (last accessed 13th January 2016)

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 complications³⁷. 20% of all adults (16+) in Sunderland have been diagnosed with hypertension compared to 17% across England. Data from the Health Survey for England suggests that there is a large group of adults that are hypertensive but have not been diagnosed. A model published by Public Health England³⁸ suggests that, in total, including those diagnosed and undiagnosed, 32% of adults in Sunderland are hypertensive in 2015 compared to 31% of adults across England.

In addition to the above health conditions which increase the risk of experiencing sight loss, people who are visually impaired are three times more likely to experience depression and are more likely to have a fall.

6.6. Lifestyle behaviours

It is estimated that 23% of adults living in Sunderland smoke compared to 18% of adults nationally. Smoking prevalence is particularly high among routine and manual occupational groups, among which estimates suggest 35% smoke in Sunderland compared to 28% across England. Results from the Active People Survey³⁹ suggest that 71% of adults in Sunderland are either overweight or obese compared to 65% nationally.

Taken together, these statistics relating to social and economic disadvantage, health outcomes and lifestyle behaviours, suggest that the proportion of the population experiencing visual impairment in Sunderland should be higher than the national average.

7. Prevalence of sight loss and usage of eye health services

7.1. Registrations

In 2014, among the Sunderland population, there were a total of 780 people registered as blind and a further 1,050 people registered as partially sighted⁴⁰. Expressed as a percentage of the total population, 0.28% of Sunderland residents are registered blind (0.25% North East, 0.26% England) and 0.38% are registered visually impaired (0.32% North East, 0.27% England). 60% of people living in Sunderland who are blind, and 55% of people who are visually impaired have an additional disability (mental health condition, physical disability, learning disability or hearing impairment). 55% of people who are blind and 55% who are visually impaired are aged 75 years or over. In 2013/14 there were 60

³⁷ UK Vision Strategy (2015) "Eye health and sight loss; statistics and information for developing a Joint Strategic Needs Assessment", available at <http://www.ukvisionstrategy.org.uk/get-involved-planning-guidance/local-needs-issues-data> (last accessed 16th January 2016)

³⁸ Eastern Region Public Health Observatory (2011) "Modelled estimate of the prevalence of hypertension in England", available at <http://www.apho.org.uk/resource/item.aspx?RID=111119> (last accessed 15th January 2016)

³⁹ Public Health England (2015) "Public Health Outcomes Framework tool, indicator2.12" based on results from Active People Survey 2012-2014, available at www.phoutcomes.info (last accessed 15th January 2016)

⁴⁰ Health and Social Care Information Centre (2014) "Registered blind and partially sighted people: Year ending 31st March 2014, England", HSCIC, Leeds available at <http://www.hscic.gov.uk/catalogue/PUB14798> (last accessed 26th January 2016)

new registrations of people who were severely sight impaired or blind and 75 new registrations of people who were visually impaired.

The number that is registered does not reflect the total number living with sight loss⁴¹. Some people may not wish to register with the Local Authority and some may experience barriers in the process of registration such as being unable to independently complete a registration application form. There will also be some people who are living with undiagnosed sight loss who have never presented to health or care services. But the number and rate of registrations is the best routinely available indicator of numbers and rate of people experiencing sight loss. The high prevalence of smoking and obesity noted above, together with a high average level of socio-economic disadvantage, may be factors that contribute to the higher prevalence of visual impairment in Sunderland compared to the England average.

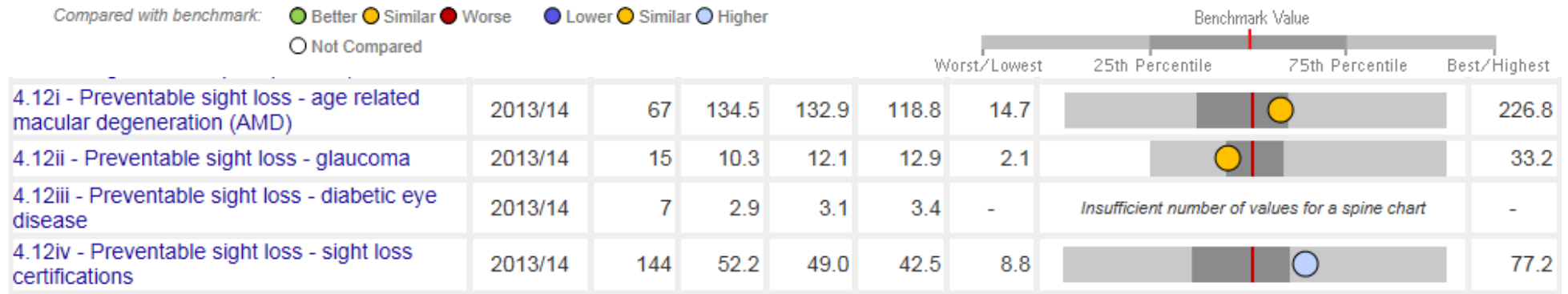
The Public Health Outcomes Framework⁴² monitors crude or average rates of glaucoma, age-related macular degeneration, diabetic retinopathy and the overall rate of certification. It presents the data in a spine chart, from which an extract is shown below.

Although the rate of new registrations of sight loss due to age-related macular degeneration is above the national average rate, it is not statistically significantly higher (at a 95% level of confidence) and the trend shows that the rate of new registrations has fallen over the past four years. However, a falling registration rate is not necessarily a sign of population health improvement. The rate may have fallen because there are genuinely fewer people who have been newly diagnosed with a visual impairment due to age-related macular degeneration living in Sunderland. Alternatively it may be that a smaller proportion of people who are diagnosed with a registrable visual impairment are choosing to register, or the administrative registration system might be working less effectively.

⁴¹ Basser M (2014) "Benefits case study: Registered blind and partially sighted (2011) publication" (p4), HSCIC, Leeds available at <http://www.hscic.gov.uk/benefitscasestudies/registeredblind>.

⁴² Public Health England (2016) "Public Health Outcomes Framework tool" at www.phoutcomes.info (accessed 29th April 2016)

Fig 1 Sight loss indicators for Sunderland in the Public Health Outcomes Framework



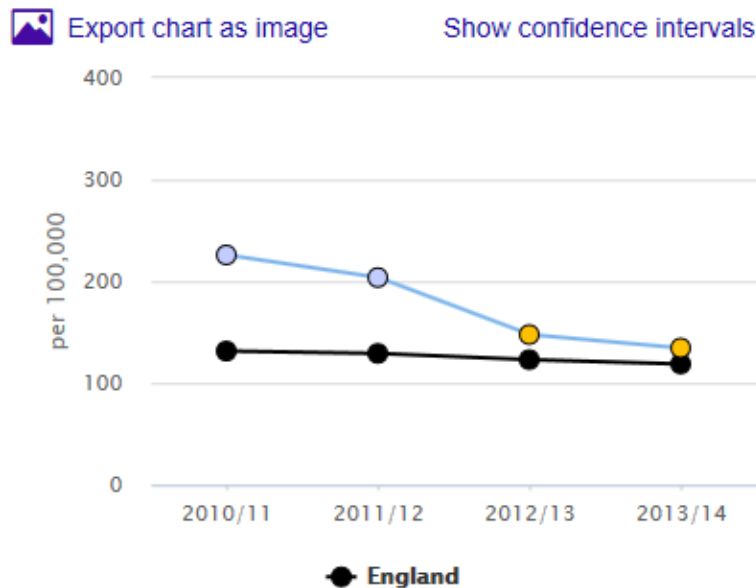
Source: Public Health Outcomes Framework tool at www.phoutcomes.info

Fig 2 Rate of registrations due to age-related macular degeneration

4.12i - Preventable sight loss - age related macular degeneration (AMD)

Sunderland

Crude rate - per 100,000



Period		Count	Value	Lower CI	Upper CI	North East	England
2010/11	●	105	226.0	184.8	273.6	171.5	131.5
2011/12	●	96	203.8	165.1	248.9	170.4	129.1
2012/13	●	72	147.7	115.5	186.0	156.8	123.1
2013/14	●	67	134.5	104.2	170.8	132.9	118.8

Source: Calculated by Public Health England Knowledge and Intelligence Team (West Midlands) from data provided by Moorfields Eye Hospital and Office for National Statistics

Source: Public Health Outcomes Framework tool at www.phoutcomes.info

7.2. Estimated current and future numbers long-term with eye conditions

Because registers of people with a certificate of visual impairment will not paint a complete picture of the community of people experiencing sight loss, models have been developed to estimate numbers with key long-term eye conditions, both now and in the future. These are referred to as prevalence models. The prevalence of a condition or disease is the total number of people experiencing that condition at any one point of time in a defined population. The Royal National Institute for the Blind have developed a tool – the Sight Loss Data Tool⁴³ – which applies age and gender specific estimates of the prevalence of major eye conditions to all English local authority population structures. It generates estimates of the total number in a population with these conditions, for the years 2011, 2015 and 2020. This allows us to consider by how much demand for eye care services will grow, in Sunderland, over the next five years. In the table below, the average percentage change between 2011 and 2015, and between 2015 and 2020 is shown, to give an idea of the scale of the likely growth in demand for related health care processes for each major eye condition.

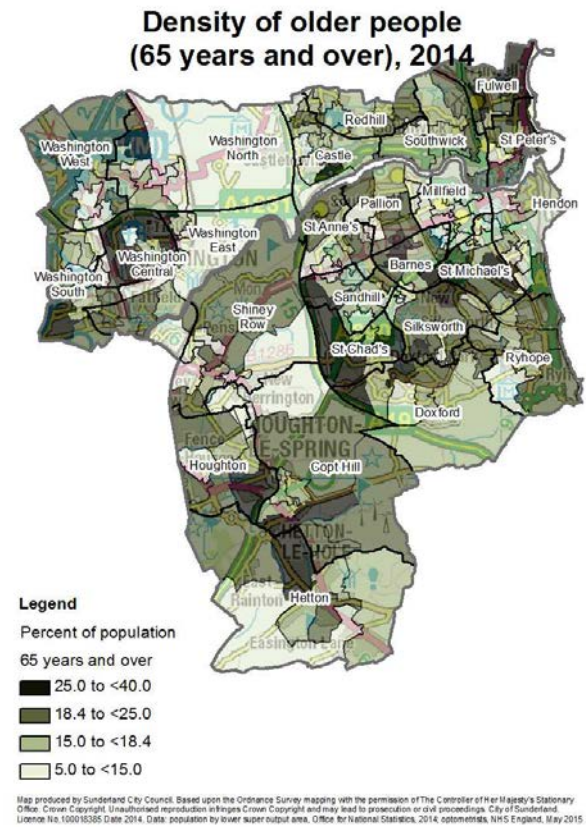
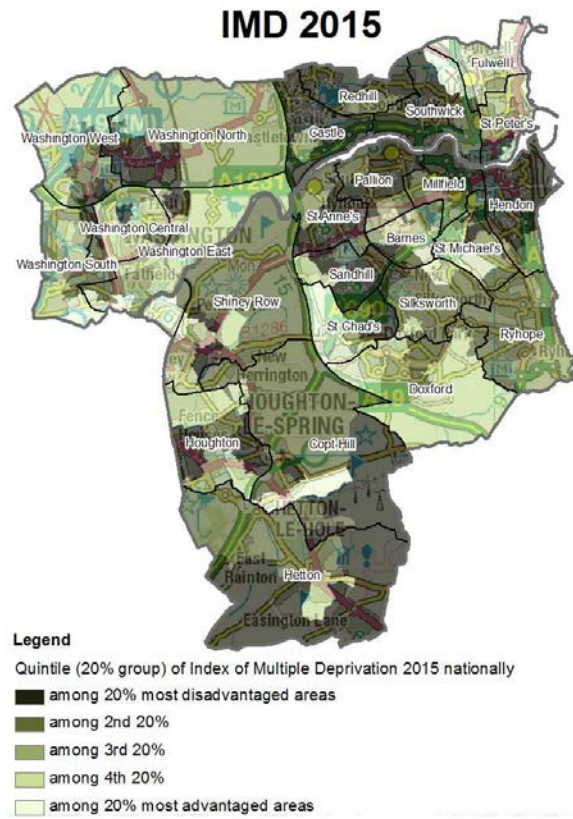
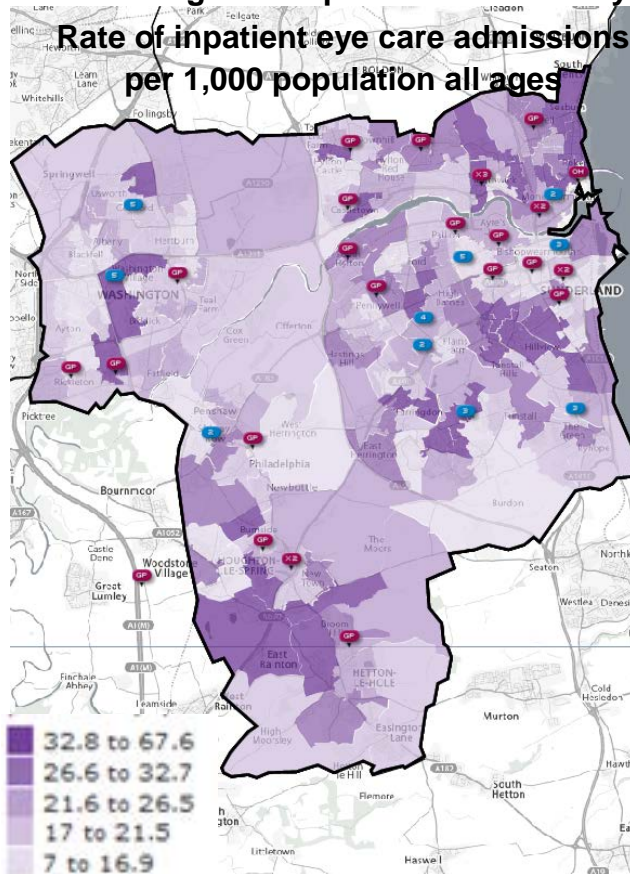
Table 1: Sunderland estimated numbers with key long-term eye conditions and average annual percentage change

	2011	2015	average annual % change 2011-15	2020	average annual % change 2015-20
Total number living with sight loss					
Early stage AMD	11,180	11,715	1.2	12,749	1.7
Late stage dry AMD	818	887	2.0	971	1.8
Late stage wet AMD	1,669	1,818	2.2	2,003	2.0
Total late stage AMD (any type)	2,360	2,566	2.1	2,826	1.9
Cataract	2,585	2,803	2.0	3,145	2.3
Glaucoma	2,590	2,603	0.1	2,675	0.5
Ocular hypertension	5,638	5,667	0.1	5,824	0.5
Diabetes	17,406	17,841	0.6	18,309	0.5
Background diabetic retinopathy	4,874	4,995	0.6	5,126	0.5
Non proliferative and proliferative diabetic retinopathy	557	571	0.6	586	0.5

Source: RNIB Sight Loss Data Tool version 2.2 (2014)

⁴³ Royal National Institute for the Blind (2014) "Sight Loss Data Tool version 2.2" available at <http://www.rnib.org.uk/knowledge-and-research-hub-key-information-and-statistics/sight-loss-data-tool> (last accessed 28th January 2016)

Fig 3: Comparison of rate of eye care admissions with deprivation and proportion of older people, 65+



Map produced by Sunderland City Council. Based upon the Ordnance Survey mapping with the permission of The Controller of Her Majesty's Stationary Office. Crown Copyright. Unauthorised reproduction in any form is prohibited. City of Sunderland. Licence No. 100018385 Date 2014. Data: population by lower super output area, Office for National Statistics, 2014, estimates, NHS England, May 2015.

Data sources: inpatient eye care admissions, SHAPE tool at <https://shape.phe.gov.uk>, 2015 Index of Multiple Deprivation, Department for Communities and Local Government, density of older people, Office for National Statistics, 2014 mid-year population estimates by lower super output area

Does the pattern of variation in the rate of eye care hospital admissions more closely resemble the pattern of variation in deprivation or density of older people?



