

JSNA 2015 Sensory Impairment (final)

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Introduction

The term 'sensory impairment' or 'sensory loss' are umbrella terms used to describe loss of the distance senses i.e. sight and hearing. The term 'sensory Impairment' encompasses

- visual impairment - including blind and partially sighted
- hearing loss including those who are profoundly deaf (born deaf), deafened (became deaf but born hearing) and have a hearing loss
- Deaf – born deaf and using BSL
- dual sensory impairment (deaf and blindness).

Sensory impairments may, like physical impairments, be congenital or acquired at any age. They are often more prevalent in older age. Most sensory impairments develop gradually. This chapter will focus on sensory impairments in adults aged 18 and over.

Almost two million people in the UK are living with sight loss, approximately one person in thirty. Sight loss affects people of all ages, but its occurrence increases markedly with age. 1 in 5 people aged 75 and over are living with sight loss. 1 in 2 people aged 90 and over are living with sight loss. Nearly two-thirds of people living with sight loss are women. People from black and minority ethnic communities are at greater risk of some of the leading causes of sight loss. As many as three quarters of people with learning disabilities are estimated to have either refractive error or to be blind or partially sighted.

The number of people in the UK with sight loss is set to increase in the future. In addition, there is a growing incidence in key underlying causes of sight loss, such as obesity and diabetes. It is predicted that by 2020 the number of people with sight loss will rise to over 2,250,000. By 2050, the numbers of people with sight loss in the UK will double to nearly four million¹.

RNIB (2010) suggest that the annual cost of sight loss in the UK amounted to a minimum of £6.5 billion in direct health care and indirect costs, such as reduced employment.

There are estimated to be about 9 million people with hearing loss in England, and 11 million in the UK. The prevalence of hearing loss increases exponentially with age. Around one in five adults has a hearing loss. The most common cause of hearing loss is age, and the average NHS hearing aid user is aged 74². Many people with hearing loss therefore have more than one long-term condition.

¹ RNIB. Key Information and Statistics. <http://www.rnib.org.uk/knowledge-and-research-hub/key-information-and-statistics> (accessed October 2015)

² Davis A, Smith P, Ferguson M, Stephens D, Gianopoulos I. Acceptability, benefit and costs of early screening for hearing disability: a study of potential screening tests and models. *Health Technol Assess* 2007;11(42)

In England's Action Plan on Hearing Loss, The Department of Health notes that hearing loss results in high personal, societal and economic costs. Hearing care costs the NHS in England £450 million per year. These costs are set to increase given the rising number and proportion of older people who will have a hearing loss in the future. Unemployment rates for people with hearing loss are much higher compared to the national average. Those with severe hearing loss who do not use hearing aids have unemployment rates nearly double of those who do. It is estimated that by 2020, older people will account for approximately a third of the working age population and around three-quarters will have some kind of disability before the age of 68³.

About 900,000 people have severe or profound deafness. Severely or profoundly deaf people cannot hear well enough to use a voice telephone, even with equipment to make it louder. This means they need to rely on telecommunication assistance such as Next Generation Text Relay⁴. A high proportion of severely or profoundly deaf people have other disabilities as well.

Among those under 60, 45% have additional disabilities. These are more likely to be physical disabilities. Among severely or profoundly deaf people over 60 years old, 77% have some additional disability. For 45%, this means significant dexterity or sight difficulties, or both.⁵

Deaf-blindness is sometimes known as dual sensory impairment or multi-sensory impairment and is more than a combination of visual and hearing impairments. It is important to stress that many deaf-blind people may not be totally deaf and totally blind. Many of the UK's 23,000 deaf-blind people have some remaining hearing and vision. Some though, have nearly complete loss of both senses. The largest group of deaf-blind people have developed hearing and vision problems as they get older.⁶

Causes of sensory impairment

The largest cause of sensory impairment is the ageing process with over 65s more likely to have some level of sensory loss.

Visual impairment

The term 'visual impairment' is used to refer to anyone who is blind or partially sighted. The four major UK blinding conditions are: cataract, Age-related Macular Degeneration (AMD), glaucoma and diabetes.

³ Department of Health. Action Plan on Hearing Loss. <https://www.england.nhs.uk/wp-content/uploads/2015/03/act-plan-hearing-loss-upd.pdf> (accessed February 2016)

⁴ Action on hearing loss. Health Matters.

http://www.actiononhearingloss.org.uk/~media/Documents/Policy%20research%20and%20influencing/Research/Hearing_Matters_2015/Hearing%20Matters%20Report.ashx (accessed February 2016)

⁵ Statistics on Deafness, Deafsign, <http://deafsign.com/ds/>

⁶SENSE <https://www.sense.org.uk/content/about-deafblindness>

In the UK, up to 26% of sight loss in people over 75 is caused by cataracts. Risk factors, in addition to age, include being of African or Caribbean origin, diet low in antioxidants and smoking.

Smoking increases the risk threshold of developing the most common form of cataracts⁷. Smokers are also up to four times more likely than non-smokers to develop AMD and smokers with a genetic predisposition to AMD are eight times more likely to get the condition. Smokers do not respond as well to AMD treatment as non-smokers. Passive smoking also increases the risk of AMD⁸.

AMD is a degenerative retinal eye disease which causes progressive loss of central vision. There are 2 types. Dry AMD is most common, develops slowly and is not treatable. Wet AMD causes more rapid sight loss, but can be remediated if detected early. Key risk factors include: smoking; vitamin and nutrient deficiency; high blood pressure and cholesterol levels, and high fat intake.

Glaucoma causes a gradual degeneration of the cells in the optic nerve. Sight is lost slowly, usually from the periphery at the onset. The main form of intervention is to control eye pressure and in doing so prevent or limit damage to the optic nerve and thus preserve vision. Risk factors include age; African or Caribbean descent; diabetes; Asian descent (acute glaucoma), and a documented family history.

Diabetic retinopathy affects the blood vessels in the retina causing blockages, failures and leaks which impair vision over time. Early diagnosis and treatment have high success rates. It is the leading cause of sight loss for people of working age in the UK.

A literature review indicated that people with a learning disability were between 8.5 and 200 times (depending on the source material) more likely to have sight impairment than the general population⁹. Routine sight tests should be promoted in this group. Additional sight tests are recommended for people with Down's Syndrome¹⁰.

It is estimated that 2% of people over 75 have both dementia and visual impairment. They have an increased risk of falls, with a wider impact on their ability to live independently and on their quality of life.¹¹ Up to two thirds of people experience some changes to their vision after a stroke¹².

Adults of working age with sight impairment are more likely to have mental health problems, and report a reduced quality of life and of social functioning generally. Older people with sight loss are more likely to experience depression.

⁷ RNIB (2008) UK Vision Strategy. London: RNIB

⁸ Macula society. <http://www.macularsociety.org/> (accessed November 2015)

⁹ Warburg M. Visual impairment in adult people with intellectual disability: literature review. J Intellect Disabil Res 2001;45:424-38

¹⁰ The International Association for the Scientific Study of Intellectual Disability (2002) Health Guidelines for Adults with an Intellectual Disability (WWW) <http://www.iassid.org/pdf/healthguidelines-2002.pdf> (accessed October 2015)

¹¹ Thomas Pocklington Trust (2005) Dementia and blindness

¹² RNIB. Stroke and sight loss. <http://www.rnib.org.uk/eye-health-sight-loss-and-other-conditions/stroke-and-sight-loss> (accessed November 2015)

Early intervention has been identified as a key element in preventing vision loss at a local and international level. For those people with vision loss, research has highlighted the need for accessible information, rehabilitation services and equipment, which can maximise independence. These services are critical in ensuring that people with vision loss are able to interact with the built environment, maintain physical and physiological health, and participate socially and economically in their community.

Other causes of visual impairment are diabetes, infection, genetics, injury.

Hearing impairment

There are three main types of hearing loss, sensorineural, conductive and mixed. Most people will have sensorineural hearing loss (90%), with 8% of people having a conductive hearing loss and a minority having mixed hearing loss¹³.

Adult hearing loss is a major public health challenge and the 6th leading cause of years lived with disability in England¹⁴.

Age-related hearing loss (ARHL)¹⁵ is a type of sensorineural hearing loss and by far the most common cause of hearing loss in England. It is associated with a gradual, progressive and bilateral hearing loss, which at first affects higher frequencies – making it difficult to understand speech. ARHL is one of four leading long-term conditions experienced by older people¹⁶.

Other causes of hearing loss are infection, physical trauma, genetics, exposure to loud noise. Maternal infection and other congenital causes are causes of deaf blindness.

