Note: This consultation document was compiled in 2019 when the charity was called Royal Blind.

**HEALTH AND SPORT COMMITTEE**

**WHAT SHOULD PRIMARY CARE LOOK LIKE FOR THE NEXT GENERATION?**

**SUBMISSION FROM ROYAL BLIND AND SCOTTISH WAR BLINDED**

Royal Blind is Scotland's largest vision impairment organisation. Our vision is to see a community in which blind and partially sighted people, including those who have other disabilities, are fully included and lead fulfilling lives. We care for, educate and employ blind and partially sighted people from across Scotland and the UK. Our sister charity, Scottish War Blinded provides a free service supporting individuals who have served in the armed forces and currently live with a vision impairment.

We endorse the Scottish Government’s ambition for a greater role for primary care and more health and care services to be delivered in the community. This can be achieved through co-production and collaboration at all levels of government and statutory services. We believe more services and support should be delivered in collaboration with third sector organisations, drawing on the expertise and added value the sector can bring.

**1. Considering the Health and Sport Committee's report on the public panels, what changes are needed to ensure that the primary care is delivered in a way that focuses on the health and public health priorities of local communities?**

We support the commitment to increase the diversion of resources to primary and community care. We believe this will be necessary if the ambitions expressed by the panel are to be realised, to co-locate a range of services and support within primary care and help more people to manage their health conditions so they can remain independent for longer.

An increasing number of people living with sight loss loss requires a focus on community provision so they can access diagnosis and treatment quickly and receive support to live well with vision impairment. There are already an estimated 171,000 people in Scotland living with vision impairment and this number is predicted to increase to over 200,000 by 2030. Public health campaigns could contribute to a reduction in prevalence, as smoking and diet are risk factors for some sight loss conditions. Nevertheless, even with successful action on public health the level of need is likely to increase as the major risk factor for sight loss is age. More than 10 per cent of over 65 year olds have some form of sight loss.

The introduction of free eye tests in 2006 and their continued provision has increased the number of Scots who are referred for sight saving treatments, reducing their dependency on health services. Nevertheless, there are significant existing pressures on health services for people with vision impairment. FOIs submitted by Royal Blind have indicated that six health board areas breached the twelve week (84 days) waiting times guarantee for inpatient and day cases for the quarter ending 31st March. Earlier this year, the Royal College of Ophthalmologists produced its workforce census which showed there had been a decrease in the number of Consultant Ophthalmologists in Scotland at a time of rising demands. A new model of delivery is required so people with sight loss conditions can access the support they need, when they need it.

**A national community led low vision service**

Royal Blind supports the development of national, community led low vision service. This is consistent with approaches already supported by the Scottish Government. The Scottish guidance on glaucoma referral and safe discharge recommended discharging stable glaucoma patients to be managed in the community, allowing those more serious cases to remain within the hospital eye service. Building on the findings of the Low Vision Service Review, the Scottish Government’s Community Eyecare Review highlight that in line with policy, many GPs no longer see patients with eye problems but direct them to optometry, helping to reduce the burden on general practice. Health boards are promoting a message that community optometrists should be the first “port of call” for eye problems. The Community Eyecare Review stated that “awareness of this change is beginning to be understood by the public but there are still issues about getting the message to the wider population.” This makes the case for further action to promote stronger links between other primary care services with community optometry, and potentially co-location of optometry services with general practice and multi-disciplinary primary care teams.

Royal Blind welcomes the recommendation of the Community Eyecare Review that:

“…as part of their planning and commissioning, Integration Authorities should consider the full range of eyecare needs of their communities. They should encourage close collaborative working not only across the statutory services to ensure the most effective use of professional skills and resources, but also with the voluntary sector.”

There is a broad range of support for people with sight loss provided by the voluntary sector, linked to statutory health services. Most health boards have an Eye Clinic Liaison Officer, employed through a national or local sight loss charity. Some areas have Vision Support Officers who specialise in complex needs and help people to access primary optometric health and social care services as well as offering emotional and practical support. The charity Seescape in Fife provides a community optician service. Community optometrists are increasingly working in partnership with their colleagues in ophthalmology. We believe these current examples of good practice should inform the development of a community-based, national low vision service, and are pleased that the Scottish Government is engaging positively in the development of such an approach.

We believe there are other opportunities for reform and new developments in primary care to improve support for people with sight loss. Our experience of providing rehabilitation services and independent living skills for people with sight loss of all ages, to help them manage their condition, means we are aware of the transformational impact this support can have. However, there is currently a lack of vision impairment rehabilitation officers based in local authorities, and too often people are waiting too long to access this support, or are not being referred for rehabilitation. There is a strong argument for greater availability of this support, and for rehabilitation staff to be part of primary care multi-disciplinary teams.