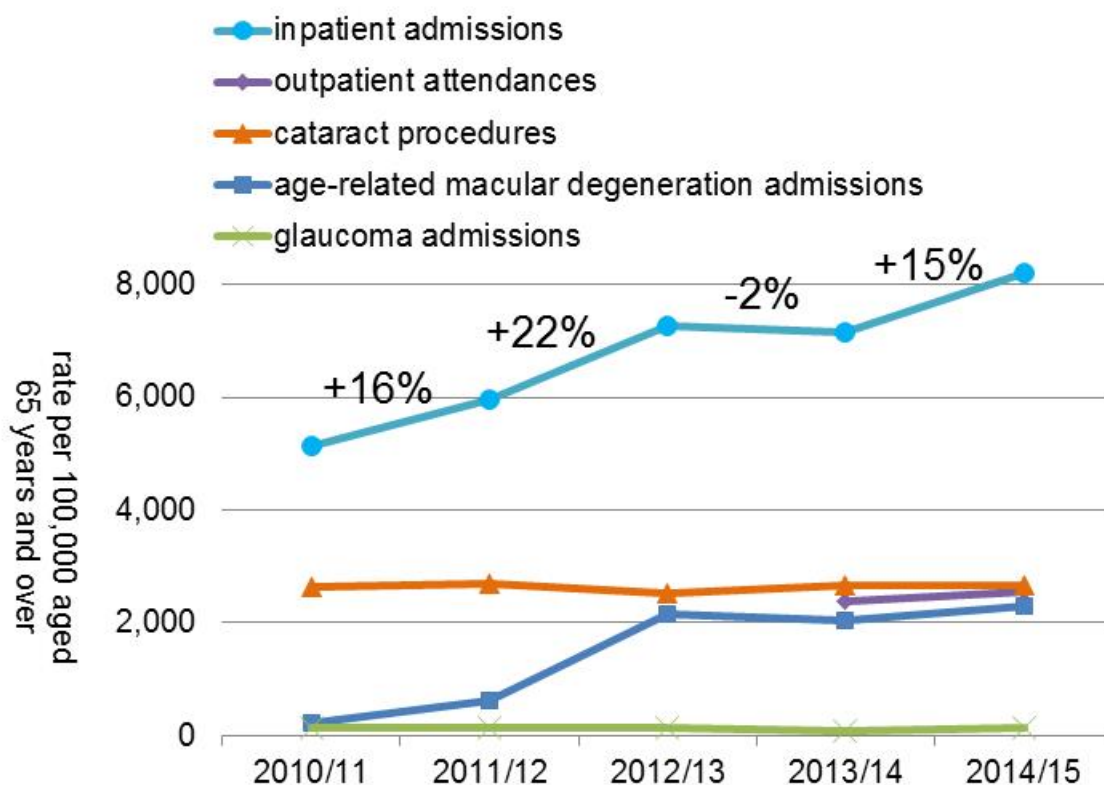
It is evident that a key factor determining rate of access to secondary eye care is age. Communities where there is a higher proportion of older people (65 years and over) generally have a higher rate of access.

7.3. Hospital eye care

Eye care hospital inpatient admissions make up 11% of all elective or planned care admissions among the Sunderland population (7,900 admissions in 2014/15) but only 1% of non-elective or emergency admissions (320 in 2014/15)⁴⁴. Most of the planned admissions are treated as day cases with only 355 bed days arising from 6,600 episodes in 2012/13. Most Sunderland residents (98%) choose Sunderland Eye Infirmary to provide their planned care. The only other significant provider was Newcastle Hospitals in 2012/13, accounting for 1% of all planned care episodes. 40% of all planned admissions are for the treatment of cataracts. A further 33% are due to other retinal disorders and 7% are due to disorders of the eyelid.

Fig 3 on p21 shows maps of rates of eye care planned hospital admissions by small area, levels of socio-economic disadvantage and the density of older people. Inspection of the maps demonstrates that there is a greater correlation between admission rates and the density of older people than there is between admission rates and levels of socio-economic disadvantage.

Fig 4 Number of ophthalmology inpatient hospital admissions among the Sunderland population of all ages



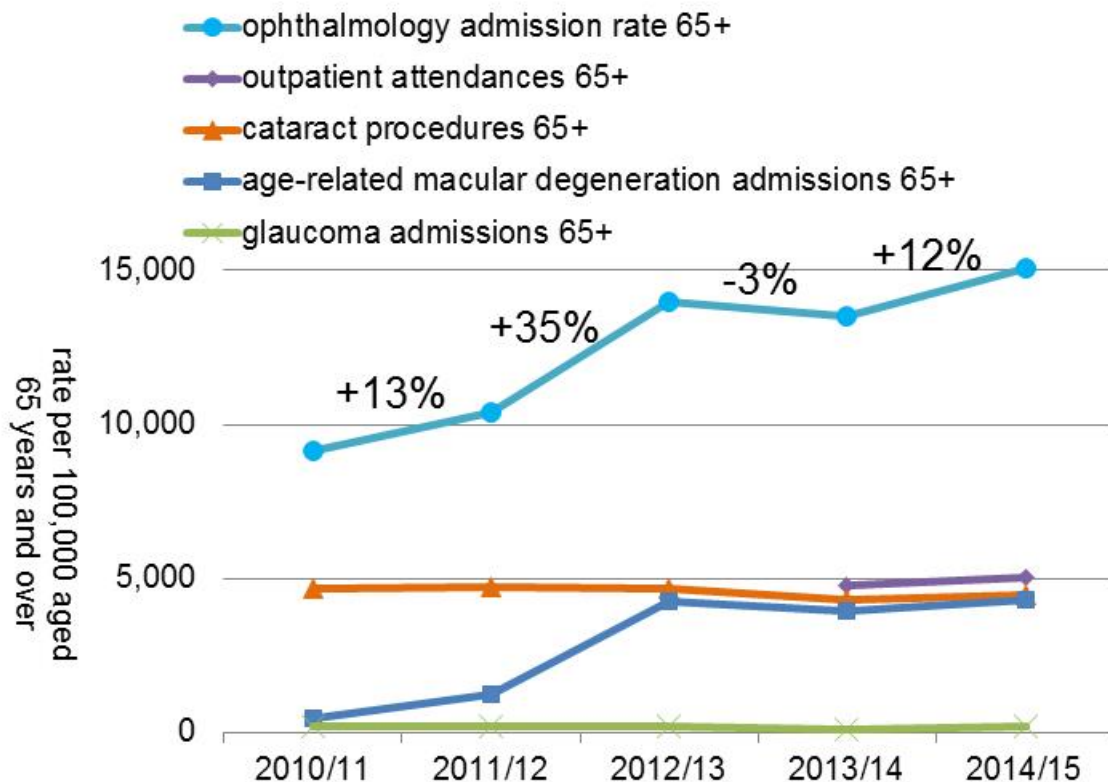
In order to estimate how demand for hospital eye care service might change in the future, it is helpful to look at recent trends in activity (Fig 4), based on hospital episode statistics relating to the Sunderland population. Between the financial years (April to March) 2010/11 and 2014/15 overall inpatient admissions (day case, planned and emergency) have

⁴⁴ Public Health England (2015) "Strategic Health Asset Planning and Evaluation (SHAPE)" available at <https://shape.phe.org.uk> (last accessed 26th January 2016)

increased by 60% from 5,100 to 8,200 per year. That equates to an average 12% increase each year, although growth has been uneven and admissions grew by 22% between 2011/12 and 2012/13.

Around three quarters of hospital eye care inpatient admissions are among people aged 65 years and over. The population of older people, both in Sunderland and across England, has been growing. Calculating a rate of admission per 100,000 population allows us to understand the growth in the rate of admissions independent of changes to the size of the population (Fig 5). The rate of ophthalmology inpatient admissions per 100,000 population aged 65 and over has grown from 9,200 in 2010/11 to 15,100 in 2014/15, a 64% increase. The total number of admissions among older people 65 years and over has grown by 76% over the same period, so only 12% of this increase can be attributed to population growth. The rate increased notably between 2011/12 and 2012/13 in the year before NICE approved ranibizumab in May 2013 to treat diabetic macular oedema and retinal vein occlusion, thus increasing the demand for intravitreal injections. Sunderland Eye Infirmary was part of a patient access scheme in 2012, because ranibizumab (marketed as Lucentis) had been approved by the North East Treatment Advisory Group.

Fig 5 Rate of hospital activity related to key long-term eye conditions among the Sunderland population 65 and over

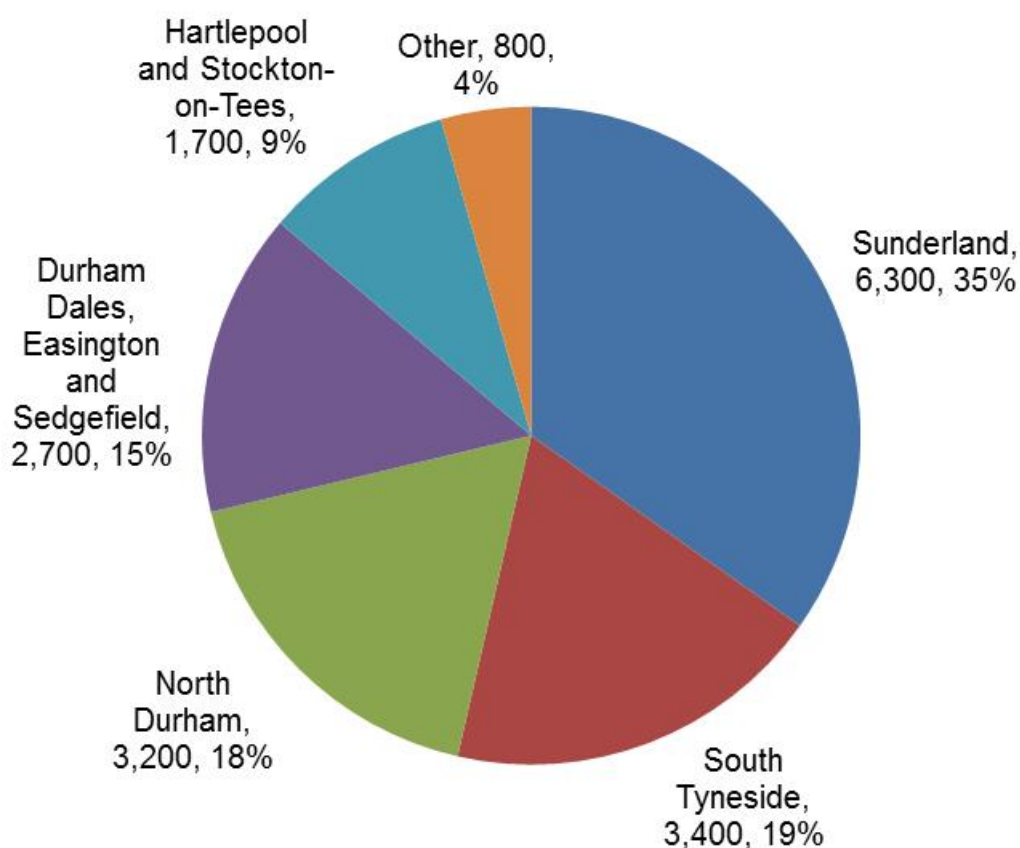


Estimates from the RNIB Sight Loss Data Tool (see Table 1 on p19) suggest that numbers of people affected by late wet, or exudative, age-related macular degeneration (AMD) will increase by around 2% per annum between 2015 and 2020 so it is reasonable to expect that AMD-related admissions will also increase at, at least, this rate. Recent activity

suggests that the number presenting with the condition appropriate for treatment will rise at a much faster rate if current trends continue.

Hospital eye care geographically located in Sunderland is delivered exclusively by Sunderland Eye Infirmary (SEI), part of City Hospitals Sunderland NHS Foundation Trust. Service users referred for eye care by their GP have a choice of provider, facilitated through the “Choose and Book” computer system operating within GP Practices, but, as noted earlier, 98% of Sunderland residents referred for planned inpatient eye care episodes choose to receive this care at SEI. This needs assessment focuses on the eye care needs of the Sunderland population but it is helpful to understand the wider picture of the care provided by SEI to all populations to recognise the demands on this health care provider. In 2012/13 SEI delivered care for 18,000 planned or elective admissions, 6,300 or 35% of which were for Sunderland residents. A further 60% of activity related to service users from South Tyneside, North Durham, “Durham Dales, Easington and Sedgefield” and “Hartlepool and Stockton-on-Tees” clinical commissioning group populations.

Fig 6 Planned eye care admissions (ICD10 H00-H59) at Sunderland Eye Infirmary by CCG population in 2012/13



Source: Public Health England, SHAPE tool at <https://shape.phe.org.uk>

In 2014/15, in addition to 8,200 inpatient admissions, there were also 5,200 new outpatient attendances and 21,400 follow-up appointments among the Sunderland population. Notably, only 50% of the outpatient first attendances were among people aged 65 years and over (compared to 75% for inpatient admissions) so it is clear that the age profile of outpatient attendances is distinctly different to that of inpatient admissions.

Expressed as whole time equivalent staff, the Sunderland Eye Infirmary employs 20 consultant ophthalmologists, 113 nursing staff, six optometrists and nine orthoptists. Within Sunderland, in addition to activity on its main site in the St Michael's ward, it runs satellite general and retinal outpatient clinics at the Galleries Health Centre in Washington. Based on its St Michael's site there is a 24 hour, 7 day dedicated ophthalmic accident and emergency unit treating around 30,000 service users each year. Other departments include a diagnostics unit, a medical photography unit, an optometry department and an orthoptic department. Within the optometry department an eye clinic liaison officer (ECLO) complements the low vision service by providing practical and emotional support and information to visually impaired service users.

As eye care constitutes a significant proportion of the total hospital care budget, and is accessed by a large number of people, even small improvements in the cost-effectiveness of treatments, the efficiency of treatment pathways, and the quality of care, have the potential to realise substantial cost efficiencies and improve the quality of the service user experience for a sizeable population. This is particularly important at a time when demand for eye health services is rising but budgets are not growing to match.

Recommendation: *this review does not include any analysis of eye care A&E attendances. A small amount of further work should be undertaken to understand trends and patterns in Eye Care A&E attendances among the Sunderland population. In particular, this work should seek to identify the number and proportion of attendances that it is considered could be treated within primary care, and how this proportion has changed over time in recent years.*

Recommendation: *eye care makes up a substantial proportion (around 10%) of inpatient hospital admissions. Also, patterns of eye care admissions are changing, due to advances in effective treatments, and due to the aging population. There should be debate at a national level to consider the value of monitoring a headline indicator of eye care hospital activity e.g. age-standardised rate of AMD hospital admissions per 100,000 people aged 65 years and over, and, if it is agreed that this would add value, this should be calculated and published annually for all CCG populations. However, differences in service pathways between provider Trusts reduce the value of such an indicator. Intravitreal injections, for example, are delivered as outpatient attendances in some provider Trusts, and as inpatient day case admissions in others.*

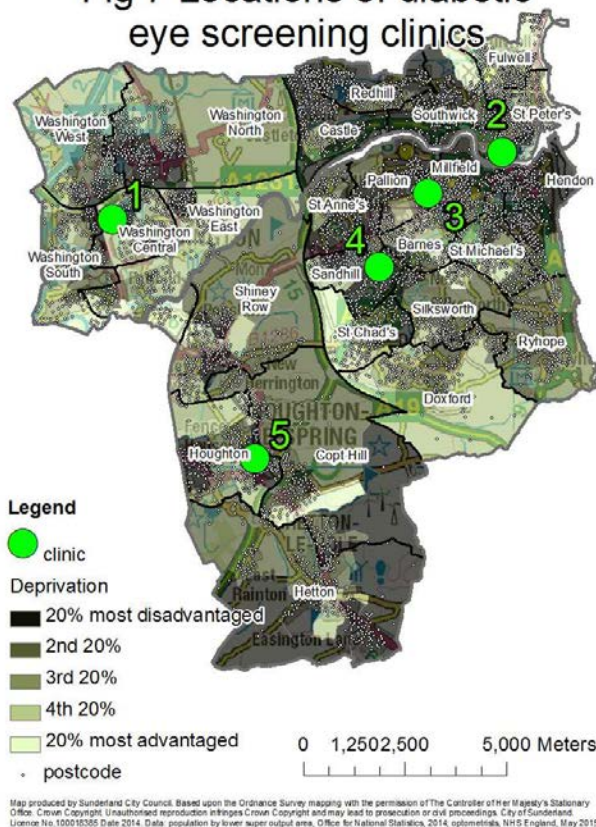
7.4. Diabetic eye screening

Diabetic retinopathy is among the most common causes of sight loss in the working age population⁴⁵. Evidence shows that early identification and treatment of diabetic eye disease could reduce sight loss⁴⁶. The main treatment for diabetic retinopathy is laser surgery. People diagnosed with type 1 or type 2 diabetes mellitus aged 12 years and over are invited to have their eyes screened annually. In England screening is provided by the NHS Diabetic Eye Screening programme⁴⁷. People with signs of retinopathy are referred to a specialist clinic for assessment as either urgent or routine. Evidence about the effectiveness of screening programmes is reviewed regularly by the UK National Screening Committee, and in January 2016 the Committee recommended that people at low risk of diabetic retinopathy should only be screened every two years⁴⁸.