Communication is an essential element of good quality of life at all ages, and it becomes fundamental to maintaining independence and inclusion as people age¹⁷. Unsupported hearing significantly increases the risk of depression¹⁸, social isolation¹⁹, loneliness²⁰, functional decline²¹, early exit from the workforce²² and reduced quality of life²³.

13 Screening for Hearing Loss in Adults Ages 50 Years and Older: A Review of the Evidence for the U.S. Preventive Services Task Force

14 Vos, T et al (2015), Global, regional, and national incidence, prevalence, and years lived with disability for 301 acute and chronic diseases and injuries in 188 countries 1990-2013: a systematic analysis for the Global Burden of Disease Study 2013. The Lancet

15 presbycusis

16 Liu, XZ and Yan, D. 2007. Ageing and hearing loss. Journal of Pathology. 211:188-197

17 Vos, T et al (2015), Global, regional, and national incidence, prevalence, and years lived with disability for 301 acute and chronic diseases and injuries in 188 countries 1990-2013: a systematic analysis for the Global Burden of Disease Study 2013. The Lancet

18 World Health Organization, 2002, Active Ageing: A Policy Framework. Geneva, Switzerland: World Health Organization; Lin FR. 2014, Hearing Loss and Healthy Aging: Workshop Summary. Washington, D.C.: National Academies Press

19 Acar, B. et al. 2011. Effects of hearing aids on cognitive functions and depressive signs in elderly people. Archives of Gerontology and Geriatrics, 52(3), pp. 250-252.

20 Hidalgo, J. L. et al. 2009. Functional status of elderly people with hearing loss. Archives of Gerontology and Geriatrics, 49(1), pp. 88-92

21 Cacioppo JT, Hawkley LC, Norman GJ, Berntson GG. Social isolation. Ann N Y Acad Sci. 2011;1231:17-22

22 Lin, F. R. et al. 2011. Hearing Loss and Incident Dementia. Archives of Neurology, 68(2), pp. 214-22 & Lin, F. R. et al. 2011 Hearing loss and cognition in the Baltimore Longitudinal Study of Aging. Neuropsychology. 2011; 25(6):763-770.

23Liu, XZ and Yan, D. 2007. Ageing and hearing loss. Journal of Pathology. 211:188-197 Helvik, A. 2012. Hearing loss and risk of early retirement. The Hunt study. European Journal of Public Health, 23(4), pp. 617-622

National and Local strategies

The UK Vision strategy (2013-18) is a cross-sector initiative, uniting all those in the UK who want to take action on issues relating to vision. It seeks to achieve three outcomes:

1. Everyone in the UK looks after their eyes and their sight
2. Everyone with an eye condition receives timely treatment and, if permanent sight loss occurs, early and appropriate support
3. A society in which people with sight loss can fully participate.

Ealing has a Local Vision Strategy and Action Plan informed by the views and experiences of people with sight loss and the organisations that work with them. The priority areas in the vision strategy are:

- Health and wellbeing
- Involvement of people
- Prevention
- Joined up services and data
- Social Inclusion and Independence
- Visually Impaired people with complex needs

The Action Plan on Hearing Loss produced by NHS England and the Department of Health (2015 and beyond) sets out a case for action to tackle the rising prevalence and personal, social and economic costs of uncorrected hearing loss and the variation in access and quality of services experienced by people with hearing loss. Aligned with NHS England's Five Year Forward View, it proposes addressing this growing challenge by promoting prevention of hearing loss, improving both the commissioning and integration of services, providing innovative models of care and ensuring that people of all ages with hearing loss are actively supported and empowered to lead the lives they want for themselves and their families in the best possible health. This would also lead to reduced inequalities in access to services and the outcomes achieved.

Ethnicity and Sensory Impairment

The Access Economics research confirms that ethnicity is a major factor in relation to eye disease. The Black population has a higher risk than the White population of developing AMD at an earlier age, but a lower risk of developing it after the age of 70. The Black population also has a much higher relative risk of developing glaucoma and cataracts. Asian people are at a higher risk of developing cataracts than the Black and White populations and also at a higher risk of developing diabetic eye disease than the White population. The White population is more likely to experience sight loss due to refractive error, compared to the Black population²⁴.

Observational studies from different countries have shown that populations of East Asian origin have a higher frequency of primary angle-closure glaucoma compared with those of European or African descent²⁵.

²⁴ RNIB (2009) Cost Oversight. The cost of eye disease and sight loss in the UK today and in the future.

²⁵ Current Opinion on Ophthalmology, April 2006 Vol 17/2 Yip et al

It is likely that, due to lack of awareness of the registration process and the benefits of registration, people from BME communities are under-represented amongst those who register blind (Severely Sight Impaired) or partially sighted (Sight Impaired).

Poorer access to services is likely to contribute towards higher risk burdens resulting in health inequalities across minority ethnic and lower socio-economic groups. British Asians appear to show higher risk of cataract and develop it an average 10 years earlier than their White counterparts²⁶.

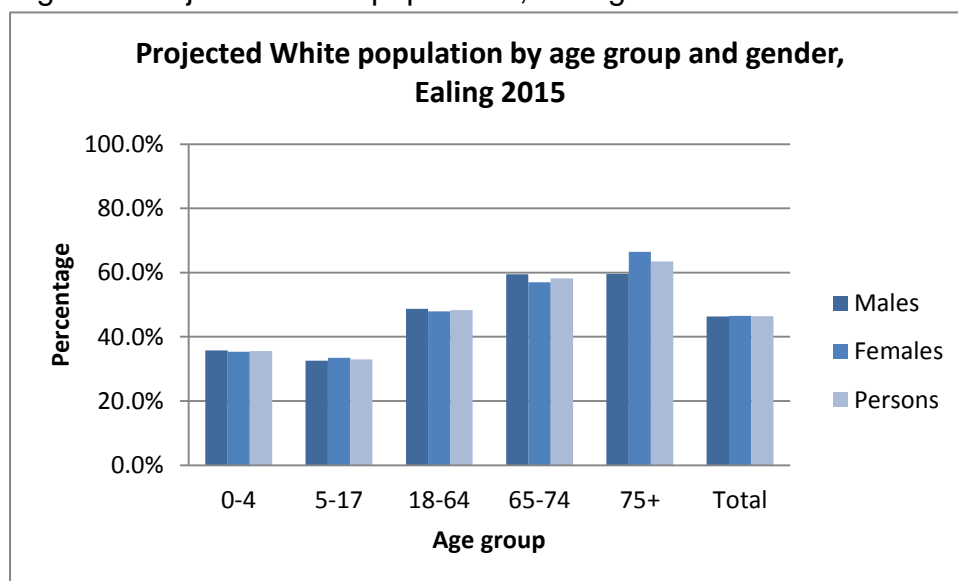
There are no accurate figures available for levels of hearing loss in Black and minority ethnic groups. However, there is evidence to suggest that some minority ethnic groups may experience higher levels of hearing loss. This is especially true of recent immigrants from regions with greater levels of poverty, poor healthcare and low levels of immunisation against diseases such as rubella²⁷.

Level of Need in Ealing

Demographics (age group, gender, ethnicity)

The GLA have projected Ealing's resident population at 349,322 persons in 2015, of which 187,220 (53.6%) are in a BME group and the rest (46.4%) are White. The charts bellows illustrate the percentage of BME and White population by broad age group and gender.

Figure1: Projected White population, Ealing 2015

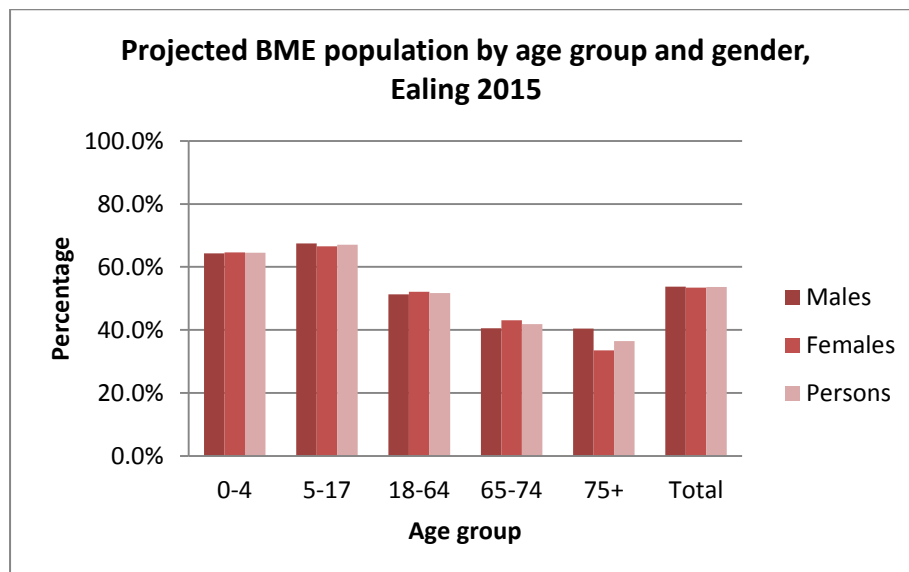


GLA 2013-based projection; Local authority population projections - SHLAA Capped Household Size-based ethnic group projections