We also believe there are significant opportunities to develop new treatments for eye conditions and speedier, more accurate diagnosis through collaboration between community opticians and optometrists, health services and academia. Scotland has a wealth of data on eye conditions and their pathology as a result of the provision of free eye tests, and the introduction of more sophisticated technology to scan eyes in opticians means an even greater information resource. Eye health can also be a marker for other conditions, for example dementia. Harnessing the potential of big data research projects, with appropriate safeguards for patient confidentiality, offers the scope for Scotland to become a world leader in this developing area of science, benefit hundreds of thousands of people with sight loss and reduce pressures on health budgets.

**2. What are the barriers to delivering a sustainable primary care system in both urban and rural areas?**

An independent review of low vision service provision across Scotland carried out by NHS Education for Scotland, published in 2017, identified a cluster of services around the more densely populated central belt of Scotland and considerably more scarcity around rural areas. The results identified an inequality of access to services in terms of both waiting times and provision of aids. We believe a national, community led low vision service could help address these inequalities in access to primary care services.

The links between loneliness and poor health are now well understood, and failure to address this issue can result in pressures on health services. We support the public panels’ call for action to identify and tackle loneliness and social isolation through primary care services. A survey conducted last year by Royal Blind and Scottish War Blinded of 281 people with vision impairment found that ninety percent had some experience of loneliness Poor access to transport was highlighted by many respondents as contributing to social isolation. Public transport links are crucial for people with sight loss so they can have equal access to primary care services. However, in many communities, both urban and rural, there have been cuts in public transport provision. Health services themselves were identified by a number of respondents as having an important role in reducing loneliness and isolation. Responses included calls for GPs to be more aware of specific sight loss conditions so patients can be referred, diagnosed and treated speedily. We believe greater access for all health and social care staff to vision impairment awareness training would improve the experience many people sight loss when they access health services.

The vision of the Christie Commission of a fundamental shift in investment from acute care to prevention has still to be realised, and this is a barrier to providing the specialist support many people with sight loss require in the community, whether that be rehabilitation, home care or residential care.

**3. How can the effectiveness of multi-disciplinary teams and GP cluster working be monitored and evaluated in terms of outcomes, prevention and health inequalities?**

We believe there is significant potential for the development of long-term performance indicators for primary care services. Current estimates of future prevalence for conditions which are closely linked to health inequalities could be compared in later years with actual prevalence to assess what impact public health campaigns and reforms in primary care may have had. Public Health England has recently reviewed its preventable sight loss indicators. We welcome the plans for the establishment of Public Health Scotland and believe similar indicators should be used by the new organisation to measure progress. Effective evaluation of outcomes requires a range of data on health conditions to be made available. There is currently a lack of data on eye health conditions which is published by the Scottish Government, and we hope this will be addressed by Public Health Scotland as it takes on responsibility for the work of ISD Scotland.

We support reforms of primary care services being taken forward through an approach of co-production with patients, involving them in developing plans for new services in their community. We believe this will help services to be designed in a way which is responsive to the needs of patients, and that this will improve outcomes. We also believe patient engagement must be an ongoing priority for primary care services, so that they can continue to meet the needs of the community. Patient opinion and experiences must be an important element of any evaluation of local primary care services.

We believe social prescribing should be promoted within primary care as a preventative measure to support people vulnerable to social isolation and poor mental health. We believe there is strong existing evidence to show the health benefits of such an approach but its integration within primary care services will allow for more research into its impact. We also support the comments made by the Scottish Youth Parliament in relation to young people being able accessing specialist mental health through their GP. We believe such an approach would also benefit people with sight loss at whatever point of their life they develop an eye condition. Our research not only indicates that that sight loss is risk factor for loneliness, but also that the experience of losing sight has significant and wide-ranging impacts on the mental health of people with vision impairment. Many report that they are not asked about their mental wellbeing or offered support with their mental health through the process of being diagnosed with a sight loss condition. We believe earlier intervention for many people with sight loss to provide support for their mental health would result in fewer incidents of crisis and in better outcomes.

We look forward to the Committee’s further consideration of the primary care services Scotland should aspire to in the future. We urge members to consider in particular:

* The benefits of national, community led low vision service to meet the needs of a growing number of people living with sight loss
* The development of multi-disciplinary primary care teams, giving patients a single point of access to a range of supports to help them manage their condition, including support for rehabilitation and mental health
* The potential to gather data on eye health in primary care to facilitate research which results in speedier, more accurate diagnosis for patients as well as new treatments for eye conditions.

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