In Sunderland, diabetic eye screening clinics are delivered at five locations across the city:

1. Galleries Health Centre – NE38 7NQ
2. Monkwearmouth Health Centre – SR6 0AB
3. Pallion Health Centre – SR4 7XF
4. Grindon Lane Primary Care Centre – SR3 4EN
5. Houghton Primary Care Centre – DH4 5HB

Fig 7 Locations of diabetic eye screening clinics



There are a number of key performance indicators that are monitored for all local programmes and English local authority populations. These are:

- The proportion of those offered diabetic eye screening who attend (DE1). This is monitored for Local Authority populations within the Public Health Outcomes Framework tool (www.phoutcomes.info) up to 2012/13 (see chart below). More recent data for the Sunderland & South Tyneside Diabetic Eye Screening

⁴⁵ Public Health England (2014) "Diabetic eye screening: overview" available at <https://www.gov.uk/guidance/diabetic-eye-screening-programme-overview> (last accessed 8th February 2016)

⁴⁶ Four Nations Diabetic Retinopathy Screening Intervals Project Study Group (2013) "Report on Findings – FINAL REPORT 11/12/13" p2, UK National Screening Committee, available at http://legacy.screening.nhs.uk/policydb_download.php?doc=547

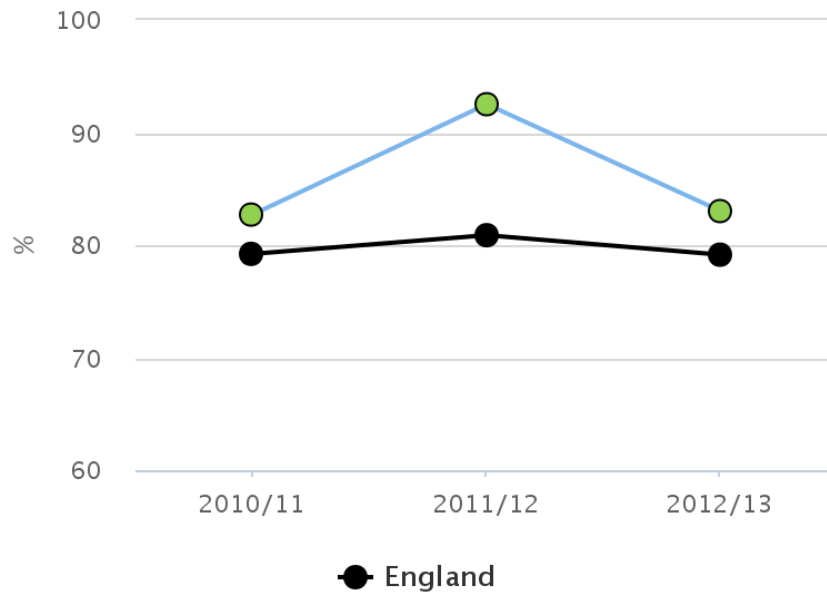
⁴⁷ Website at <https://www.gov.uk/topic/population-screening-programmes/diabetic-eye>

⁴⁸ UK National Screening Committee (2016) "The UK NSC recommendation on Diabetic Retinopathy screening in adults" available at <http://legacy.screening.nhs.uk/diabeticretinopathy> (last accessed 8th February 2016)

Programme (SSTDESP) as a whole is published on the GOV.UK website⁴⁹. In 2014/15 84.8% of people offered a screening appointment by the SSTDESP attended compared to 82.9% across England as a whole. Targets are; acceptable $\geq 70\%$, achievable $\geq 80\%$.

Fig 8 % of those offered diabetic eye screening who attend

2.21vii – Access to non-cancer screening programmes – diabetic retinopathy – Sunderland



source Public Health England, Public Health Outcomes Framework tool at www.phoutcomes.info

- Results issued within 3 weeks of screening (DE2) – in 2014/15 99.8% of results were issued within 3 weeks by the SSTDESP compared to 97.4% across England. Targets are; acceptable $\geq 70\%$, achievable $\geq 95\%$.
- Consultation within four weeks of notification for R3 (referred proliferative diabetic retinopathy) screen positive (DE3) – due to small numbers of referrals results are not published for individual programmes, but across the North East in 2014/15 80.2% were seen for a consultation within four weeks compared to 79.8% nationally. Target is; achievable $\geq 80\%$.

7.5. Children’s eye screening

All 4 or 5 year old children attending a Sunderland infant or primary school have their eyes screened by an orthoptist from Sunderland Eye Infirmary during the reception school year. The aim of this screening is to detect eye conditions common among children such as strabismus (squint) which can lead to amblyopia (lazy eye).

⁴⁹ <https://www.gov.uk/government/publications/nhs-screening-programmes-kpi-reports-2014-to-2015> (last accessed 9th February 2016)

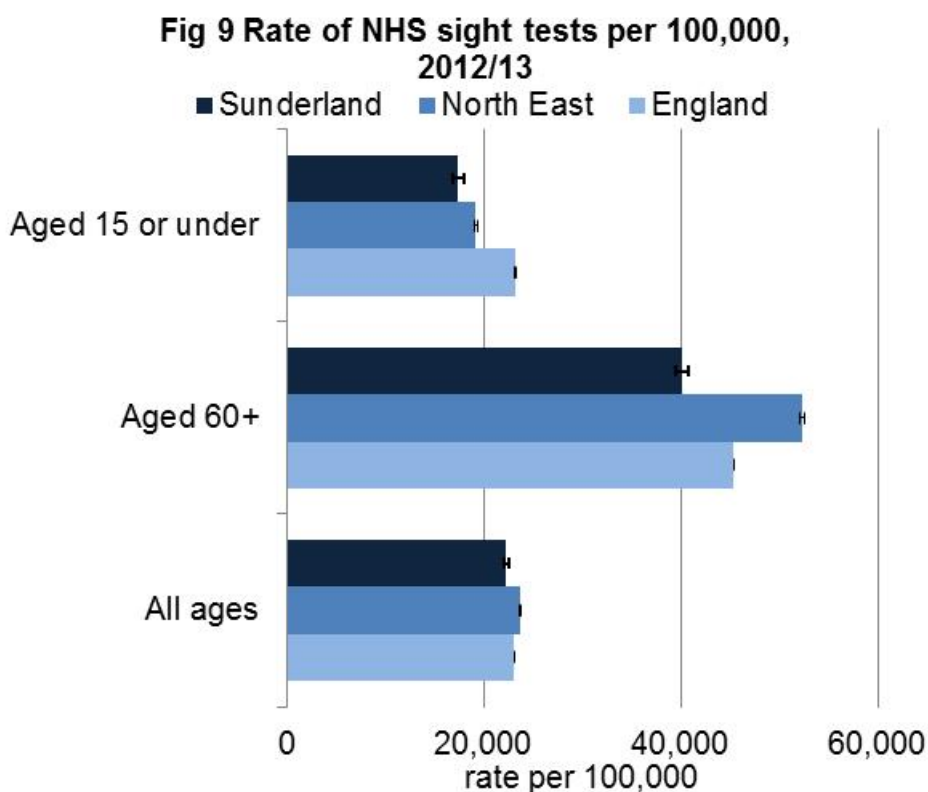
Recommendation: summary results from the programme for Sunderland as a whole (uptake and number and rate of referrals) are fed back to stakeholders, e.g. commissioners and school head teachers, at the end of each academic year. This will help to engage stakeholders and inform them of the benefits of the programme. It will also provide information that could be included in a news item in a school newsletter to parents and carers, highlighting the importance of vision screening.

7.6. Community eye care

In 2015 there were 26 optometric practices in Sunderland that provided eye care in the community. 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 health⁵⁰.

A detailed examination of the eye can reveal conditions such as high blood pressure or diabetes. Optometrists make a health assessment, offer clinical advice and when necessary prescribe spectacles or contact lenses. In addition, optometrists can dispense, fit and supply spectacles or contact lenses. They must supervise dispensing to patients under the age of 16 or who are registered as sight impaired unless this is being supervised by a dispensing optician, doctor or another optometrist.

Dispensing opticians advise on, fit and supply spectacle frames and lenses after taking account of each patient's lifestyle and vocational needs. Dispensing opticians are also able to fit contact lenses after undergoing further specialist training.



Source: RNIB Sight Loss Tool (2015). error bars show 95% confidence limits

⁵⁰ The College of Optometrists (2016) "What is an optometrist?" available at http://www.college-optometrists.org/en/college/about-optometry/What_is_an_optometrist.cfm (last accessed 5th February 2016)

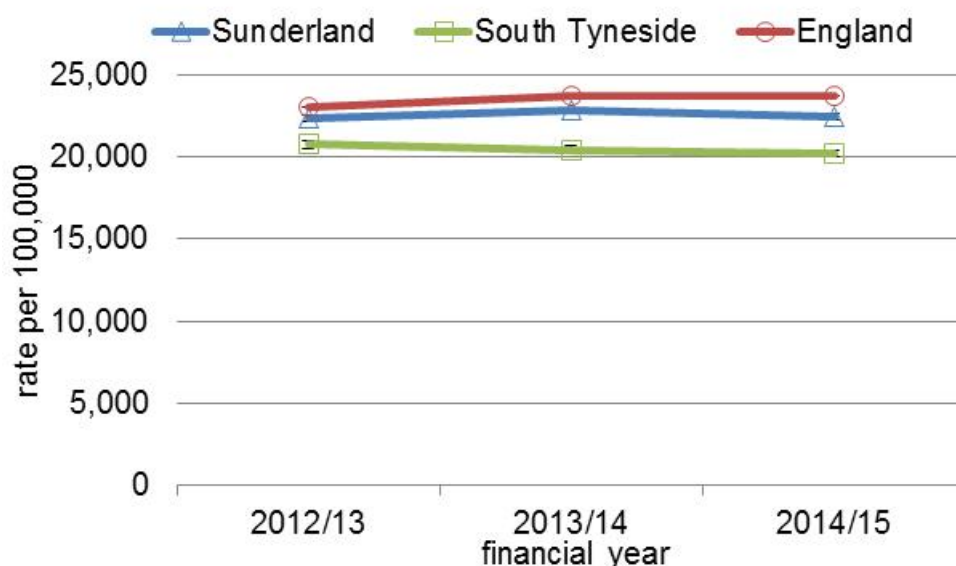
Table 2: Number and rate of NHS sight tests in Sunderland in 2012/13

	Number	Sunderland rate per 100,000	North East rate per 100,000	England rate per 100,000
Total	61,360	22,253	23,688	23,067
Aged 60+	26,475	40,127	52,324	45,410
Aged 15 or under	8,360	17,363	19,184	23,200
Student aged 16-18	3,185			
Income Support	16,970			

Source: RNIB Sight Loss Tool

The recommended interval between eye tests varies with individual circumstances but is usually around two years⁵¹. 2012/13 statistics⁵² (Fig 9) show that the rate of uptake of sight tests in 2012/13 was significantly lower than the national average in Sunderland among people of all ages, older people and children and young people. This suggests the need for additional prevention activity to increase awareness of the importance of regular sight tests, both to test for acuity of vision and to check for other health issues. In 2014/15 the Sunderland rate of eye tests remained below the national average (Fig 10). There would need to be take up of an additional 3,500 sight tests each year in Sunderland (a 6% increase) to raise the local rate to the national average.

Fig 10 Rate of eye tests among people of all ages



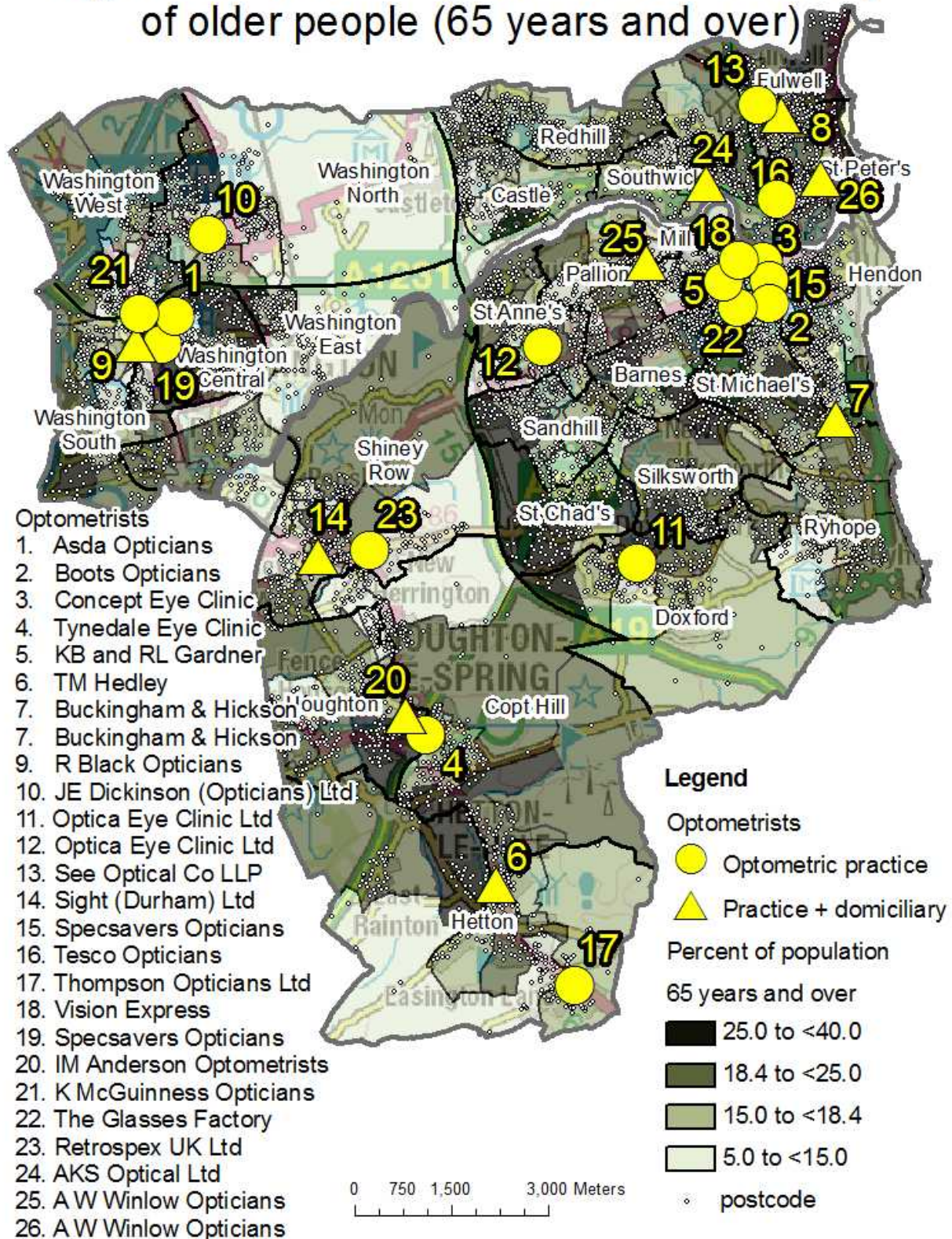
Source: Health and Social Care Information Centre, error bars show 95% confidence

The rate of uptake of NHS sight tests could also be affected by the accessibility of community optometric practices. Maps on the following pages show the distribution of community optometrists in relation to both the density of older people and the distribution of socio-economic disadvantage. Although there is an absence of any provision in the West of the Sunderland North locality (Castle and Redhill wards) where there are particularly disadvantaged communities, these will be served by the practices in Southwick, St Peters or those in the city centre. The most westerly of these communities are 2 miles or 3-4km away from the nearest provision.