²⁶RNIB (2005) Open Your Eyes, Campaign report 25

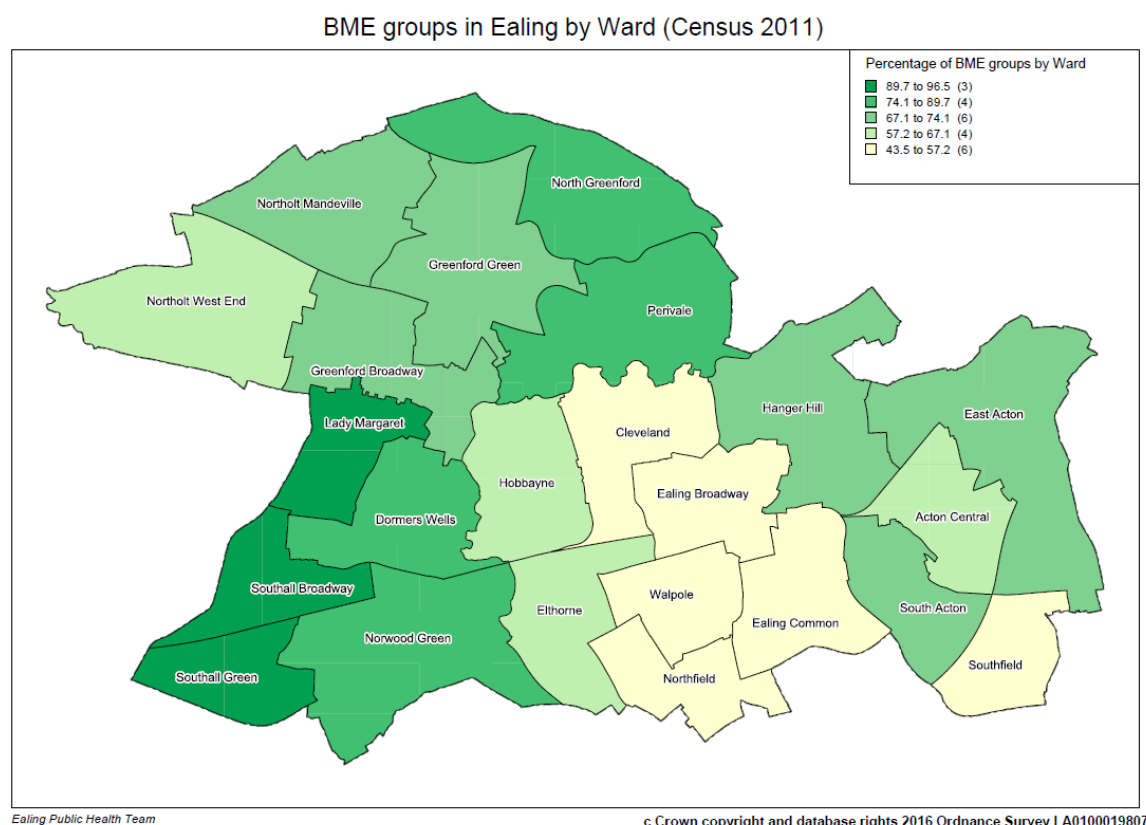
²⁷ Facts and Figures on Deafness and Hearing Loss (2011) Action on Hearing Loss

Figure2: Projected BME population, 2015



GLA 2013-based projection; Local authority population projections - SHLAA Capped Household Size-based ethnic group projections

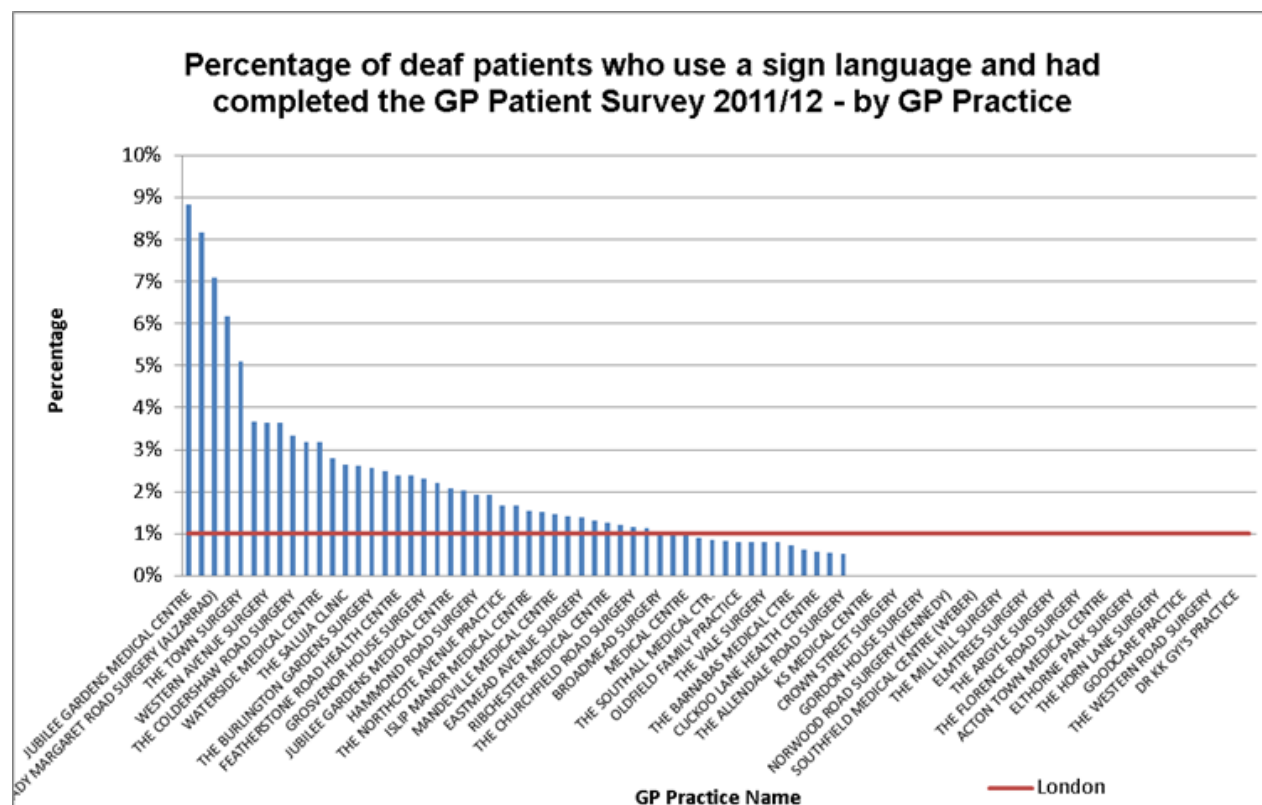
Map1: BME groups by wards in Ealing



Registered population over 50 (QoF)

The over 50s GP registered population is shown as a proportion of all registrations (all ages) in the chart below. Ealing's average proportion is 25.4% (102,246 out of 408,265). The GP Practice range is from 38% the highest to 11% the lowest. More than half of the practices (47 out of 77) rank above or are equal to the Ealing average.

Figure 3: Percentage of patients aged over 50 by GP Practice, 2013/14



Source: Department of Health, 2011-12 GP Patient Survey

Figure 3 shows the variation between practices in the number of people registered who are 50 and over amongst practices in Ealing. We know that sensory impairments increase with age and hence this could indicate varying caseloads between practices.

Visual Impairment

Table1: Projected Visual impairment in older population between 2014 and 2030

Visual impairment	2014	2015	2020	2025	2030
Ealing: People aged 65-74 predicted to have a moderate or severe visual impairment	1,182	1,210	1,383	1,501	1,691
London: People aged 65-74 predicted to have a moderate or severe visual impairment	29,176	29,786	32,710	35,498	41,552
England: People aged 65-74 predicted to have a moderate or severe visual impairment	288,607	295,322	312,883	316,764	357,515
Ealing: People aged 75 and over predicted to have a moderate or severe visual impairment	2,257	2,306	2,542	2,988	3,447
London: People aged 75 and over predicted to have a moderate or severe visual impairment	56,408	57,325	62,694	73,544	82,708

England: People aged 75 and over predicted to have a moderate or severe visual impairment	542,773	553,536	630,726	762,612	850,801
Ealing: People aged 75 and over predicted to have registrable eye conditions	1,165	1,190	1,312	1,542	1,779
London: People aged 75 and over predicted to have registrable eye conditions	29,114	29,587	32,358	37,958	42,688
England: People aged 75 and over predicted to have registrable eye conditions	280,141	285,696	325,536	393,606	439,123

Source: POPPI, 2015

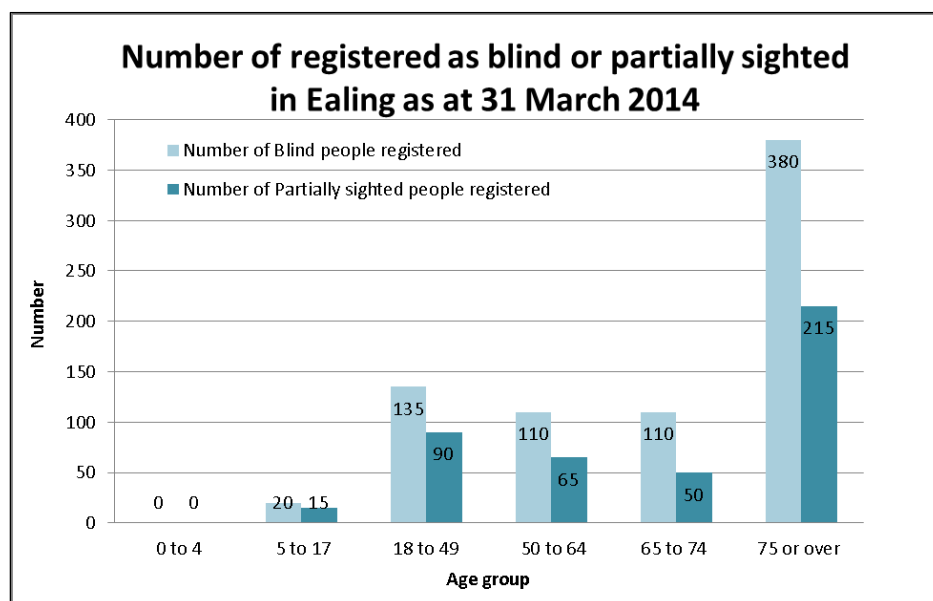
The above figures are taken from 'The number of people in the UK with a visual impairment: the use of research evidence and official statistics to estimate and describe the size of the visually impaired population', Nigel Charles, RNIB, July 2006. The overall prevalence of all causes of visual impairment in those aged 65-74 years and over with visual acuity (VA) of less than 6/18 (moderate or severe) is 5.6%, and 12.4% for those aged over 75. VA of less than 6/18 is largely used as the point which approximates to the statutory threshold for qualifying as registered severely sight impaired (blind) or registered sight impaired (partially sighted). Of those aged 75 and over, approximately half have cataracts or refractive error (i.e. correctable sight loss) and if these are excluded, the prevalence estimate of those with 'registrable' eye conditions is 6.4% in this age group. A small proportion has both cataracts and some other registrable cause of vision impairment and these are included within this figure. Age related macular degeneration is the most common cause of registerable sight loss in older people. The prevalence rates have been applied to ONS population projections of the 65 and over population to give estimated numbers of people predicted to have visual impairment to 2030.

Registered blind and partially sighted

There were a total of 755 registrations of blind persons and 440 registrations of partially sighted persons in Ealing as at 31st March 2014. The chart below illustrates the registrations of blind and partially sighted people by age group. Sight loss is more prevalent in older age groups; however there is a high number of registrations of blind people in the age group 18-49.

These figures are lower than the estimates of blind/partially sighted people in Ealing, which could indicate underreporting in certain areas.

Figure 4: Number of people registered as blind or partially sighted



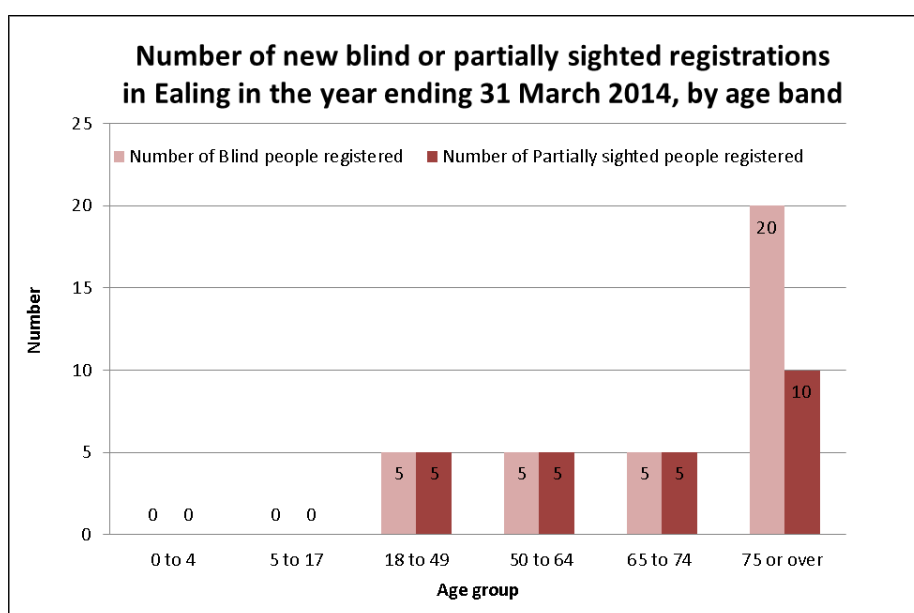
Health and Social Care Information Centre, 2014

Figure 4 shows the higher proportion of blind/partially sighted people in Ealing in the older age groups.

Number of new blind and partially sighted registrations

The total number of new registrations of blind people in Ealing in the year ending 31st March 2014 was 35. Similarly, there were 25 new registrations of partially sighted people. The chart below shows these registrations by age group.

Figure 5: Number of new blind or partially sighted registrations

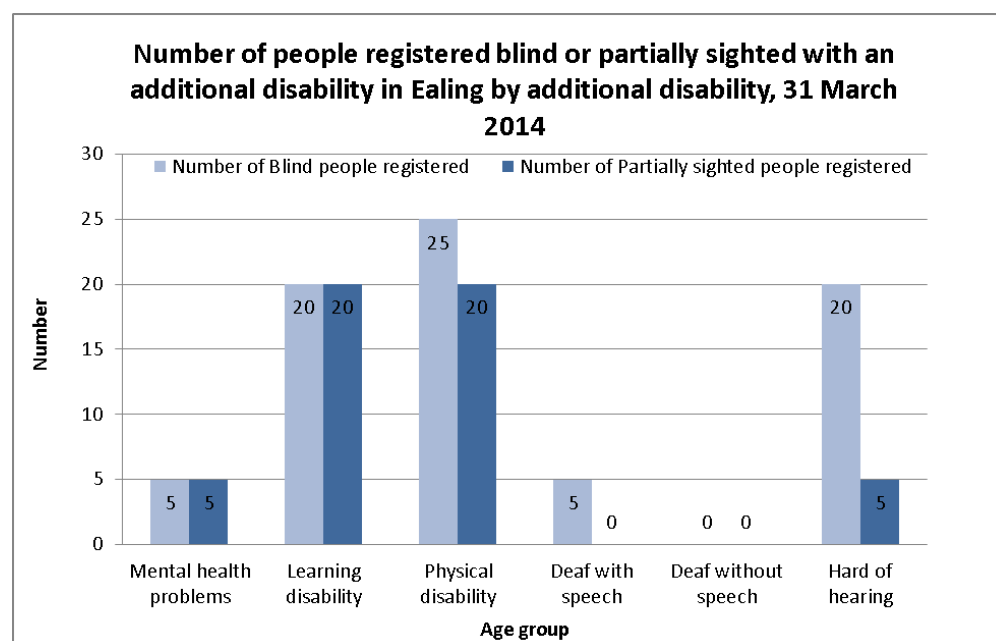


Health and Social Care Information Centre, 2014

Number of people registered partially sighted or blind with an additional disability

The chart below shows numbers of people who are registered blind or partially sighted and have an additional disability, by additional disability. 75 blind people and 50 partially sighted also had an additional disability. Most of these people had a physical disability, a learning disability or a hearing disability.