⁵¹ NHS Choices (2015) "Eye tests for adults" at <http://www.nhs.uk/video/Pages/Adulteyetest.aspx> and "Eye tests for children" at <http://www.nhs.uk/Conditions/eye-tests-for-children/Pages/Introduction.aspx>

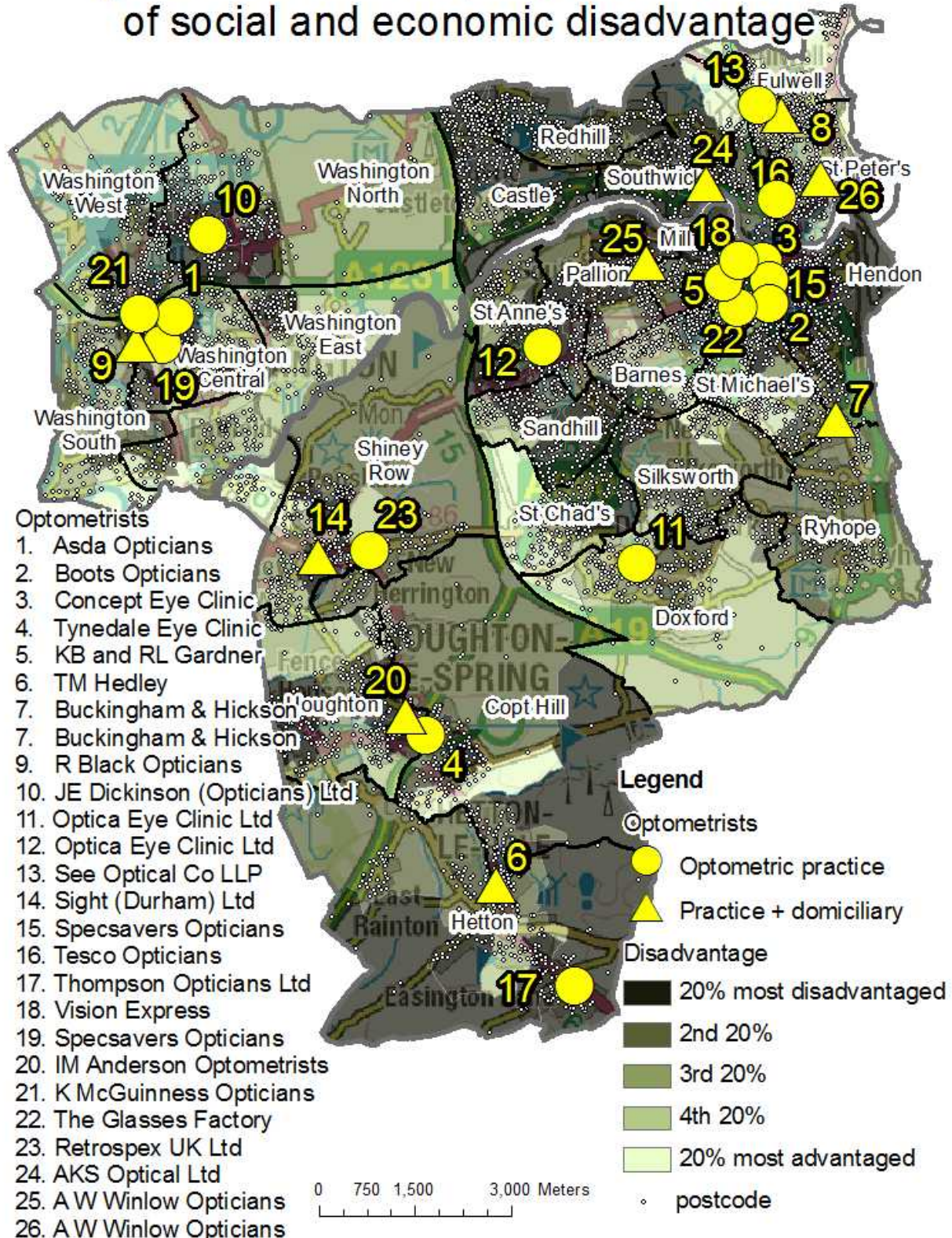
⁵² RNIB (2014) "Sight Loss Data Tool"

Fig 11 Locations of optometrists and density of older people (65 years and over)



Map produced by Sunderland City Council. Based upon the Ordnance Survey mapping with the permission of The Controller of Her Majesty's Stationary Office. Crown Copyright. Unauthorised reproduction infringes Crown Copyright and may lead to prosecution or civil proceedings. City of Sunderland. Licence No.100018385 Date 2014. Data: population by lower super output area, Office for National Statistics, 2014; optometrists, NHS England, May 2015

Fig 12 Locations of optometrists and levels of social and economic disadvantage



Map produced by Sunderland City Council. Based upon the Ordnance Survey mapping with the permission of The Controller of Her Majesty's Stationary Office. Crown Copyright. Unauthorised reproduction infringes Crown Copyright and may lead to prosecution or civil proceedings. City of Sunderland. Licence No.100018385 Date 2014. Data: population by lower super output area, Office for National Statistics, 2014; optometrists, NHS England, May 2015

7.7. Enhanced service provision in the community

There are a number of eye care pathways that aim to provide additional services at community optometric practices. This has the dual advantage of bringing care closer to service users, but also relieving pressure on secondary eye care services. Schemes where there is some provision in Sunderland are described below. Detailed pathways for these services have been proposed by the Local Optical Committee Support Unit⁵³. Examples of further pathways not provided in Sunderland, but in place in other local areas are also described.

7.7.1. Pathways in place in Sunderland

7.7.1.1. Glaucoma and ocular hypertension repeat readings

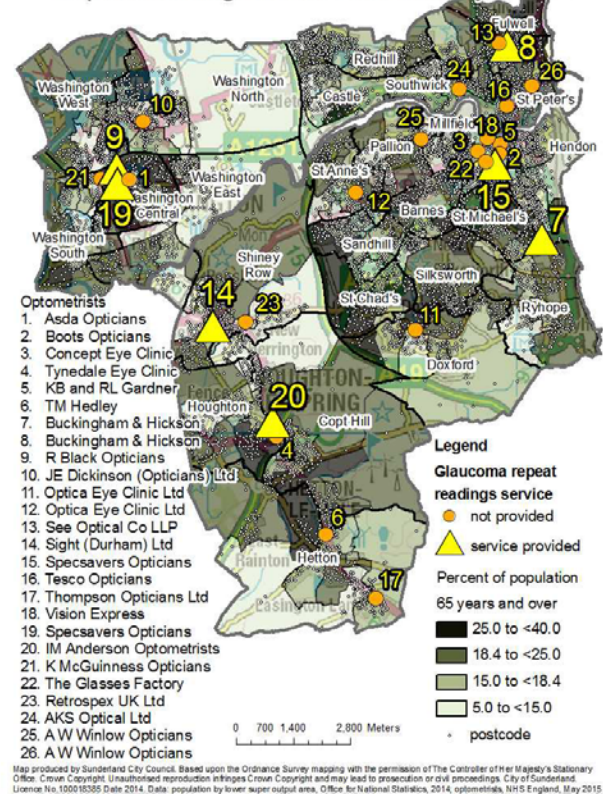
The aims of the service are to:

- Make an earlier diagnosis of glaucoma or ocular hypertension
- Improve accuracy of referrals
- Reduce the number of referrals to secondary care
- Provide care closer to home and at times most suitable to patients; avoiding unnecessary waiting and delays, therefore, improving quality of care via a more effective and efficient service.
- Provide patient choice
- Improve efficiency and reduce costs
- Provide equity of service for all

In the financial year 2014/15, 158 people used this service in Sunderland, and at February 2016 there were seven optometric practices delivering the service out of 26 practices in total located in Sunderland (Fig 13).

This service is currently provided at community optometric practices in four of the five Sunderland localities. The exception is Sunderland West, where there are communities with a particularly high concentration of older people in the St Chads and Sandhill wards.

Fig 13 Optometric practices providing a glaucoma repeat readings service at February 2016



⁵³ www.locsu.co.uk (last accessed 9th February 2016)

7.7.1.2. Cataract Choice

The aims of the service are to:

- Provide service users with a confirmed cataract, information to make an informed choice on where they can receive treatment
- Offer a choice of up to five providers of cataract surgery in line with Choose and Book
- Provide information to the service user about cataracts, cataract surgery, and, in relation to providers of cataract surgery, provider details, waiting times and provider outcomes

The service user is not required to make an appointment with the GP, once a decision to refer has been made, unless advised to by the optometrist on medical grounds. However, the pathway includes the GP as a source of required information e.g. NHS number, medications and medical history. The optometrists will continue to provide counselling on cataracts and cataract surgery and assess the patient's suitability for referral.

In the financial year 2014/15, 358 service users in Sunderland used this service, and at 30th June 2015 there were 12 current optometric practices delivering the service out of 26 practices in total located in Sunderland.

This service is currently provided at community optometric practices in four of the five Sunderland localities. The exception is Sunderland West, where there are communities with a particularly high concentration of older people in the St Chads and Sandhill wards.

7.7.1.3. Children's Eye Screening

Children can wait several weeks to be seen in secondary care by either an optometrist, orthoptist or a consultant ophthalmologist. Early diagnosis and commencement of treatment in the management of these conditions is critical to avoid the development of amblyopia or reduce its severity. The community pathway means that children referred in do not wait as long for an appointment and receive treatment and management closer to home, releasing the time of secondary eye care staff such as consultant ophthalmologists and orthoptists. Optometrists can offer appointments after school and at weekends which means that parents will not have to take children out of school.

Fig 14 Optometric practices providing a cataract choice service at February 2016

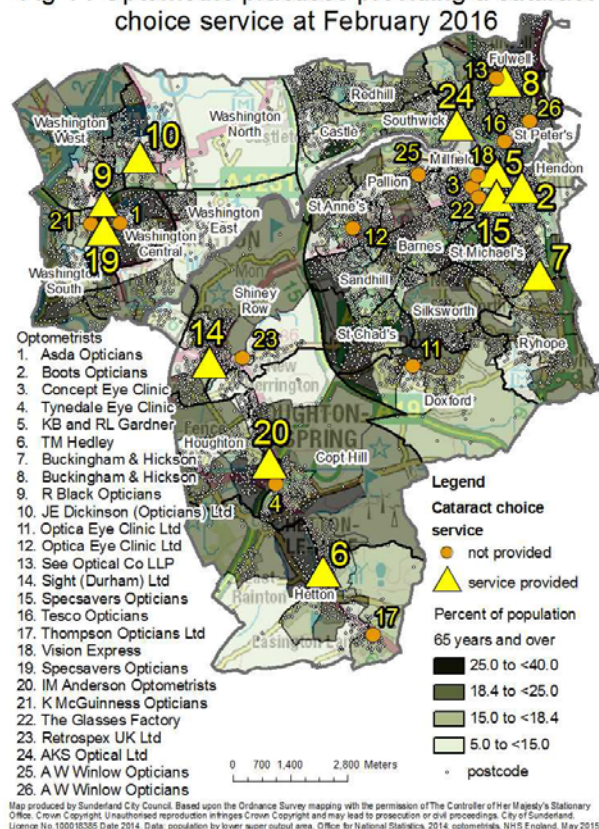
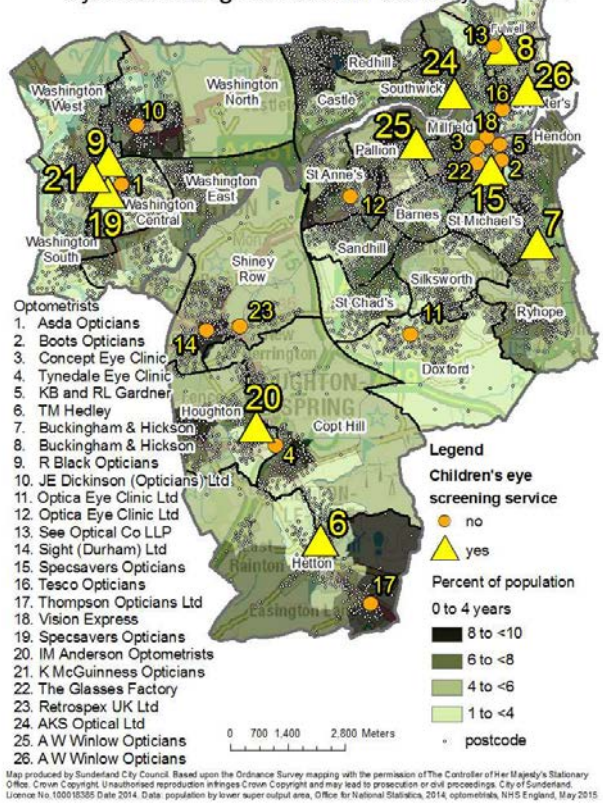


Fig 15 Optometric practices providing a children's eye screening service at February 2016



Currently eye screening services are offered to all children of reception class age who are registered with a GP Practice within the boundaries of Sunderland Clinical Commissioning Group. Of these children, a number fail the initial screening and require a further intervention. For many children where complex eye problems are not suspected, it is appropriate that referral is made to a community optometrist to make further assessment including a General Ophthalmic Services (GOS) Sight Test and to offer appropriate management.

Patients will be referred to the community optometry service by the orthoptist-led screening service. Assessment and treatment will be undertaken by a number of accredited optometrists within specially equipped premises locally.

The service supports the national and local strategic priorities of providing care closer to home by moving appropriate work from secondary care to primary care settings; evidence based practice and providing patient choice.

In the financial year 2014/15, 189 service users in Sunderland used this service, and at 30th June 2015 there were 11 optometric practices delivering the service out of 26 practices in total located in Sunderland. In the communities of Concord and Sulgrave (both in Washington North ward), Easington Lane (in Hetton ward) and Pennywell (in St Anne's ward) there is a high proportion of children 0-4 years of age and a local community optometric practice but the practice does not currently provide a children's eye screening service. In the communities of Downhill (in Redhill ward) and Town End Farm and Hylton Castle (in Castle ward) there is a high proportion of children 0-4 years but no local community optometrist. For these communities, in an area of high social and economic disadvantage, and thus a high proportion of households with no access to a car, good public transport links through to Southwick and the city centre will be important to facilitate access to children's eye screening and other community optometric services.

7.7.2. Pathways in place in other local areas, but not currently provided in Sunderland

7.7.2.1. Primary Eyecare Assessment and Referral Service or Minor Eye Conditions Service (PEARS or MECS)

This service allows for the assessment and management of certain minor eye conditions within the community optometric practice, avoiding referral or presentation to

ophthalmology, A&E or a GP. A MECS examination is undertaken by an accredited optometrist within suitably equipped premises. Management is maintained within the primary care setting for as many patients as possible, thus avoiding unnecessary referrals to hospital services. Where referral to secondary care is required it will be to a suitable specialist with appropriate urgency.

Patients can be referred into the service by their own GP or the practice nurse or surgery receptionist. Patients can also self-refer. Optometrists must, within reason, be able to offer an acute MECS examination within 48 hours of the day that the appointment has been requested by the GP or pharmacist (excluding weekends and public holidays) unless it is for routine assessment. Urgent referrals for potentially sight-threatening eye conditions should be seen on the same day or referred directly to an eye casualty unit. A clinical audit of ophthalmology referrals in Easington⁵⁴ demonstrated that around 30% of referrals could be managed by a MECS service. A survey in Stockport across 8 GP practices⁵⁵ suggested that 20% of ophthalmology referrals into secondary care could have been assessed and treated by a community optometrist with the necessary additional training to deliver a MECS-type community service. This type of service (termed Minor Eye Conditions Assessment and Treatment Service) is currently commissioned in the Durham Dales, Easington and Sedgfield Clinical Commissioning Group (CCG) and Darlington CCG areas⁵⁶.

7.7.2.2. Community Eye Care Pathway for Adults and Young People with Learning Disabilities

It is estimated that 2% of the population have a learning disability⁵⁷. Among these people, it is likely that 10% will have a visual impairment⁵⁸. An additional 40% of children and 60% of adults with a learning disability are also likely to have a refractive error or severe myopia or hyperopia⁵⁹.

A pilot programme has been commissioned by Durham Dales, Easington and Sedgfield CCG and North Durham CCG⁶⁰ which supports people with a moderate to severe learning disability from the age of 14 upwards, assisted by their health care workers, to gain the best access to eye care. In addition to increased prevalence of sight problems, it has been identified that vision problems are under-reported among this population group for a

⁵⁴ Darke J (2014) "Eye Health Needs Assessment for Durham, Darlington and Tees" p124, Durham County Council available at <http://www.teespublichealth.nhs.uk/document.aspx?id=10425&siteID=1012> (last accessed 17th February 2016)

⁵⁵ Local Optical Committee Support Unit (2015) "Minor Eye Conditions Service (MECS) Pathway (version 2)" available at http://www.locsu.co.uk/uploads/community_services_pathways_2015/locsu_mecs_pathway_rev_may_2015_v2.pdf (last accessed 17th February 2016)

⁵⁶ Darke J (2014) p120

⁵⁷ Emerson E, Robertson J (2011) "The estimated prevalence of visual impairment among people with learning disabilities in the UK" pp3-5, Improving Health and Lives available at <https://www.rnib.org.uk/sites/default/files/Emerson%20report.pdf> (last accessed 17th February 2016)

⁵⁸ Ibid pp8-10

⁵⁹ Ibid pp8-10

⁶⁰ Darke J (2014) p125

variety of reasons⁶¹. Given these characteristics, community optometric practices represent accessible and available premises at which to provide eye care. A proposed pathway for such a service has been published by the Local Optical Committee Support Unit⁶².

7.7.2.3. Adult Low Vision Pathway

The aim of this service is to offer adults with sight loss quicker access to low vision assessment and support closer to home. Where appropriate, service users would be able to try different magnifiers and other low vision aids before purchasing an aid if one suits the user. Specifically the service aims to:

- reduce unnecessary referrals to the hospital low vision clinic
- reduce patient anxiety and free up capacity within an overburdened hospital clinic
- provide a more cost-effective service closer to the service user

A proposed pathway for such a service has been published by the Local Optical Committee Support Unit⁶³ and an enhanced low vision service provided by community optometrists with specialist training is currently in place in Stockton-on-Tees and Middlesbrough⁶⁴.