Figure 6: Number of people registered blind or partially sighted with an additional disability



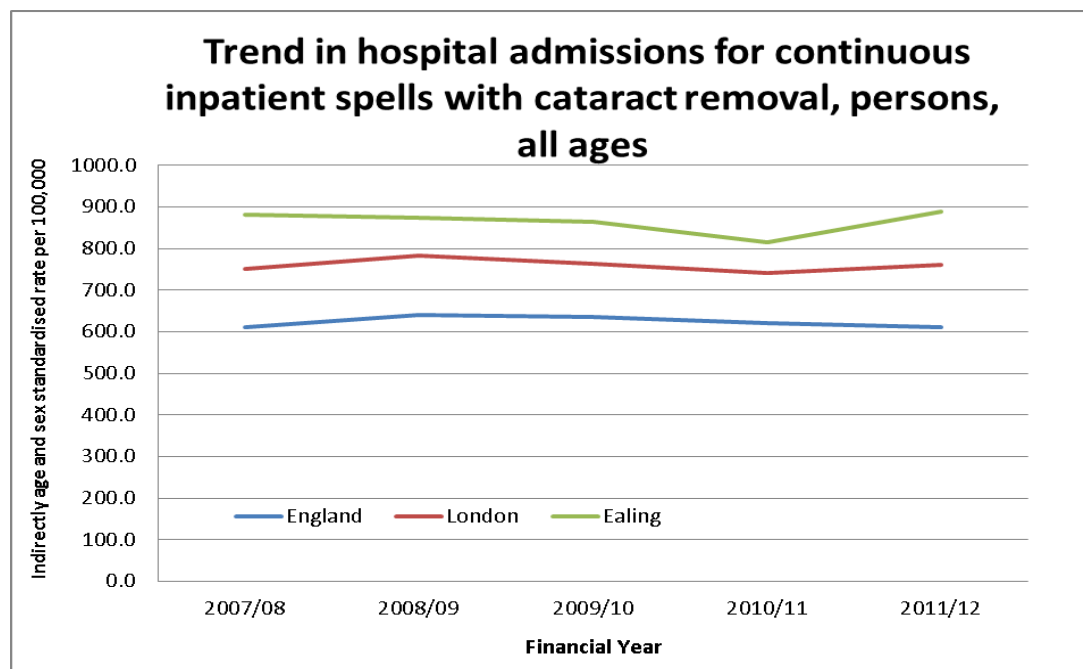
Health and Social Care Information Centre, 2014

Hospital procedures: cataract removal

In 2011/12 there were 2,070 (f: 1,149, m: 921) hospital procedures for cataract removal in Ealing. The chart below shows all person age and sex standardised rates per 100,000 people in Ealing, London and England between 2007/08 and 2011/12. The rate in Ealing has increased over time and it remains higher (888.2 per 100,000) than London (761.9 per 100,000) and England (609.8 per 100,000). There is a difference between the male and the female rates for cataract removals in Ealing with 890.1 per 100,000 in females and 581.50 per 100,000 in males.

This indicates that public health services for cataract prevention need to be improved in Ealing, as the demand for a cataract operation has been increasing. The services should be equally distributed between the male and the female population, as there is no major difference in need between the two sexes.

Figure 7: Trends in hospital admissions for continuous inpatient spells with cataract removal



Data source: Health and Social Care Information Centre

Hearing Impairment

Table2: The table below shows the impact different levels of hearing loss can have on people.

The impact of different decibel levels of hearing loss ²⁸		
Better ear average hearing level in decibels of hearing loss (dB HL)	Hearing in a quiet environment	Hearing in a noisy environment
20-34 dBHL	Does not have problems hearing what is said	May have real difficulty following/ taking part in a conversation
35-49 dBHL	May have difficulty hearing a normal voice	Has difficulty hearing and taking part in conversation
50-64 dBHL	Can hear loud speech	Has great difficulty hearing and taking part in conversation
65-79 dBHL	Can hear loud speech directly in one's ear	Has very great difficulty hearing and taking part in conversation

²⁸ These impacts are taken from the Global Burden of Disease Expert Group – see Stevens G, Flaxman S, Brunskill E et al. Global and regional hearing impairment prevalence: an analysis of 42 studies in 29 countries. Eur J Public Health 2013;23:146-52.

80-94 dBHL	Has great difficulty hearing	Cannot hear any speech
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The table below is based on the combined prevalence from two studies: Adrian Davis (Ed.), Hearing in Adults (1995), Whurr Publishers Limited, and Adrian Davis et al, Health Technology Assessments 11(42):1-294 (October 2007).

Table 2: % of people aged 65 yrs and over predicted to have moderate/severe or profound hearing impairment, Ealing

Age range	% males - moderate or severe	% females - moderate or severe	% males - profound	% females - profound
65-74	22.69	15.79	0.43	0.78
75-84	60.63	63.43	0.41	0.8
85+	85.05	84.8	3.45	4.73

Source: POPPI, year?

Table 3: Number of people aged 65 yrs and over predicted to have moderate or severe hearing impairment, projected till 2030

Moderate or severe hearing impairment by age group	2014	2015	2020	2025	2030
Ealing: People aged 65-74 predicted to have a moderate or severe hearing impairment	4,022	4,099	4,707	5,092	5,792
Ealing: People aged 75-84 predicted to have a moderate or severe hearing impairment	8,208	8,332	8,764	10,193	11,747
Ealing: People aged 85 and over predicted to have a moderate or severe hearing impairment	4,245	4,330	5,349	6,623	7,557
Ealing: Total population aged 65 and over predicted to have a moderate or severe hearing impairment	16,474	16,760	18,821	21,907	25,096

Source: POPPI, 2015

Table 4: Number of people aged 65 yrs and over predicted to have profound hearing impairment, projected till 2030

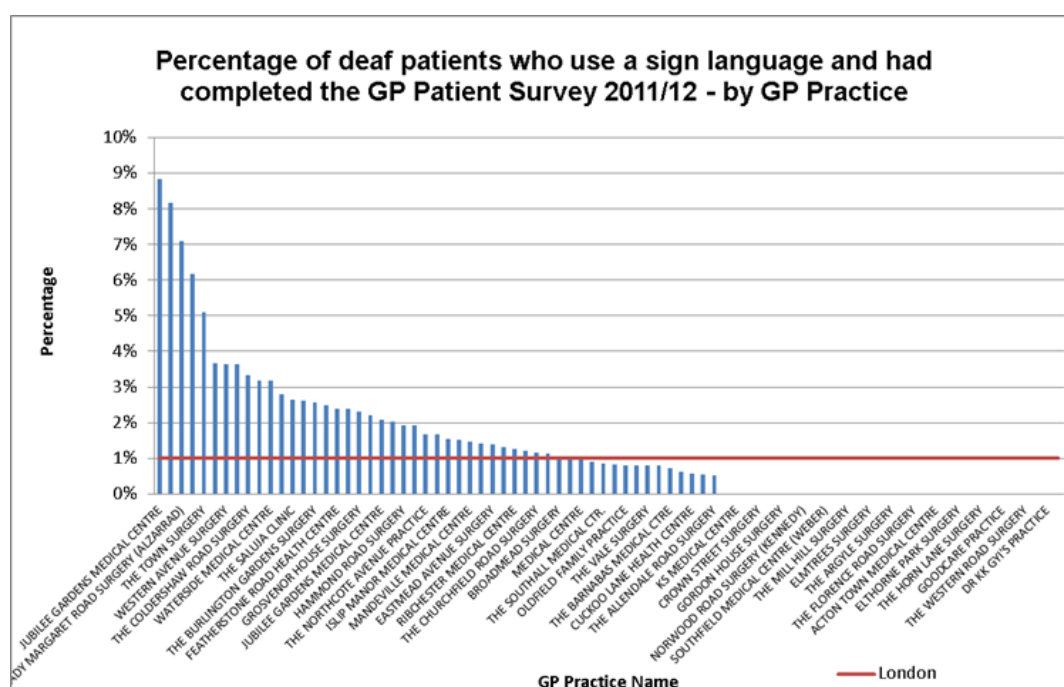
Profound hearing impairment by age group	2014	2015	2020	2025	2030
Ealing: People aged 65-74 predicted to have a profound hearing impairment	130	132	152	164	185
Ealing: People aged 75-84 predicted to have a profound hearing impairment	83	84	88	102	118
Ealing: People aged 85 and over predicted to have a profound hearing impairment	213	217	266	327	372
Ealing: Total population aged 65 and over predicted to have a profound hearing impairment	426	433	506	592	675

Source: POPPI, year, 2015

Deaf people who use sign language

In 2011/12 the GP Practice Patient Survey asked if a patient was a deaf person who uses a sign language. There were 82 practices in Ealing at that time. The chart below illustrates the 'yes' answers to this question as a percentage of those who participated in the survey. The total number of people who participated in Ealing was 6,579, of whom 80 (1.2%) answered 'yes' in the survey question. The proportion in GP Practices in Ealing ranked from 9% (Jubilee Gardens Medical Centre) to 0%. The average percentage of deaf patients who use a sign language in London was 1%.

Figure 8: Percentage of deaf people who use sign language and had completed the GP patient survey 2011/12



Source: GP Patient Survey 2011/12

PANSI Adult (18-64) data on hearing and sight loss

Table 5: Number of people under 65 yrs predicted to have moderate or severe hearing impairment, projected till 2030

Moderate or severe hearing impairment by age group	2014	2015	2020	2025	2030
Ealing: People aged 18-24 predicted to have a moderate or severe hearing impairment	48	48	47	45	51
Ealing: People aged 25-34 predicted to have a moderate or severe hearing impairment	308	303	292	286	278
Ealing: People aged 35-44 predicted to have a moderate or severe hearing impairment	781	791	831	842	835
Ealing: People aged 45-54 predicted to have a moderate or severe hearing impairment	2,515	2,571	2,691	2,834	3,004
Ealing: People aged 55-64 predicted to	3,652	3,714	4,177	4,633	4,851

have a moderate or severe hearing impairment					
Ealing: Total population aged 18-64 predicted to have a moderate or severe hearing impairment	7,304	7,426	8,039	8,640	9,018
Ealing: People aged 18-24 predicted to have a profound hearing impairment	0	0	0	0	0
Ealing: People aged 25-34 predicted to have a profound hearing impairment	0	0	0	0	0
Ealing: People aged 35-44 predicted to have a profound hearing impairment	0	0	0	0	0
Ealing: People aged 45-54 predicted to have a profound hearing impairment	20	20	21	21	22
Ealing: People aged 55-64 predicted to have a profound hearing impairment	40	41	46	50	53
Ealing: Total population aged 18-64 predicted to have a profound hearing impairment	60	61	67	72	75

Source: PANSI, 2016

The table below is based on the prevalence of visual impairment in the UK, A review of the literature, by Tate, Smeeth, Evans, Fletcher, Owen and Rudnicka, RNIB, 2005. They report that most studies have been done in the older population and there is a scarcity of data in younger adult age groups in the UK. A review by Nissen et al of epidemiological studies performed in Western Europe North America and Australia covering the age group 20 to 59 years found the prevalence of blindness was 0.08 and of visual acuity 6/24 to 6/48 was 0.07%. These figures agree well with the prevalence of registrations in a similar age range and we conclude that registration data provide reasonably accurate estimates of the prevalence of serious vision impairment in the younger adult age groups". The RNIB suggest a lower figure of 1 in 500 as an estimated basis of people who would be registerable. The Tate study also argues as do others that estimates of less than severe visual impairment are unreliable with a high degree of variance reported in self report studies. A mean of the three figures 0.065% has been used as an estimate of the numbers of people with a severe visual impairment."

Table 6 below is based on the combined prevalence from two studies: Adrian Davis (Ed.), Hearing in Adults (1995), Whurr Publishers Limited, and Adrian Davis et al, Health Technology Assessments 11(42):1-294 (October 2007). Rates for moderate or severe and profound hearing loss, are as follows:

Table 6:% of people under 65 yrs and over predicted to have moderate/severe or profound hearing impairment, Ealing

Age range	% males - moderate or severe	% females - moderate or severe	% males - profound	% females - profound
18-19	0	0	0	0
20-24	0.18	0.24	0	0
25-34	0	0.95	0	0
35-44	0.78	2.09	0	0
45-54	7.15	4.13	0	0.09
55-64	14.81	8.09	0.12	0.13

Table 7: Number of people under 65 yrs predicted to have a serious vision impairment, projected till 2030

Number of people under 65 predicted to have a serious vision impairment	2014	2015	2020	2025	2030
Ealing: People aged 18-24 predicted to have a serious visual impairment	20	19	19	19	21
Ealing: People aged 25-34 predicted to have a serious visual impairment	43	43	43	43	42
Ealing: People aged 35-44 predicted to have a serious visual impairment	36	37	39	40	40
Ealing: People aged 45-54 predicted to have a serious visual impairment	29	30	31	32	34

Ealing: People aged 55-64 predicted to have a serious visual impairment	21	21	24	26	27
Ealing: Total population aged 18-64 predicted to have a serious visual impairment	149	150	155	160	164

Source: PANSI, 2016

Older people living alone

The General Household Survey 2007 estimated that in the population aged 65-74, 20% of males and 30% of females live alone. The proportion increases in the age group 75+, with 34% of males and 61% of females predicted to live alone.

The table below shows the estimated numbers of people aged 65 and over living alone by gender in Ealing between 2014 and 2030.

Table 8: Estimated population aged 65 and above living alone in Ealing by gender

	2014	2015	2020	2025	2030
Males aged 65-74	2,000	2,040	2,340	2,540	2,920
Females aged 65-74	3,330	3,390	3,900	4,200	4,710
Total population aged 65-74	5,330	5,430	6,240	6,740	7,630
Males aged 75 and over	2,618	2,686	3,026	3,672	4,216
Females aged 75 and over	6,405	6,466	7,015	8,174	9,394
Total population aged 75 and over	9,023	9,152	10,041	11,846	13,610

Source: POPPI, 2015

Adults and social services data

Of the 5,064 adults with a disability known to the Council in 2014/15 year, 22% were aged 18 to 64 and 78% over 65 years of age.

Of all disabled people known to the Council, 2% reported as having a sensory impairment. 34% of people with a sensory impairment were aged 18 to 64 and 66% aged over 65. In 2014/15 out of the 5064 people with a disability supported by Adult Services:

- 0.3% had a dual sensory impairment
- 1.8% had a visual impairment
- 0.2% had a hearing impairment

These figures clearly demonstrate an underestimate in the number of people with sensory impairments known to the council.

Table 9: Benefit claimants - disability living allowance by disabling condition

Condition	Ealing	London	England
Blindness	360	8,710	59,240
Deafness	230	6,350	38,120

ONS, May 2015

Public Health Outcomes Framework

Indicators from the Public Health Outcomes Framework (PHOF) linked to sensory impairments taken from indicator set on premature mortality:

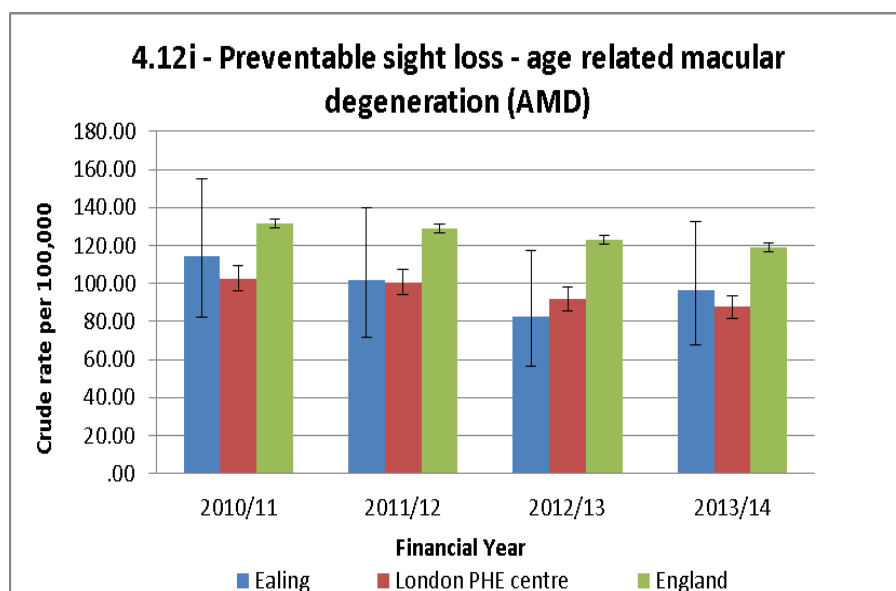
4.12i Preventable sight loss – age related macular degeneration

4.12ii Preventable sight loss – glaucoma

4.12iii Preventable sight loss – diabetic eye disease

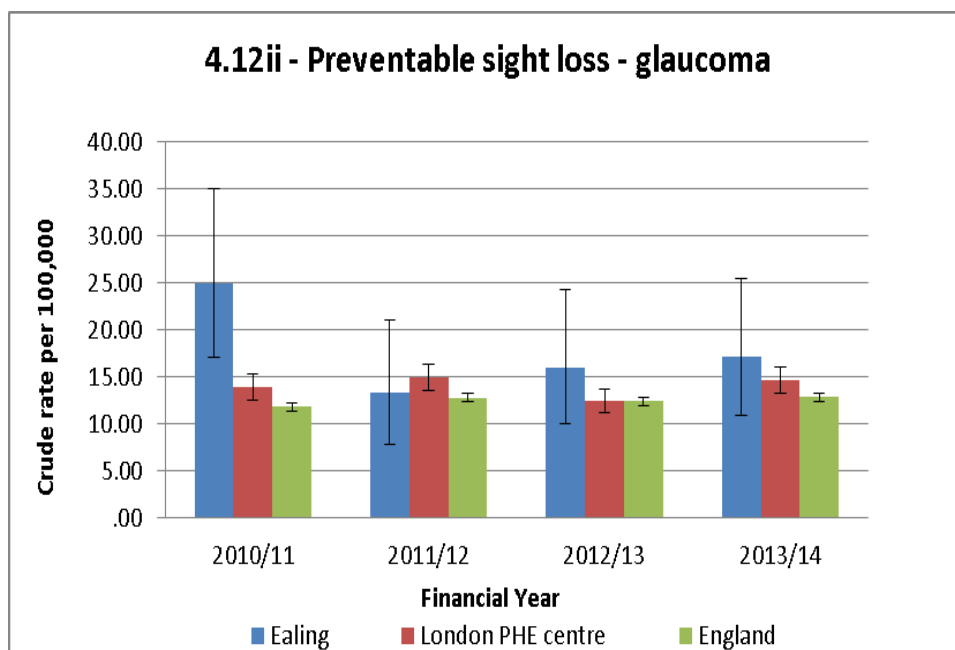
4.12iv Preventable sight loss – sight loss certifications