7.7.2.4. Healthy Living Opticians

A service has been commissioned in Dudley in the West Midlands⁶⁵ through which 12 community optical practices offer an NHS Stop Smoking Service, alcohol screening and brief advice, NHS Health Checks and weight management.

7.7.3. Conditions for enhanced community provision to be cost-effective

Discussions with ophthalmologists identified that quality of referral into secondary care from glaucoma / intra-ocular pressure referral refinement and cataract community care pathways needs to be consistent for these services to be cost-effective i.e. so as to limit the number of inappropriate referrals.

Recommendation: *Enhanced community care pathways have the potential to reduce demand on secondary care services. Ophthalmologists and optometrists, through the Local Optical Committee and Local Eye Health Network, should meet to discuss the desirability and challenges of expanding existing community care pathways and*

⁶¹ McCulloch DL, Sludden PA et al (1996) "Vision care requirements among intellectually disabled adults: a residence-based pilot study", J Intellect Disabil Res. 1996 Apr;40 (Pt 2):140-50, abstract at <http://www.ncbi.nlm.nih.gov/pubmed/8731471> (last accessed 17th February 2016)

⁶² Local Optical Committee Support Unit (2013) "Community Eye Care for Adults & Young People with Learning Disabilities Pathway (Revised)" available at http://www.locsu.co.uk/uploads/enhanced_pathways_2013/locsu_pwld_pathway_rev_nov_2013.pdf (last accessed 17th February 2016)

⁶³ Local Optical Committee Support Unit (2011) "Adult Community Optical Low Vision Community Service Pathway" available at http://www.locsu.co.uk/uploads/enhanced_pathways_2013/locsu_adult_low_vision_pathway_rev_nov_2013.pdf (last accessed 24th March 2016)

⁶⁴ Darke J (2014) "Eye Health Needs Assessment for Durham, Darlington and Tees" p26

⁶⁵ Dudley Local Optical Committee (2016) "Dudley Health Living Optician Scheme" at <http://dudleyloc.co.uk/hlo/> and <http://dudleyhlo.co.uk/> (accessed 29th April 2016)

introducing new pathways. Any barriers such as suitably trained workforce capacity issues should be identified and actions to remove these barriers taken forward. Variations in provision of enhanced community optometric services across Sunderland, and variations in need between local communities, highlighted above, should inform these discussions.

7.8. Habilitation and rehabilitation

Habilitation is the process of assisting a child to acquire developmental skills when impairments have caused delaying or blocking of acquisition of these skills. In the context of eye health, this concerns the acquisition of skills by a child that has been born with a visual impairment or who has developed impairment soon after birth. In relation to eye health, rehabilitation is assisting a child, young person or adult to relearn skills having experienced trauma or an eye condition that impairs vision.

7.8.1. Children's Sensory Team

The Children's Sensory team within Sunderland City Council aims to be involved with all children living in the city who have significant sensory impairments (hearing and/or vision). It aims to give children, their parents or carers, families and teachers the advice and support needed to minimise the effects of a child's difficulties in the educational setting.

The team is involved with children from birth to the time they leave the education system and its work takes it into homes, nurseries and schools where it offers advice to ensure that a child has the best possible access to learning. This may range from advice on the management of the classroom and curriculum materials to specialist help or equipment.

The team becomes involved in supporting a child with a visual impairment when it receives a referral and medical report from a hospital eye department (typically either Sunderland Eye Infirmary or the Royal Victoria Infirmary in Newcastle). Depending on their needs, a child will receive universal services (a support package including an amount of time from a specialist teacher), targeted services (advice to parents, carers and teachers, developing skills, remediation work, advice towards a child's Education, Health and Care Plan, and attendance at review meetings) and specialist services (touch typing, braille, specialist vision assessments, specialist equipment assessments, environmental assessments and pre-school group sessions).

In the recent past the team hasn't had a place where it can post information to the internet, but it has established a web presence within Sunderland City Council's Local Offer website⁶⁶ and it is hoped that this will increase awareness of the team's work among the local community of children who are visually impaired, their parents, carers, families and teachers. The team acknowledges that, currently, provision of mobility training is often hard to find. It is currently working to improve communications with the low vision clinic at Sunderland Eye Infirmary.

⁶⁶ Sunderland City Council (2016) "Local Offer – supporting children and young people with special educational needs and disabilities 0-25 years" available at <https://sunderland.fsd.org.uk/kb5/sunderland/fis/localoffer.page> (last accessed 19th April 2016)

7.8.2. Adult sensory team

Habilitation (children) and rehabilitation (young people and adults) following sight loss was undertaken in Sunderland by a single officer working within Sunderland City Council. This person received referrals, typically from the eye clinic liaison officer at Sunderland Eye Infirmary, either before or during registration of sight loss. In 2016 provision of this service transferred from the Council to a local voluntary sector organisation, The Sunderland and County Durham Royal Society for the Blind. The Society are commissioned to provide the service by the Council. Contact is made with a client soon after referral, for triage and an assessment of the need for early intervention. A rehabilitation specialist works with clients in the home, outside in their local area and in the work environment, teaching mobility skills and helping them to master everyday tasks that support independent living and employment.

The role can include braille training, the use of magnifiers and other low vision aids and the use of software such as screen readers which can help when using information technology. Currently, where there is not an urgent need for early intervention, the service has a three to four month waiting list. Where the officer is working with children, it is recognised that better communication between the rehabilitation officer and special educational needs coordinators (SENCOs) in schools would help to make the role more effective. It is also acknowledged that there would be benefit in developing stronger links with care homes, to facilitate the support of older people who experience sight loss.

On bereavement, where a person with a visual impairment has lost a close family member, and thus a support network, the person's practical needs can often be overlooked. The rehabilitation specialist can provide a vital role in helping the visually impaired person to learn the practical skills which can help them to cope in their new circumstances. Clients can be referred to counselling where appropriate, and each of the five Sunderland localities now has a carers' link to which carers of people who have a visual impairment can be referred for support.

A sensory impairment exhibition that took place annually between 2009 and 2014 was a useful event, where people with sight loss could go and try low vision aids and new technologies which are often not available in high street shops. This didn't take place in 2015. The exhibition was organised by the Sunderland and County Durham Royal Society for the Blind and the organisation report that they are considering re-staging it after a two year break. The Society holds mini exhibitions, monthly, in their offices in central Sunderland when representatives of businesses who produce specialist vision aids attend to demonstrate them. There is also a low vision clinic at Sunderland Eye Infirmary which people can be referred in to at any time.

7.9. Voluntary sector organisations and community interest companies

Third or voluntary sector organisations play an invaluable role as they have an in depth knowledge of the needs and views of their members and service users. They encourage service user involvement in the development and evaluation of a broad range of services. They also have a strong focus on providing advice, information and emotional support to people. Services provided by local voluntary sector organisations concerned with vision,

sight loss and related issues are outlined in the table below. Contact details of all these organisations are included in Annex B.

Table 3: Local voluntary sector organisations concerned with vision and eye health

Provider	Activities	Location
Action for Blind People	<p>Providing an eye clinic liaison officer service to all North East NHS ophthalmology departments</p> <p>Running a telephone emotional support and counselling service jointly with RNIB</p> <p>Delivering “Living with sight loss” courses</p> <p>Hosting the “Action Connect” online community for people with sight loss</p>	National organisation with offices in Wallsend and Middlesbrough
Guide Dogs	<p>Training and provision of guide dogs</p> <p>Children and young people’s services</p> <p>“My guide” sighted guides scheme</p> <p>Training for businesses and organisations around making workplaces and services more accessible for people with sight loss</p> <p>Information and advice</p> <p>Campaigning</p>	National organisation with an office in Benton, Newcastle upon Tyne, covering the North East region
Healthwatch	<p>Gathering views of the public and service users about health and care services accessed by people living in Sunderland</p> <p>Feeding findings back to service providers and commissioners</p> <p>Facilitating the Healthnet forum of voluntary sector organisations concerned with health and care issues</p> <p>Coordinating a team of volunteers who are authorised to enter and</p>	National organisation with an office in central Sunderland

Table 3: Local voluntary sector organisations concerned with vision and eye health

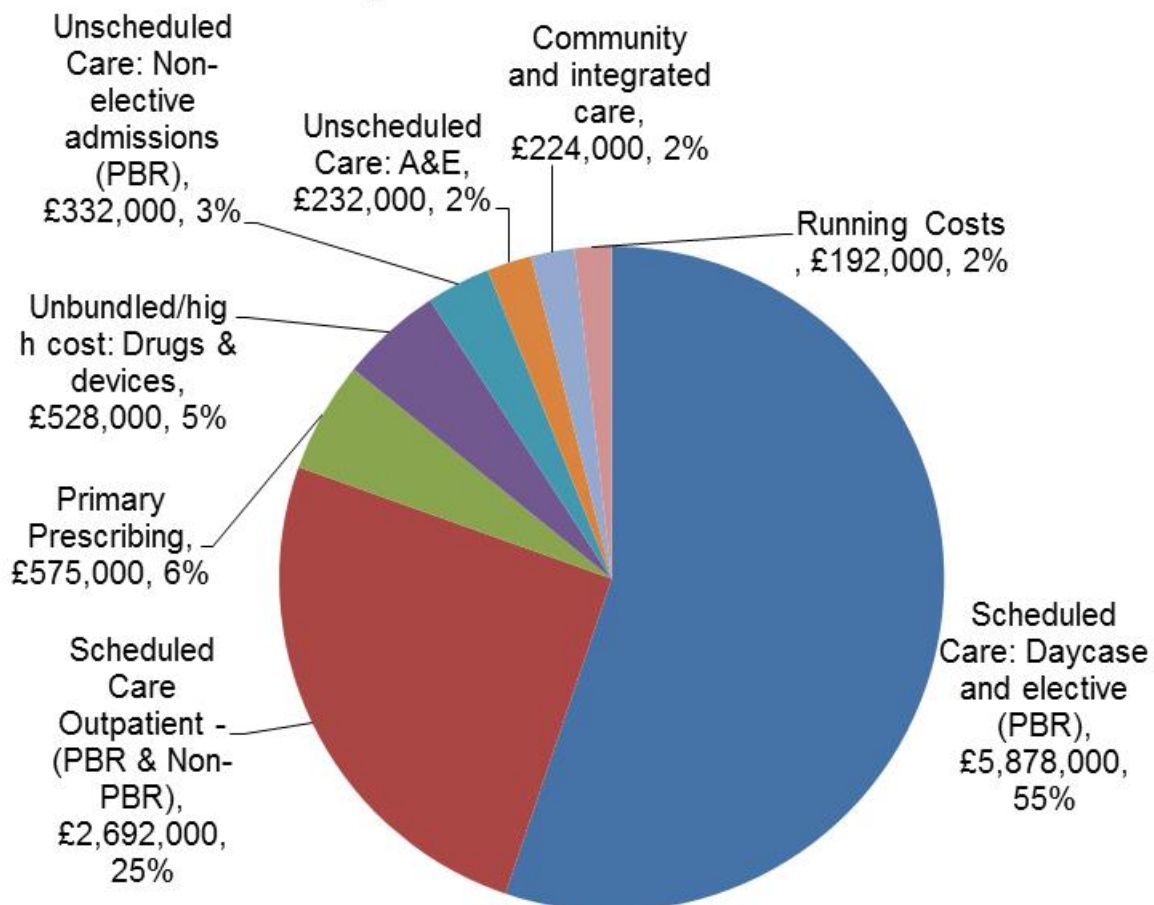
Provider	Activities	Location
	observe health and care services as they are being delivered	
Royal National Institute for the Blind	<p>Campaigning</p> <p>Membership – member forums in the North East providing information and peer support and a regular magazine</p> <p>National advice and information line</p> <p>Emotional support service by telephone counselling (jointly provided with Action for Blind People)</p> <p>Advice for businesses to make services or work environments more accessible for people with sight loss</p>	National organisation with an office in Wallsend, Newcastle upon Tyne covering the North East region.
Sunderland and County Durham Royal Society for the Blind	<p>Local implementation for British Wireless for the Blind</p> <p>Computer mentoring and technology support</p> <p>Professional counselling service</p> <p>Gardening group</p> <p>Peer support group for people with macular disease</p> <p>A resource centre where people can try, and purchase vision aids</p> <p>A library of audio books available on loan</p> <p>Undertakes surveys among its 1,400 members to direct its service delivery</p> <p>Befriending service</p>	Office in central Sunderland

8. Expenditure on eye care services

The 2013-14 release of NHS England's CCG Programme Budgeting Tool shows that there was a total expenditure of £11m in this year within Sunderland on problems of vision. The largest proportion of total spend was on planned hospital eye care (inpatient £5.9m or 55%, outpatient £2.7m or 25%).

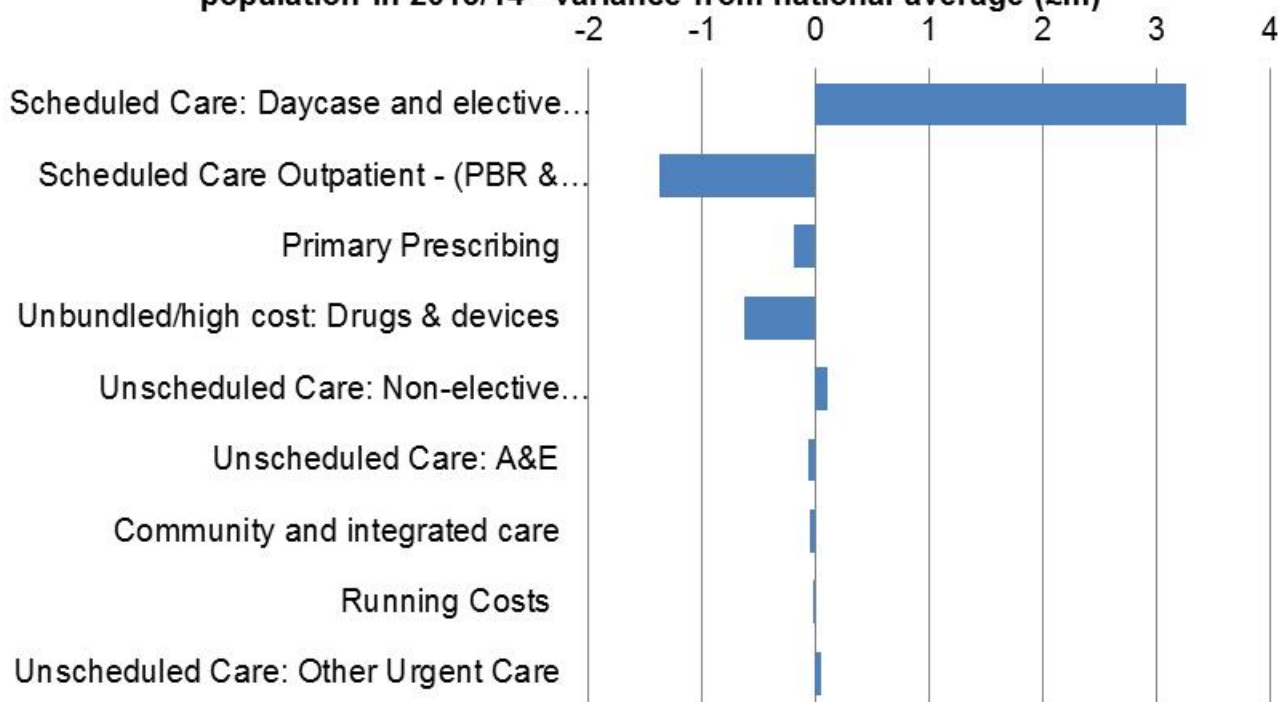
Expenditure in 2013/14 was 10% higher than average national expenditure per 100,000 population. Much of the variance of expenditure on day case and elective care will be due to the classification of age-related macular degeneration (AMD) treatments at City Hospitals Sunderland as day case inpatient admissions whereas in many other provider Trusts they are classified as outpatient attendances.

Fig 16 Expenditure for the population of Sunderland on problems of vision in 2013/14



Data source: NHS England, 2013/14 CCG programme budgeting benchmarking tool

Fig 17 Expenditure on problems of vision for the Sunderland population in 2013/14 - variance from national average (£m)



Data source: NHS England, 2013/14 CCG programme budgeting benchmarking tool

9. Findings from engagement and surveys

This section highlights findings from a number of different sources:

- an engagement event held at Sunderland Civic Centre in March 2015 attended by a wide range of stakeholders (see Annex A)
- four surveys aimed at eye health service users, optometrists, GPs and ophthalmologists, published on the Council's website and open for a period of four weeks in July and August 2015
- a series of one-to-one discussions with service providers and service commissioners

9.1. Prevention and screening

During the engagement event it was said that work needs to be done training health visitors in visual awareness and common eye conditions so that they can pass on this knowledge to new parents. The health visitor's role is to support families, infants and young children in the first five years of life promoting healthy lifestyles and preventing illness. In addition to assessing parenting skills and the family and home situation, the health visitor will consider the development needs of young children, and looking for anomalies in vision is part of this process. A vision checklist forms a separate page within the "Personal child health record" red book, and a vision check is part of both the newborn health check carried out in hospital and the six to eight week infant health check undertaken by a GP. Thus there is a system in place which ensures that the health visitor will discuss a baby's vision with parents and look for anomalies throughout the four year

period when the health visitor is available for advice and support, but ultimately their role is to signpost to a GP where a possible anomaly is spotted.