Figure 9: Preventable sight loss – Age Related Macular Degeneration (AMD)



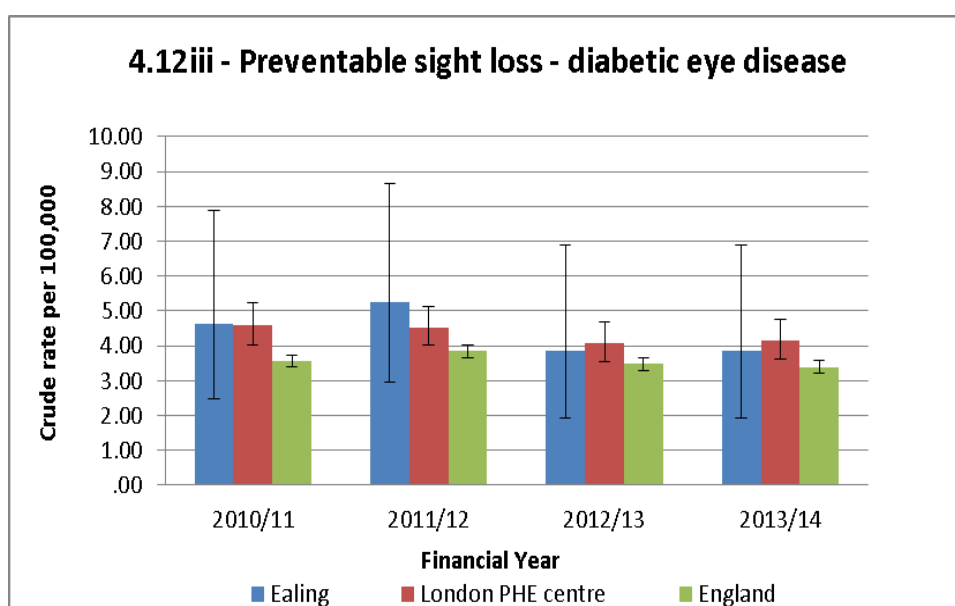
Source: PHE: Public Health Outcomes Framework

Figure 10: Preventable sight loss – Glaucoma



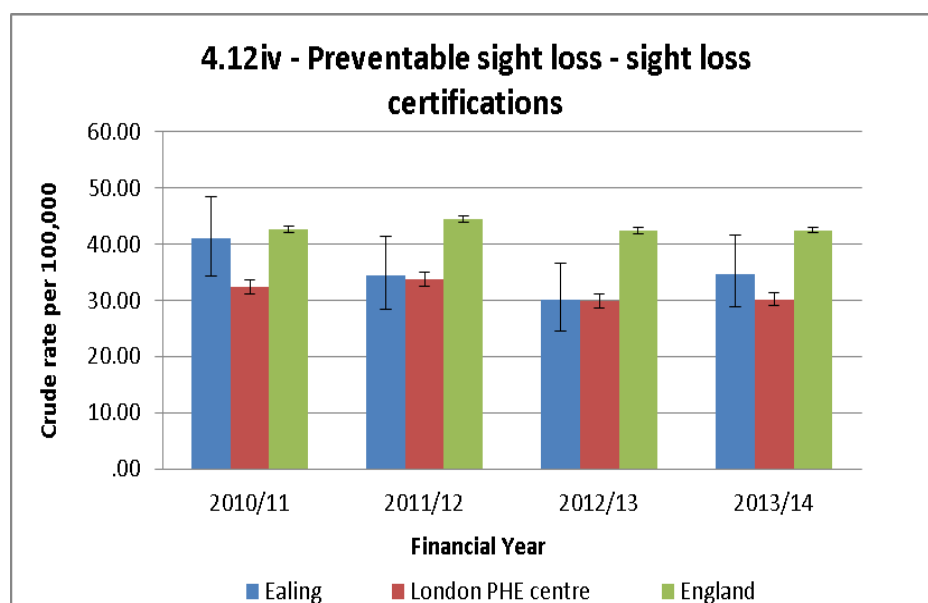
Source: PHE: Public Health Outcomes Framework

Figure 11: Preventable sight loss – Diabetic eye disease



Source: PHE: Public Health Outcomes Framework

Figure 12: Preventable sight loss – sight loss certifications



Source: PHE: Public Health Outcomes Framework

The crude rates of preventable sight loss due to Age Related Macular Degeneration (AMD), Glaucoma and Diabetic eye disease in Ealing are not significantly different from the London and England average.

Evidence of what works

Visual impairment

Lifestyle factors

1) Stopping Smoking

Stopping smoking can halt or reverse damage to the eyes, depending on the severity and type of disease. In the case of AMD, smokers are at least twice as likely to develop it and former smokers have only a slightly increased risk compared with people who never smoked. A British study of people aged 75 or older, found that those who had quit smoking for 20 years or more had the same risk of developing AMD as non-smokers²⁹. Another study found that the benefit for stopping smoking is seen after 10 years with reductions in risk, although risks do not return to that of non-smokers till 20 years after stopping smoking³⁰.

This is supported by the findings of the 2010 US Surgeon General's Report. Since there is also a dose-response relationship between smoking and AMD, quitting smoking early

²⁹ Evans JR, Fletcher AE, Wormald RP. 28,000 cases of age related macular degeneration causing visual loss in people aged 75 years and above in the United Kingdom may be attributable to smoking. *Br J Ophthalmol*. 2005 May;89(5):550-3

³⁰ British Journal of Ophthalmology. *J R Evans, A E Fletcher, R P L Wormald* 2005;89:550–553. doi: 10.1136/bjo.2004.049726

in life is important. Stopping smoking reduces the risk, over time, of developing or exacerbating AMD³¹.

More recent data is not available. A US study found that, compared with men who continued to smoke, those who had quit 20 years or more before entry into the study had an approximately 21% reduced risk of cataract³².

A Swedish study found that the greater the number of cigarettes smoked, the longer it took after quitting to reduce the risk of cataract development to that of a non-smoker³³.

2) Diabetes Control

In the Diabetes Control and Complications Trial (DCCT), it was found that 6.5 years of intensive therapy for patients with type 1 diabetes aimed at achieving glycaemia as close to the nondiabetic range as safely possible, as compared with conventional therapy at the time, was associated with a 76% reduction in the onset of retinopathy and a 52% reduction in disease progression³⁴.

The Eye Clinic Liaison Officer

Having an Eye Clinic Liaison Officer or ECLO (also known as Sight Loss Adviser or Vision Support Officer) is one of the most effective ways of supporting patients in the eye clinic. ECLOs are key in helping patients understand the impact of their diagnosis and providing them with emotional and practical support for their next steps. Research conducted to evidence the cost effectiveness of providing an early intervention ECLO support service found that an investment of £1 in an ECLO service can net a return of £10.57 to health and social care expenditure budgets³⁵.

Good practice guidance: The RNIB, supported by the Association of Directors of Adult Social Services (ADASS), have produced good practice benchmarks for services for people who have a sight impairment which are as follows³⁶:

- Emotional support e.g. peer support and counselling
- Methods of referral e.g. eye care liaison officers
- Information and advice e.g. regarding access to work, technology, information prescriptions and advocacy
- Assessments which are timely, meet additional needs, are holistic and for older people, a single assessment of health and social care needs

³¹ U.S. Department of Health and Human Services. How Tobacco Smoke Causes Disease: The Biology and Behavioral Basis for Smoking-Attributable Disease: A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2010.

³² Lindblad BE, Håkansson N, Wolk A. Smoking Cessation and the Risk of Cataract: A Prospective Cohort Study of Cataract Extraction Among Men. JAMA Ophthalmol. 2014 Jan 2.