A view was expressed during engagement that routine eye tests should be reinstated beyond five years of age delivered from a mobile testing unit. Current policy set out by the UK National Screening Committee in 2013⁶⁷ is that all children's vision should be screened by an orthoptist at 4 or 5 years of age. The Committee considered evidence of the efficacy of screening prior to and beyond 4 or 5 years of age and concluded that neither is cost effective.

It was identified that very little prevention activity currently takes place within the school curriculum and there is no dedicated workforce capacity to deliver the prevention messages, other than teachers who do not have specialist knowledge in the area. Outside the formal curriculum, there are opportunities to promote eye health messages e.g. within a newsletter sent to parents and carers. School nurses in Sunderland do not currently carry out and specific health promotion activity around vision or eye health. They are, however, developing resource packs on sun protection which will include information regarding the benefits of wearing sunglasses with ultraviolet protection in bright sunlight. School nurses do provide vision screening advice as part of individual health assessments but these are only undertaken for individuals identified with a particular need.

People at the engagement event felt that very little prevention work takes place targeted at an adult audience. There are important health messages that need to be conveyed which could prevent future eye conditions, such as the importance of regular sight tests, wearing sunglasses in bright sunlight and wearing protective goggles when playing some sports. It should be highlighted that free eye tests are available for young people under 16, young people under 19 in full-time education, people aged 60 or over, some benefits and tax credits claimants and people with diagnosed diabetes or glaucoma. In particular, these prevention messages should be conveyed by voluntary sector organisations such as the Carers' Centre and Age UK who are in contact with vulnerable groups at increased risk of sight loss including older people and people with dementia.

Results from the eye health questionnaire aimed at service users suggested that there is a need for prevention work promoting the importance of regular eye tests and of seeking immediate advice from a health professional on noticing symptoms of an eye condition. Of people diagnosed with an eye condition (n=80) only 40% of respondents reported that they had had an eye test every two years or more frequently prior to diagnosis. 20% said they had never had an eye test. On noticing symptoms of their eye condition, half waited more than one month before seeking advice.

A view was expressed at the engagement event that the links between both smoking and obesity, and an increased risk of visual impairment^{68,69} are not well understood. Among

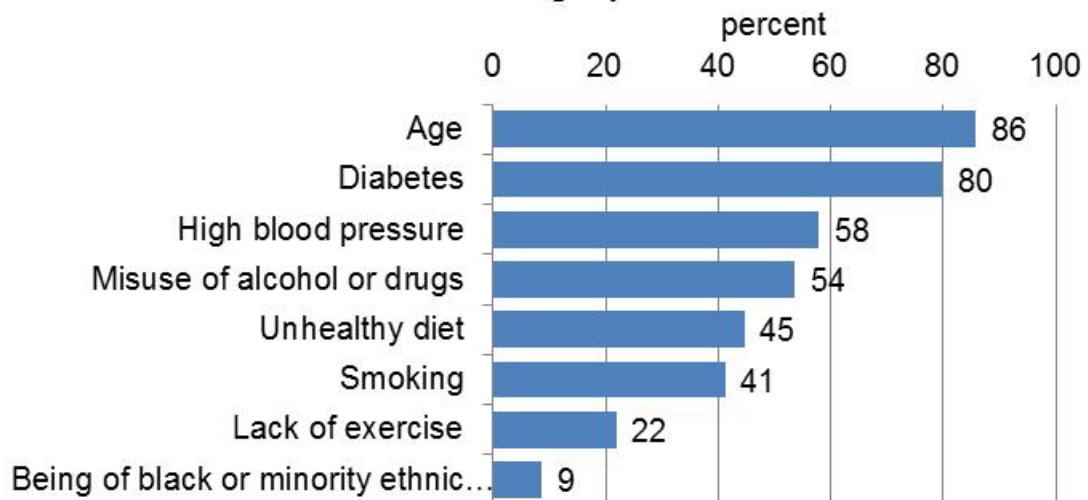
⁶⁷ UK National Screening Committee (2013) "Screening for vision defects in children aged 4 to 5" available at <http://legacy.screening.nhs.uk/vision-child>

⁶⁸ Royal National Institute for the Blind (2016) "Obesity and sight loss" at <http://www.rnib.org.uk/eye-health-looking-after-your-eyes/obesity-and-sight-loss> (last accessed 24th March 2016)

⁶⁹ Royal National Institute for the Blind (2016) "Smoking and sight loss" at <http://www.rnib.org.uk/eye-health-looking-after-your-eyes/smoking-and-sight-loss> (last accessed 24th March 2016)

responses to the eye health survey aimed at eye health service users, when unprompted, 20% of the 233 people responding stated poor diet or diabetes (both linked to obesity) as risk factors for sight problems but less than 3% stated smoking as a risk factor. Age and family history were identified as risk factors for sight loss by 22% and 19% of survey respondents respectively and there is good evidence to support these connections^{70,71}. However, the single largest response (33% of survey respondents) identified extended use of visual display units (VDUs) as a risk factor and this issue was also raised during engagement. However, there is little evidence to support this link⁷². When asked whether identified factors are linked to an increased risk of sight problems, a higher proportion recognised the links.

Fig 18 Which of the following do you think are linked to an increased risk of sight problems?



Data source: Sunderland City Council, service user eye health questionnaire, August 2015, 233 responses

The literature distributed to support people who are attempting to quit smoking⁷³ emphasises the positive benefits of quitting, so that it is a motivational aid. Some mention is made of the causes of ill health for which there is the greatest smoking-related burden of disease e.g. lung cancer, heart disease and stroke but no mention is made of the link between smoking and sight loss. This could explain the low awareness of this link among eye health service users.

It was commented at the engagement event that the NHS Health Check should include a question asking service users how long it is since they have had a sight test. The NHS Health Check is a nationally mandated service which has to be commissioned by all local

⁷⁰ Zacks D (2006) "Why does eyesight deteriorate with age?" Scientific American, available at <http://www.scientificamerican.com/article/why-does-eyesight-deteriorate/> (last accessed 24th March 2016)

⁷¹ Lylas G, Mogk MD (2015) "Risk factors for age-related macular degeneration (AMD)", VisionAware, available at <http://www.visionaware.org/info/your-eye-condition/age-related-macular-degeneration-amd/risk-factors-for-amd/125> (last accessed 24th March 2016)

⁷² Cole BL, Maddocks JD, Sharpe K (1996) "Effect of VDUs on the eyes: report of a 6-year epidemiological study", Optometry and Vision Science 1996 Aug;73(8):512-28, abstract available at <http://www.ncbi.nlm.nih.gov/pubmed/8869982> (last accessed 24th March 2016)

⁷³ For example "It's so much easier since I quit" Your guide to quitting for good with Smokefree" pp8-9 available at <http://www.stopsmokingglos.nhs.uk/images/downloads/quittingguide.pdf> (last accessed 4th April 2016)

authority public health teams⁷⁴. It is aimed at people aged 40 to 74 years and its primary aim is to assess an individual's risk of a future cardiovascular event (a heart attack, a stroke or a related disease). The exact content of the health check is determined locally and a review of the service specification is being undertaken in 2016 by the public health team within Sunderland City Council. The view that a question about an individual's history of sight tests should be included has been communicated to the review team. If this is to be included, it is suggested that people who have not had a sight test within the past two years are advised that this is the recommended interval between sight tests for adults without any other relevant clinical indications⁷⁵.

It was noted at the engagement event that eye health awareness training for people who are deaf or severely hearing impaired using British Sign Language is needed. In 2010, there were 230 people living in Sunderland registered as deaf⁷⁶. Also, health promotion literature promoting eye health should be available in languages other than English where these are spoken among communities from black and minority ethnic groups where there are a significant minority that don't have English as a first language. An example in Sunderland would be the Bangladeshi community as there were 2,100 people from this ethnic group resident in Sunderland at the 2011 Census⁷⁷. Only a proportion of this population will not be able to speak English well or at all. At the 2011 Census, of 14,300 people among the Sunderland population who stated that their ethnic group was not "White UK", 1,200 or 8% identified that they could not speak English well or at all⁷⁸. People from Asian populations, together with those from African and African-Caribbean communities, are at a higher risk of developing diabetic eye disease⁷⁹.

A theme that cropped up at many different points during engagement and discussions with practitioners was the role of GPs both in eye health prevention and care pathways. Several people commented during engagement that GPs had an important role to play reminding service users of the importance of regular eye tests and using basic tools such as the Snellen Chart or Amsler Grid to test eyes opportunistically which can inexpensively allay fears in many cases. The reminder about regular sight tests is particularly important for groups such as those with a learning disability and people diagnosed with dementia. It was commented that there was a lack of awareness among GP Practice staff of adaptations to community sight test services and diabetic eye screening services which

⁷⁴ NHS Choices (2016) "NHS Health Check", available at <http://www.nhs.uk/Conditions/nhs-health-check/Pages/NHS-Health-Check.aspx> (last accessed 17th April 2016)

⁷⁵ College of Optometrists (2016) "The routine eye examination" available at <http://guidance.college-optometrists.org/guidance-contents/knowledge-skills-and-performance-domain/the-routine-eye-examination/> (last accessed 31st March 2016)

⁷⁶ Health and Social Care Information Centre (2010) "People Registered as Deaf or Hard of Hearing – England, Year ending 31 March 2010" available at <http://www.hscic.gov.uk/article/2021/Website-Search?productid=1758&q=deaf+or+hard+of+hearing&sort=Relevance&size=10&page=1&area=both#top> (last accessed 24th March 2016)

⁷⁷ Office for National Statistics (2014) "DC2101EW – Ethnic group by sex and age" from NOMIS at www.nomisweb.co.uk

⁷⁸ Public Health England (2016) "Local Health" available at www.localhealth.org.uk

⁷⁹ UK Vision Strategy (2015) "Eye and sight loss; statistics and information for developing a Joint Strategic Needs Assessment" p12, available at [http://www.ukvisionstrategy.org.uk/sites/default/files/JSNA_Guidance_for_Eye_Health_and_Sight_Loss_2015_refresh_FINAL_1%20\(1\).pdf](http://www.ukvisionstrategy.org.uk/sites/default/files/JSNA_Guidance_for_Eye_Health_and_Sight_Loss_2015_refresh_FINAL_1%20(1).pdf) (last accessed 30th March 2016)

facilitate access for those with additional needs such as people with a learning disability, autism or dementia.

The Sunderland and South Tyneside diabetic eye screening service add a flag to identify people on their clinical records with additional needs such as a learning disability or autism. The service offers a double time appointment slot and uses an accessible or “easy read” version of their letter of invitation to an appointment which uses pictures such as a clock and a calendar to indicate the date and time of the appointment. The service includes disability awareness training as part of continuing professional development for its staff and, in November 2015, ran a development session on the theme of supporting patients with dementia and mental illness delivered by an older persons’ medicine practitioner. An observation was made by a service user at the engagement event that there was no domiciliary (home visit) diabetic eye screening service available in Sunderland. A patient transport service is offered to diabetic eye screening service users with severely limited mobility. Adaptations offered by optometric practices are discussed in section 9.3 on p46.

Recommendation: *elements of the school Personal, Social, Health and Economic (PSHE) curriculum that highlight the health risks of smoking should include the increased risk of long-term eye conditions such as age-related macular degeneration and cataracts arising from smoking. Similarly literature available to people accessing NHS Stop Smoking Services should highlight the reduced risk of sight loss arising from giving up smoking.*

Recommendation: *elements of the school Personal, Social, Health and Economic curriculum that relate to healthy lifestyles should include content highlighting measures that can reduce the risk of poor eye health in later life such as regular eye tests, wearing sunglasses in bright sunlight and wearing protective goggles when playing some sports.*

9.2. Hospital eye care

When asked which health, social care or voluntary sector services they currently used, 73% of respondents to the service user eye health questionnaire (n=170) listed hospital ophthalmology departments and 11% (n=26) listed eye casualty A&E. When asked which services they valued the most, 27% (n=63) included hospital ophthalmology departments and 25% (n=59) included eye casualty A&E.

Of those who had been diagnosed with an eye condition, over half (53%, n=42) said that they had felt very well supported when given their diagnosis, a quarter (24%, n=19) said that they were fairly well supported and less than 6 people (<7%) reported not feeling supported at all. When adjusting to and managing their condition, 58% (n=46) had felt very well supported, 26% (n=21) fairly well supported and 11% (n=9) did not feel supported at all.

When asked about their best experience with eye health services, 15% (n=36) specified excellent service that they had received from eye hospital staff. This was the second most frequent answer after excellent service from optometrists (19%, n=45). When asked about their worst experience with eye health services, less than 3% of responses (n≤6) noted

poor clinical expertise or poor service at hospital eye departments and less than 3% (n≤6) noted long waiting times at hospital eye departments.

At the engagement event held in March 2015, it was clear that Sunderland residents valued the service provided by Sunderland Eye Infirmary and recognised that the population are particularly fortunate to have a 24 hour eye casualty unit that serves a much wider geographical area, within the city boundaries. The adapted care processes provided at the Eye Infirmary for people with a learning disability were praised by some, while others reported a lack of awareness of the needs of this population group.

The care provided by Sunderland Eye Infirmary was reviewed by the Care Quality Commission in January 2015⁸⁰ and “Urgent and Emergency Services”, “Surgery” and “Outpatients and diagnostic imaging” were all, individually, rated as “Good”. It was also rated as good across each of the five domains “Safe”, “Effective”, “Caring”, “Responsive” and “Well-led”. Two of the waiting time targets that the Infirmary is required to meet⁸¹ are: 95% of patients to be admitted, transferred or discharged within 4 hours of their arrival in A&E, and patients to start treatment within 18 weeks of referral (90% for admitted patients, 95% for non-admitted patients). The Infirmary reports consistently achieving 98% against both targets.

It was noted at the engagement event that, in particular, people living outside Sunderland are presenting to eye casualty in increasing numbers because of the 24/7 service that it offers. It was reported that attendances are increasing by around 1,000 per year. There was concern that many presentations are inappropriate either because they are non-urgent or because they could be managed in primary care. A recommendation on p22 of this report suggests a limited study of patterns of recent attendance at the eye casualty unit at Sunderland Eye Infirmary which could provide evidence to support these observations.

Concern was expressed during the engagement event that the emotional needs of some service users are not being met. In particular, it was felt that these needs are both short and medium-term i.e. immediately after diagnosis, but also intermittently in the years following diagnosis, especially where sight is gradually deteriorating. Sunderland Eye Infirmary has an eye clinic liaison officer (ECLO) whose role it is to provide both practical and emotional support post-diagnosis, where sight has been impaired. The officer also has the role of linking service users with appropriate services and organisations to support them in the community as they adapt to life with a visual impairment. In 2015 the ECLO provided a service four days a week (0.8 whole time equivalent) but, at August 2015, a business case had been submitted to increase provision to five days a week. Appointment with the ECLO is ordinarily on the same day as diagnosis. The unmet need for emotional and practical support beyond diagnosis is discussed in section 9.4 concerning habilitation, rehabilitation and post-diagnosis support on p50.

⁸⁰ Care Quality Commission (2015) “Sunderland Eye Infirmary, Quality Report” available at http://www.cqc.org.uk/sites/default/files/new_reports/AAAC0171.pdf (last accessed 4th April 2016)

⁸¹ NHS England (2013) “Everyone Counts: Planning for Patients 2014/15 – 2018/19” available at <https://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid.pdf> (last accessed 4th April 2016)

A theme of discussions at engagement events held in Sunderland and South Tyneside was the difficulty of travel to attend appointments at Sunderland Eye Infirmary, particularly for people with a learning disability, older people who are likely to be less mobile and people with a severe visual impairment. It was noted that one in ten people who don't attend for their first appointment, also fail to attend the rescheduled appointment. High "did not attend" (DNA) rates may be linked to difficulties travelling to the Eye Infirmary. Identifying population groups that find it most difficult to access services and developing a subsequent action plan to improve access, could be a way of both improving patient experience but also reducing 'did not attend' rates, thus improving the cost-effectiveness of services. Factors affecting attendance at appointments identified at the engagement event included flexibility of appointment times, availability of an interpreting service and availability and awareness of both NHS and voluntary sector patient transport schemes.

Staff at Sunderland Eye Infirmary noted that, where possible, outpatient appointments are delivered at satellite clinics if this is more convenient for the service user, and that, in 2015, two additional clinics had been scheduled at South Tyneside General Hospital. Within Sunderland, satellite clinics are delivered at Washington Galleries health centre. The Eye Infirmary is currently undertaking a review of its off-site provision, recognising the potential that this provision has to provide more care closer to home.

Recommendation: *once the review of offsite provision and any subsequent changes to services are complete, that the Eye Infirmary considers undertaking a travel survey among service users. The survey could include questions about method of travel, length of journey, ease of journey and characteristics of service users including age, gender, ethnic group, area of residence and severity of visual impairment. A parallel study of the likelihood that service users do not attend appointments could also be undertaken to establish if there is any correlation between ease or difficulty of travel to appointment and the risk of DNA among different population groups. Such a study has the potential to provide a greater understanding of the needs of people who find it difficult to access hospital eye care, but also, with a suitable action plan, it has the potential to reduce DNA rates.*

Responses to a questionnaire seeking views from ophthalmologists confirmed findings from trends in inpatient and outpatient activity. Most responses acknowledged that an aging population, the development of new treatments and the broadening of existing treatments to new diagnostic groups are all putting increasing demand on services and increasing pressure on staff.

9.3. Community eye care

Results from the eye health questionnaire aimed at service users reflected the important role of the community optometrist as being the place people go to first for regular sight check-ups, but also to seek advice, when they notice the symptoms of an eye condition. 80% of people responding to the survey (n=182) said that they currently use a local optometric practice or dispensing optician and 85% of these people (n=153) listed their optometrist or optician among the health and care services they value the most. Of 80

survey respondents that had been diagnosed with an eye condition, 70% (n=57) first sought medical advice from their optometrist when they noticed symptoms.

70% of survey respondents reported finding it “very easy” to access sight tests and a further 20% “fairly easy”. The map on p27 shows that there is a good geographical spread of community optometrists across Sunderland and nine of 26 practices located within Sunderland offer home visits. The NHS Choices website lists the addresses and opening times of all 26 practices at <http://www.nhs.uk/Service-Search/> (search on “Opticians” and “Sunderland”).

When asked what, if anything, would make eye tests easier to access, no single answer appeared in more than 6% of responses. 6% of people responding (n=13) felt that longer opening hours would make access easier and 5% (n=12) felt that sight tests should cost less or be free of charge. 20% of survey respondents (n=45) identified excellent service from an optometrist when asked about their best experience when using eye health services. Conversely, 5% (n=11) identified poor clinical expertise at an optometric practice or optician as their worst experience when using eye health services.

Because it was commented during engagement that GP Practice staff were not aware of adaptations to community eye care services, existing and potential adaptations are discussed here. Nine optometric practices in Sunderland offer home visits for sight tests (see maps pp27-28) which allow access to this service for people with poor mobility. Some, but not all, optometric practices offer sight tests using picture rather than letter recognition. Service users or their carers wishing to access this service should enquire with an optometric practice in advance to find out if they provide this service. An enhanced service, offering sight tests for people with a learning disability, delivered by optometrists with specialist training, has been piloted in County Durham (see section 7.7.2.2 on p32 for a description of this service), but is not currently available in Sunderland.

A service user with a learning disability attending the engagement event in March 2015 recounted a visit to a community optometrist in Sunderland where they had requested an alternative vision test using picture recognition as they were unable to complete the letter recognition eye test (using a Snellen chart). They were told that the practice was unable to provide an alternative test and the service user reported that staff had been unpleasant. A check against the General Ophthalmic Services (GOS) contract and questions asked of practicing optometrists with a specialist knowledge in this area revealed that there is no contractual obligation to provide an alternative within the GOS contract. However, provision of such an alternative would seem to be a reasonable adjustment which would make optometric services more accessible to those with a learning disability or other additional needs.

9.4. Habilitation, rehabilitation and post-diagnosis support

Capacity to deliver habilitation and rehabilitation support for people with a visual impairment in Sunderland is limited. There are currently two qualified teachers of the visually impaired supporting children and advising parents, carers and teachers in educational settings (the Children’s Sensory Team), and one specialist officer provided habilitation and rehabilitation services in the home and work setting (the Adult Sensory

Team). The Children's Sensory Team, working in educational settings, reports waiting times of 2-3 weeks and the Adult Sensory Team has said that waiting times are usually 3-4 months.

People attending the engagement event identified that there were sometimes waiting times of 6 months for the rehabilitation service and that at times, there has been a conflict of opinion between health professionals and service users relating to what is considered appropriate and necessary mobility training.

It was noted at the engagement meeting that uptake of low vision equipment among children and young people who are visually impaired is poor. Parents or carers and teachers need to be trained to recognise when use of low vision equipment is appropriate, encourage relevant people to obtain the equipment and help them to use it correctly.

At the engagement event there were comments that there is unmet need for emotional support beyond diagnosis, particularly where sight is slowly deteriorating. This may refer to the availability of suitable counselling services in the community. Information on voluntary or third sector organisations in Sunderland on pp36-38 notes that both telephone and face-to-face counselling services, and peer support groups, all specifically aimed at supporting people who experience sight loss, are hosted by locally-based organisations. It may be that awareness of these services is low. Community optometrists may also have a role in providing support and reassurance during follow-up appointments after a diagnosis in secondary care.

Recommendation: *it would be useful to review the information provided to eye care patients when visiting the eye clinic liaison officer at Sunderland Eye Infirmary to ensure that it includes information about all available community support services for people with a visual impairment offered either by GP Practices or by local voluntary sector organisations.*

Recommendation: *some additional engagement work is undertaken to speak to people living with a visual impairment in Sunderland. This work should seek to understand whether the unmet need for emotional support identified within this study is due to a low awareness of existing services, barriers to accessing these services or whether the existing services are different from those that people would like to access.*

9.5. How well does the eye health care system work, as a whole

44% of respondents to the service user eye health questionnaire (n=102) reported feeling very well informed about their eye health care, 35% (n=81) felt fairly well informed and 11% (n=25) felt poorly informed. When asked if there were any gaps in services, two thirds of respondents (66%, n=154) said there were no gaps and 12% (n=29) said there were gaps. No single gap was identified more than four times, but 3% of responses (n=7) suggested low awareness of existing eye clinic liaison officer and low vision support services.

A general point was raised at the engagement event that people experiencing sight impairment often only hear about available services by word of mouth. Better information

provision is needed at all stages in the care pathway. Information needs to be provided in a range of formats e.g. large print, 'easy read' or translated into other languages commonly spoken in the local community. Information packs should be available specifically for different age groups e.g. children and young people, working age adults and older people. Guides should be written in plain English, free of jargon, and should give people an idea of what to expect from different services and organisations. These needs are currently being highlighted by NHS England's Accessible Information Standard⁸², which comes into full effect from 31st July 2016.

9.6. How well do eye health services work together?

35% of respondents to the service user questionnaire (n=82) reported that local eye health services work "very well" together to support their needs. Another 35% (n=82) said that they work together "fairly well" together. 9% (n=20) reported that they didn't work together very well.

Some community optometrists reported feeling frustrated that, having referred service users into secondary care, directly or via a GP, they got no feedback from ophthalmologists following a hospital appointment. This makes continuing care more difficult and could lead to tests being duplicated. This view was supported by responses to an eye health questionnaire aimed at optometrists practicing in Sunderland. Respondents were asked how effective local communication links and feedback processes across primary and secondary care were. Of nine responses, over half indicated that communication links and feedback processes across primary and secondary care were "not at all effective". Where optometrists commented on how these could be improved, the two most common responses were to implement direct referrals from the community optometrist into secondary care and to implement a process where the letter sent to the service user's registered GP was automatically copied to the referring optometrist. It was noted at the engagement event that direct referral could speed up the referral process, but that, currently, these direct referrals, other than in cases of urgent need, can only be made by optometrists who have done additional training and are signed up to a locally commissioned service. Less than half of community optometric practices are signed up to enhanced services which include the use of the direct referral route (7, 11 and 12 out of 26 for glaucoma / intra-ocular pressure referral refinement, cataract choice and children's eye screening respectively).

Both in one-to-one discussions and at the engagement event, ophthalmologists were clear that the information on comorbidities and prescribed medications included in secondary care referrals by GP Practices greatly increased the quality of referrals from community optometrists and that this step should not be removed from referral pathway. If the benefits of shorter waiting times through 'direct' referral schemes such as cataract choice, glaucoma / intra-ocular pressure referral refinement and minor eye conditions service are to be realised, then referrals may need to be uniformly passed via GP Practices to the hospital ophthalmology team using secure electronic transmission. The issue of

⁸² NHS England (2016) "Accessible Information Standard: making health and social care information accessible" available at <https://www.england.nhs.uk/ourwork/patients/accessibleinfo-2/> (last accessed 13th April 2016)

information from GPs adding value to secondary care referrals should be referenced in discussions about increasing the provision of enhanced community-based services which could increase the number of 'direct' referrals into secondary care.

Other than where referrals are made via an enhanced service, the local eye care pathway in Sunderland refers incidental findings to a service user's registered GP. It was emphasised at engagement that optometrists should verbally encourage patients to book a GP appointment when screening highlights a potential or early stage eye condition.

The engagement event and subsequent discussions with optometrists happened between March and May 2015. The optometrist questionnaire was implemented in July and August 2015. In February 2015 the Royal College of Ophthalmologists and College of Optometrists jointly issued advice for members on the sharing of patient information following referral⁸³. The agreement means that when a patient has consented for their clinical information to be shared, ophthalmologists will share that information with the referring optometrist. This advice is in line with Dame Fiona Caldicott's Information Governance review⁸⁴ which recognises the value of sharing information to support patient care as well as requiring appropriate safeguards to ensure that confidential information relating to care is used appropriately.

Recommendation: *Sunderland Eye Infirmary collaborates with ophthalmology colleagues in other NHS Trusts and the Cumbria and North East Local Eye Health Network, to participate in a planned region wide audit of feedback of clinical findings from secondary care to community optometrists.*

Recommendation: *ophthalmologists and optometrists, through the Local Optical Committee and Local Eye Health Network, should discuss practical ways in which i) referrals from community to secondary care can be streamlined without reducing the quality of referrals, and ii) feedback to optometrists can be improved.*

9.7. Living with a visual impairment

A range of issues were raised both at the engagement event in March 2015, and within responses to an eye health survey aimed at service users, which suggest that people with a visual impairment continue to experience difficulties undertaking every day activities that most people take for granted. These include visiting the town centre to go shopping or access leisure services, attending healthcare appointments or walking around their local community. People were concerned with increasing numbers of obstructions on pavements preventing easy access, including signage and furniture associated with retail premises, cars parked on pavements and wheelie bins obstructing pedestrian access.

⁸³ The College of Optometrists (2015) "Agreement reached on the sharing of patient information between ophthalmologists and optometrists" available at http://www.college-optometrists.org/en/college/news/index.cfm/sharing_patient_information_following_referral (last accessed 1st April 2016)

⁸⁴ Caldicott, Dame Fiona (Chair) (2013) "The Information Governance Review" p21, Department of Health, London available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192572/2900774_InfoGovernance_accv2.pdf (last accessed 1st April 2016)

Stone seats in Sunderland city centre were noted as a particular issue as they blend in with the pavement.

As ways of improving access, people attending the engagement event noted that colour contrast built in to street furniture, buildings and signage makes it easier for people who are visually impaired to navigate and move about safely. Sunderland City Council has powers to ensure that highways are kept clear of any obstructions, and this includes both pavements and carriageways. Pages on the Council's website^{85,86,87} describe its jurisdiction and how residents can raise particular access issues.

There was a low awareness among people attending the engagement event of the availability of physical activity opportunities appropriate for people with a visual impairment. These could be provided by sports clubs or within Council leisure centres. Washington Community Resource Centre, a day care centre for vulnerable and learning disabled adults, offers 'sit and be fit' classes. A person with a visual impairment attending had wanted to try archery but was unable to find a provider or club who offered adapted provision. Activities suitable for children and young people up to 24 years of age with additional needs are listed on the Local Offer website⁸⁸ maintained by Sunderland City Council. There is an option to identify activities suitable for the visually impaired but this only returns one organisation located in Sunderland.

10. Conclusions

This study has shown that sight loss affects a large number of people in Sunderland. Out of a population of 270,000, at least 1,000 people have severe sight loss and 7,000 are visually impaired. Many more have impaired vision that is below the threshold that makes them eligible for registration. And the number affected by sight loss is growing as life expectancy rises and the population 'ages'. We have also seen that demand on eye health care services is outpacing the growth in numbers with eye conditions, because treatments are improving and are now appropriate for a wider range of eye conditions. Eye care now accounts for 10% of all planned episodes of hospital care. Perhaps most importantly, it is recognised that a large proportion of sight loss is avoidable, particularly among older people with undetected sight loss, although there is debate about the exact proportion⁸⁹.

During engagement to inform this needs assessment, people who use eye health services and who have a visual impairment living in Sunderland have clearly said that they value local eye care services and recognise that they deliver a high quality of care.

⁸⁵ Sunderland City Council (2016) "Nuisance vehicles" available at <http://www.sunderland.gov.uk/index.aspx?articleid=1320> (last accessed 15th April 2016)

⁸⁶ Sunderland City Council (2016) "Using the street or pavement space for displays and A-boards" available at <http://www.sunderland.gov.uk/index.aspx?articleid=8568> (last accessed 15th April 2016)

⁸⁷ Sunderland City Council (2016) "Pavements" available at <http://www.sunderland.gov.uk/index.aspx?articleid=1292> (last accessed 15th April 2016)

⁸⁸ Sunderland City Council (2016) "Local Offer – supporting children and young people with special educational needs and disabilities 0-25 years" available at <https://sunderland.fsd.org.uk/kb5/sunderland/fis/localoffer.page> (last accessed 19th April 2016)

⁸⁹ Shickle D (2015) "What proportion of sight loss is preventable? The need for a confidential enquiry for the eye care pathway" *Ophthalmic and Physiological Optics* **35** (2015) 591-594, abstract at <http://onlinelibrary.wiley.com/doi/10.1111/opo.12231/abstract> (last accessed 19th April 2016)

This study has reached a number of important conclusions:

- Evidence-based screening services for children 4-5 years and people with diabetes are available in Sunderland and uptake is good, but there is scope for more eye health prevention activity, particularly within the school Personal, Health, Social and Economic curriculum and aimed at older people. The rate of uptake of routine sight tests in Sunderland is below regional and national averages. Prevention activity could help to increase uptake of routine sight tests. This will reduce undetected sight loss and identify early-stage eye conditions. Early diagnosis and treatment of some eye conditions can avoid sight loss.
- The volume of hospital eye care activity has risen faster than population projections have predicted. Forward planning of these services will need to take this upward trend in activity into account both in terms of clinic capacity and workforce planning.
- Direct referral by community optometrists into secondary care can speed up the referral process, but there needs to be parallel electronic notification of both the chosen eye hospital and a service user's registered GP Practice. In this way, the Practice can add information on comorbidities and prescribed medications before forwarding the referral on to the eye hospital without slowing down referral. Direct referral is not currently widely used in Sunderland.
- The delivery of locally commissioned enhanced services by community optometrists has the potential to reduce demand on hospital eye care services and offer the provision of these services closer to the service user's home. Some services are currently being commissioned in Sunderland (glaucoma / intra-ocular pressure referral refinement, cataract choice and children's eye screening) but there is not uniform provision across all of the five Sunderland localities. There are other enhanced services (minor eye conditions service, learning disability community eye care pathway and adult low vision pathway) that are available in other areas in the North East but are not currently commissioned in Sunderland. A Healthy Living scheme has worked well in Dudley, in the West Midlands, that involves both pharmacies and optical practices.
- Some people living with a visual impairment in Sunderland experience an unmet need for emotional support in the community in the years following diagnosis with a long-term eye condition. There are talking therapy services available by referral from a GP and there are counselling and peer support services available through local voluntary sector organisations, but awareness of these services may be low. Further work is needed to understand why people are not accessing existing services.

What is needed going forward is a process by which an action plan can be developed to address the recommendations within this needs assessment, the identified actions can be taken forward and new challenges can be addressed as they emerge. With continuing collaboration between different parts of the health care system there is the potential to make the eye health care system in Sunderland work even more

effectively, further improve standards of care and reduce the number of people experiencing sight loss in the future.

Annex A

Eye Health Needs Assessment Engagement Event

Café Refresh, Sunderland Civic Centre, Wed 4th March 2015, 6.00pm-8.00pm

Key points raised during discussions

The event was attended by 26 people. 13 were service users, advocates or members of organisations representing visually impaired service users, 5 were service providers, 3 were commissioners and 5 were from public health.

Organisations represented:

Healthwatch Sunderland
NHS England Primary Care Commissioning Team
Cumbria and North East Local Eye Health Network
Northumberland, Tyne and Wear Local Optical Committee
Royal National Institute for the Blind, who attended with two visually impaired service users living in Sunderland
Sunderland and County Durham Royal Society for the Blind
Sunderland and South Tyneside Diabetic Eye Screening Service (part of South Tyneside NHS Foundation Trust)
Sunderland Care and Support
Sunderland Carers' Centre
Sunderland City Council, adults' sensory team
Sunderland City Council, children's sensory team
Sunderland City Council, public health team
Sunderland Community Treatment Team – Learning Disabilities (part of Northumberland, Tyne and Wear NHS Foundation Trust)
Sunderland Disability and Independence Advisory Group
Sunderland Eye Infirmary – part of City Hospitals Sunderland NHS Foundation Trust
Voluntary and Community Action Sunderland (VCAS)

1. **Prevention – improving eye health, reducing avoidable sight loss, public and professional education**

Very little prevention work promoting eye health takes place in schools. There is no identified workforce capacity for people to deliver this training, other than teachers who will not have any specialist knowledge in the area.

It would be helpful if information about common childhood eye conditions such as squints could be provided to schools in a plain English format suitable for school newsletters etc..

There is a need to raise awareness of eye health issues among the general public, and ways to reduce the risk of eye damage e.g. wearing sunglasses in bright sunlight and wearing protective goggles for some sports. Only a tiny proportion of eye care spend is devoted to prevention. Spend on prevention should be higher.

Links between smoking, obesity and visual impairment are not well understood. There is a need to raise awareness of the links e.g. as part of NHS Stop Smoking Service support. An example is that 10% of smokers will have eye health problems.

There should be more information about eye strain arising from continual use of a computer screen without a break.

Many people are unaware of the importance of a regular eye test. Messages aimed at both children and adults should remind people of the importance of a regular vision test and the availability of free tests for young people under 16 years, people 16, 17 or 18 in full-time education, older people 60 years or over, anyone registered as partially sighted or blind, and people in receipt of certain benefits. NHS optical vouchers, which contribute towards the cost of spectacles or contact lenses, are also available for people aged under 16 years and people on certain benefits. Children should have a vision test every two years.

The NHS Health Check should include a question asking service users how long it is since they have had an eye test. Also, GPs should opportunistically ask this question more often. There is value in a brief intervention e.g. by GPs, to educate service users and remind them of the importance of eye tests.

Work needs to be done training health visitors in visual awareness and common childhood eye conditions so that they can pass on the knowledge to new parents.

Information on eye health and prevention must be provided in different languages (particularly Bangladeshi in Sunderland), in accessible formats e.g. for people who have a learning disability and using British Sign Language.

People will have a GP and dentist, but why not have an optometrist that they see as “their own”. Repetition and consistency of prevention messages is important. It is particularly important to get parents or carers to ensure the oldest sibling has regular eye tests as this embeds good practice when younger siblings arrive.

2. Vision screening – including diabetic and children’s eye screening

Schoolchildren, and parents or carers via newsletters, letters etc. should be reminded that children should have a regular eye test every two years throughout childhood. Targeted work promoting these messages should be undertaken, especially into communities with a high proportion of people from BME groups such as Hendon and Millfield.

All schools attached to Sunderland City Council will have reception screening by an orthoptist (a health professional that identifies and treats muscular eye conditions such as squints). This is a conscious decision, related to quality. There is information in schools about squints. But the onward referral pathway [from school eye screening] is weak.

School age children should have eyes tested every two years or as advised. There is no automatic routine eye test after age of five years. Routine eye tests should be reinstated in school beyond five years of age delivered from a mobile sight testing unit.

There is work to be done to raise awareness among GPs of the need to remind adults also to have an eye test every two years or as advised at a community optometrist. Also GPs should be using some basic tools such as the Snellen Chart or the Amsler Grid eye test opportunistically which can quickly and inexpensively allay fears in some cases.

Promotion of messages about the importance of regular eye tests among adults should be undertaken through carers' centre, Age UK and other organisations representing vulnerable groups. Mechanisms need to be in place to ensure that people with dementia continue to have their sight checked regularly e.g. reminder at annual review with GP.

Optometrists should verbally encourage patients to book a GP appointment when screening highlights a potential or early stage eye condition. The local eye care pathway in Sunderland now refers incidental findings to a GP.

People often choose/change their optometrist based on current price offers, which means that it becomes difficult for the optometrist to offer satisfactory continuity of care.

South Tyneside CCG has recently commissioned/funded a one-stop-shop for all nine key annual healthcare diabetes interventions.

No domiciliary (home visit) eye screening service is currently available in Sunderland.

A service user with a learning disability visited an optometrist in Washington. The service user is unable to complete the letter recognition eye test (using a Snellen chart), but the optometrist wasn't able to offer an alternative picture recognition test, which is a contractual obligation. In addition, the attitude to the service user was insensitive. In the service user's words "they were horrible to me". This suggests that there are variable standards of care across primary vision care for people with a learning disability.

There is a lack of awareness among GP Practice staff of availability of adapted services such as community eye screening or diabetic eye screening.

There is no widely recognised place where people can find a list of all community optometrists including address and opening times.

The diabetic eye screening service was praised for providing a good service.

All diabetic eye screening programmes are now working together as of January 2015.

3. Referral pathways and feedback, including emergency eye care

A service user recounted an experience of referral from a community optometrist in October for a cataract assessment, where treatment did not commence until April.

A service user who had been certified blind was assessed for his/her social care needs by a third party organisation i.e. not by the Council and was surprised at this.

Sunderland Eye Infirmary offers adapted care for people with a learning disability. Also, Sunderland is well served, because it has a 24-hour eye hospital.

Better vision awareness and knowledge among GPs could avoid some A&E attendances.

Direct referral from a community optometrist into secondary care (a hospital eye clinic) could speed up referrals. Currently these direct referrals can only be made by optometrists who have done additional training and are signed up to a locally commissioned service. Very few community optometrists are qualified and registered to directly refer. *[it should be noted that all optometrists can make urgent referrals into secondary care where there is a clinical need].*

Service users are unclear about referral pathways for referral to Sunderland Eye Infirmary i.e. is this via community optometrists or GPs? There were examples from service users of cases where it appeared that health professionals were unaware of these pathways. And are service users offered a choice of hospital via Choose and Book?

Feedback following a hospital appointment goes to the service user's GP Practice and not to the optometrist who initially referred via a GP. This limits the quality of continuing care that the optometrist can offer.

There is no protocol or guideline relating to direct digital referral.

There is a need to reduce delays in a Certificate of Visual Impairment being sent from Sunderland Eye Infirmary to social care teams within the Sunderland City Council.

Following diagnosis with a long-term eye condition by a consultant, which can be devastating news, the emotional needs of service users are not being met. These needs are both short and medium to long term i.e. immediately after a diagnosis but also intermittently in the years following diagnosis, particularly where sight is gradually deteriorating.

In relation to emergency referrals, people from outside Sunderland are presenting in increasing numbers because of the 24/7 service that Sunderland Eye Infirmary offers. Numbers of appointments are increasing by around 1,000 each year. 'Myths' don't help e.g. "it can't wait" or "I can't get an appointment".

4. Low vision services – rehabilitation and reablement

Sunderland Eye Infirmary has an Eye Clinic Liaison Officer (ECLO) and an in-house optometrist, to discuss all the visual aids that are available. The ECLO is able to provide emotional and practical support, post-diagnosis, where sight has been impaired. The officer can link service users with appropriate services and organisations to support them in the community as they adapt to life with a visual impairment. This is an essential service for visually impaired people and currently is only funded on a one-year rolling basis. There is no certainty that funding will continue beyond the current year.

Reablement services are provided in Sunderland through separate children's and adults' sensory services, delivered by Sunderland City Council. Children or adults are referred to these services by an ophthalmologist or via an ECLO following diagnosis by an ophthalmologist. Waiting times after referral to the sensory teams can be up to six months.

Rehabilitation and reablement services in Sunderland are poor for children.

In other local populations reablement services are delivered through the Gateshead and South Tyneside Sight Service. This is a third sector organisation that runs offices/workshops in Gateshead and South Tyneside where people who are sight impaired can gain hands on experience of using vision aids or adaptations such as screen reading software for computers. Gateshead offers a more comprehensive service than South Tyneside including a sessional optometrist with experience of adapting care for vulnerable groups.

Emotional health and wellbeing is a key issue for people experiencing sight loss, but is generally ignored.

If someone loses sight through trauma resulting in a long hospital stay, they should be provided with reablement support while still in hospital.

Reablement must take account of emotional health and wellbeing and so there should be opportunity for referral into counselling where appropriate, at different stages in the care pathway. Adjusting to life with a visual impairment often involves a period of bereavement and people who are sight-impaired are at an increased risk of common mental health conditions such as anxiety or depression.

Visual impairment affects family and carers as well as the individual that is experiencing visual impairment. Services should meet needs of family and carers too and link people into third sector organisations that can provide ongoing support.

There should be access to low vision equipment as part of a community service. This could be through a prescription for low vision equipment or referral to an equipment service. People who have a visual impairment shouldn't have to purchase magnifiers from optometrists at full cost.

A local third sector organisation has a stock of indent magnifiers.

No rehabilitation or enablement is available through social care in Sunderland. It has to be bought in for children and the system does not work. An example was cited of a child in Sunderland that requires mobility training and help with daily living that has to be bought in by parents/carers. It is particularly important to provide appropriate mobility and independence training for children and young people with a visual impairment as this promotes independence in later adulthood.

There are long waiting times for rehabilitation and mobility training for people who have recently been diagnosed with a visual impairment.

There is often a conflict of opinion between health professionals and service users around what is appropriate and necessary mobility training.

There is a very low uptake of low vision equipment among children and young people who are visually impaired. Parents/carers and teachers need to be trained to recognise when use of low vision equipment is appropriate, encourage this group of people to obtain the equipment and help them to use it appropriately.

5. Equity of provision and access, including eye health in seldom heard groups

Engagement with eye screening is strongly age-related. Uptake of screening among younger age groups is much lower, compared to older age groups.

Factors influencing engagement with services include flexibility of appointment times e.g. are out of hours appointments available, availability of interpreting service, availability of and awareness of how to book patient transport service. Even in prison settings there is often a 10% “did not attend” (DNA) rate.

Videos are available to encourage uptake among vulnerable groups e.g. “Your Voice Counts” video which highlights the issue of hate crime aimed at people with a learning disability (details available from Sunderland and South Tyneside Diabetic Eye Screening Service).

People experiencing sight impairment often only hear about available services by word of mouth. Better information provision is needed at all stages of the care pathway. Information needs to be provided in a range of formats e.g. large print, easy read, translated into other languages. Information packs should be available specifically for different age groups e.g. children and young people, working age adults and older people. Guides should be written in plain English, free of jargon, and should give people an idea of what to expect from different services and organisations.

There tends to be more optometrists in more affluent areas.

20-40 year olds with type I diabetes are the biggest group who turn up with advanced eye disease.

When people who have DNA'd are given a specific time, date and venue for their next appointment, only nine out of ten turn up.

'Did not attend' (DNA) letters remind service users that they were being checked for glaucoma which is a sight-threatening disease.

For patients with a moderate to severe learning disability, there has been a specific pilot project commissioned locally by Durham, Darlington, Easington and Sedgefield Clinical Commissioning Group (CCG) and North Durham CCG offering adapted provision.

Access to a pictorial alternative to the standard (Snellen) eye chart is a contractual requirement for all community optometrists. *[subsequent discussions with optometrists practicing locally with a specialist knowledge in this area have revealed that there is no contractual obligation to provide an alternative to the Snellen eye chart within the General Ophthalmic Services (GOS) contract, but that alternative provision could be considered a reasonable adjustment under the provisions of the Equality Act 2010]*⁹⁰

6. Any other issues

Often people have difficulty coming to terms with a visual impairment and so not everyone registers with the Local Authority after receiving a Certificate of Visual Impairment (CVI).

People have experienced Sunderland Eye Infirmary sending out information which is an inappropriate format.

There should be volunteers to meet and greet service users at all hospitals.

GP surgeries are not accessible. All health and social care staff should have visual impairment awareness training.

Certificates of Visual Impairment should be updated and checked annually.

Colour contrast incorporated into the design of street furniture, buildings and signage makes it easier for people who are visually impaired to navigate and move about safely. Signage should also be at a height such that both people walking and people in wheelchairs are able to clearly see it. Stone seats in Sunderland city centre are a particular problem as they blend into the pavement.

An increasing amount of street furniture makes it more difficult to navigate town centre shopping areas for people with a visual impairment. Do residents have any way of complaining if this is causing a barrier to access? *Sunderland City Council is responsible for the provision and maintenance of a range of items of [street](#)*

⁹⁰ HM Government (2010) "Equality Act 2010" Chapter 2, Section 20 available at <http://www.legislation.gov.uk/ukpga/2010/15/section/20> (last accessed 29th April 2016)

[furniture](#)⁹¹. If you are reading this on a computer connected to the internet, follow the link for further details. Some items of street furniture can cause an obstruction or a hazard, whether they are permanent or temporary. Such items need a [licence](#)⁹² from the council. Similarly, the Council is responsible for [clearing obstructions on pavements](#)⁹³.

Wheelie bins left in the middle of pavements are a common obstruction.

Cars parked on pavements make walking difficult for the sight impaired. If there is regular parking on pavements do local residents have any redress and who should they raise the issue with? *Cars repeatedly parked on pavements which obstruct access for pedestrians may be classified by a local authority as a “nuisance vehicle”*. [This page](#)⁹⁴ on the Sunderland City Council website tells you how to report a nuisance vehicle.

Whether in community care (optometrists) or secondary care (ophthalmologists) views were expressed that many staff do not have any awareness of the needs of people with a learning disability and don't adapt care accordingly. Practical adaptations, depending on the needs of the individual, might include double time appointments, accessible or easy read patient information, adapted vision tests (pictures rather than letters) and adapted screening equipment. Views were expressed that all staff in health care services, from receptionists to clinicians, should be required to undertake learning disability awareness training and follow a refresher course at regular intervals. People with a learning disability could be involved in the delivery of this training. However, this does require adequate resourcing.

Are services accessible for older people and vulnerable groups such as people with a learning disability? Who is eligible for patient transport service? Are service users made aware that this service is available and what the eligibility criteria are? Currently there is no service whereby a service user can get support when attending a health appointment (eye care or other). Health facilitators, employed by Sunderland City Council, did offer this service but it was recently decommissioned. This was a valued service.

There was a low awareness among people attending of the availability of physical activity opportunities appropriate for people with a visual impairment. These could be provided by sports clubs or within Council leisure centres. Washington Community Resource Centre, a day care centre for vulnerable and learning disabled adults, offers 'sit and be fit' classes. A person with a visual impairment attending had wanted to try archery but was unable to find a provider or club who offered adapted provision.

⁹¹ <http://www.sunderland.gov.uk/index.aspx?articleid=1301>

⁹² <http://www.sunderland.gov.uk/index.aspx?articleid=758>

⁹³ <http://www.sunderland.gov.uk/index.aspx?articleid=1292>

⁹⁴ <http://www.sunderland.gov.uk/index.aspx?articleid=1320>

People with a visual impairment reported having difficulty accessing municipal leisure services in Sunderland.

Public transport is inaccessible for people who are visually impaired. Bus companies should train all staff in visual awareness regularly. Currently they only require staff to undertake disability awareness training every five years.

All services delivered by Sunderland City Council need to deliver information in accessible formats, not just the sensory teams.

When service improvements are made these need to be sustained. Often they are introduced with short-term funding and are then withdrawn.

The numbers of people registered as blind or visually impaired understate the true number of people with these sensory impairments. This is because they don't take into account people who have moved into the area with a visual impairment or who went through the Eye Infirmary.

Public Health, Sunderland City Council, July 2015

Annex B

Public Health England's Strategic Health Asset Planning and Evaluation (SHAPE) tool was used to understand patterns of hospital eye care activity within this needs assessment. It is a valuable resource, providing detailed information about geographical variations in rates of access of hospital services. If the following recommendation is adopted the value of the tool could be substantially enhanced.

Recommendation: *the SHAPE tool is a valuable resource with which to analyse patterns of hospital activity. It should be recommended to Public Health England that the tool is extended to include outpatient attendance data, and that more recent inpatient activity data is loaded into the tool. The value of the tool would be further enhanced if there was the capacity to examine historical trends over time in levels and rates of inpatient and outpatient activity.*