³³ Lindblad BE, Håkansson N, Svensson H et al. Intensity of Smoking and Smoking Cessation in Relation to Risk of Cataract Extraction: A Prospective Study of Women. Am J Epidemiol. 2005 Jul 1;162(1):73-9.

³⁴ The DCCT/EDIC Research Group. N Engl J Med 2015; 372:1722-1733 April 30, 2015 DOI: 10.1056/NEJMoa1409463

³⁵ RNIB. The benefits of ECLOs

³⁶ ADASS (2002) Progress in Sight: national standards of social care for visually impaired adults London: ADASS

- Equipment e.g. provision of equipment to support activities of daily living, communication and mobility, Access to Work
- Training (in proper use of aids and equipment)
- User involvement
- Dealing with complaints
- Inter-agency working

The Thomas Pocklington Trust, a leading provider of housing, care and support services for people with sight loss in the UK, has also identified priorities in their research including support in the home for small household tasks and the importance of lighting.

Prevention of sight loss and promoting good visual health

There is evidence that suggests that over 50 per cent of sight loss is due to preventable or treatable causes; in older people this percentage is estimated to be between 50 and 70%.

The evidence from the Department of Health commissioning toolkit for community-based eye care services suggests the following factors can promote good visual health

- An awareness of the impact of a healthy lifestyle on eye health
- An understanding of the risk factors for sight-threatening conditions by people in the risk groups
- Regular sight tests
- Effective eye care services that are accessible to all parts of the population
- Effective services in other areas that have an impact upon, or will be affected by, visual health and vision services

Deaf/hearing impairment

There is evidence to support:

- Hearing aids and ongoing support improves quality of life by reducing the psychological and social effects of hearing loss³⁷
- Cochlear implants for profoundly deaf people who do not benefit from hearing aids³⁸

There is some evidence to support:

- Screening programmes in people over 65 which lead to early detection and cost benefits³⁹
- Hearing therapists to support aids and communication strategies⁴⁰

³⁷ Chisolm, T. et al. 2007. A Systematic Review of Health-Related Quality of Life and Hearing Aids: Final Report of the American Academy of Audiology Task Force on the Health-Related Quality of Life Benefits of Amplification in Adults. *Journal of the American Audiology*, 18(2), pp. 151-183; Davis, A. et al., 2007. Acceptability, benefit and costs of early screening for hearing disability: a study of potential screening tests and models. *Health technology assessment*, 11(42) pp. 75-78; Acar, B. et al. 2011. Effects of hearing aids on cognitive functions and depressive signs in elderly people. *Archives of Gerontology and Geriatrics*, 52(3), pp. 250-252.

³⁸ The Ear Foundation (2011) (WWW) <http://www.earfoundation.org.uk/hearing-technologies/cochlearimplants>

³⁹ Action on hearing loss (2011) (WWW) <http://www.actiononhearingloss.org.uk/news-and-events/allregions/news/rnid-calls-for-a-national-hearing-screening-programme.aspx>

⁴⁰ Deafness research (2009) (WWW) Sudden sensorineural hearing loss

- Use of cognitive behaviour therapy (CBT) to treat distressing tinnitus
- Lip-reading classes to improve communication skills and help people deal with hearing loss⁴¹
- Assistive technology can increase independence and safety (hearing aid compatible telephones, flashing doorbells, smoke detection and alarm clocks)⁴²
- Implementation of the reasonable adjustments required by the 2010 Equality Act and Equality Duty does reduce discrimination (e.g. access to communication support)⁴³
- Screening people over 85 in care homes identifies significant hearing impairment not previously identified or remediated
- Action on Hearing Loss produced a report⁴⁴, setting out eight standards covering the needs of deaf people in the community, day and residential settings

The British Deaf Association⁴⁵ have created a checklist of actions in conjunction with Deaf BSL users, Sign Language Interpreters (who have a pivotal role in health interactions) and healthcare professionals

Each commitment requires action to overcome the disadvantages that Deaf people using BSL face when accessing health services.

The five commitments are:

1. Ensure access for Deaf people to information and services at first points of contact.
2. Promote equal access in health settings, particularly in reception areas.
3. Ensure accurate diagnosis and appropriate treatment.
4. Provide clear and accessible information about treatment and management of health.
5. Engage and involve local Deaf communities on a regular basis.

Current Interventions & Assets

There are a range of services commissioned by both the NHS and local authorities to meet the needs of people with a sensory loss.

Visual impairment/Sight loss

In primary care settings, local optometrists can provide enhanced services for people with visual impairments.

Local GP services can encourage patients to take up regular eye examinations and refer people to eye clinics as required.

North West London launched a Diabetic Eye Screening Programme in 2015

<http://www.nwldesp.co.uk/>

<http://www.deafnessresearch.org.uk/factsheets/sudden-sensorineural-hearing-loss.pdf>

⁴¹ Action on hearing loss (2011)

⁴² Action on hearing loss (2011) Annual survey 2010

⁴³ Action on hearing loss (2011) A research report on hearing loss in the workplace (WWW)

⁴⁴ RNID (1999) Best Practice Standards: Social Services for Deaf and Hard of Hearing People

⁴⁵ British Deaf Association. Improving Access for British Sign Language Users.

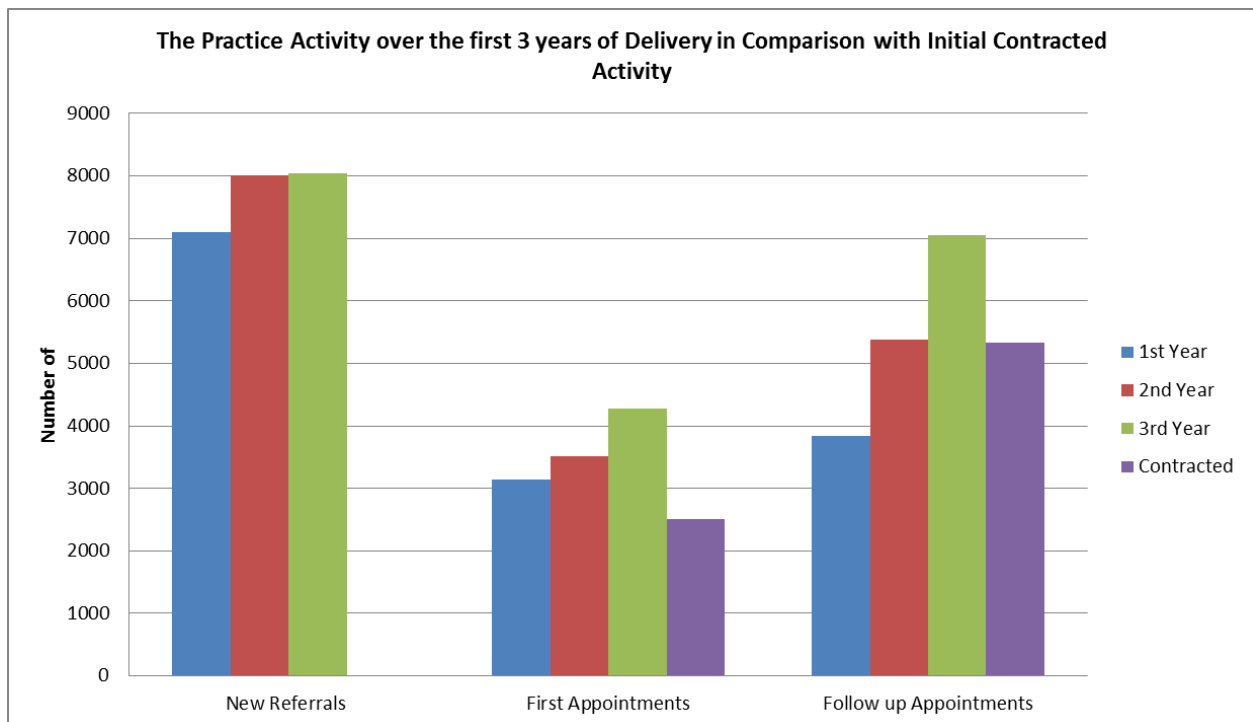
<http://www.cydraddoldebhawliaudynol.wales.nhs.uk/sitesplus/documents/1120/BDA%20Improving%20Access%20for%20British%20Sign%20Language%20Users%20Checklist%20for%20Health%20Boards%20and%20NHS%20Trusts%2020131.pdf> (accessed February 2016)

Community Services

The Practice provides a community ophthalmology service for Ealing Patients. The service was originally commissioned in March 2012 with the following objectives

- Improve quality of care within primary and community settings
- Reduce the waiting time
- Provide services closer to patients' homes
- Improve access to advice and information and increase knowledge and awareness of the management of Eye conditions
- Increase patients' satisfaction with Eye services

The Practice receives approx. 760 referrals per month. Approximately 50% of referrals come from GPs and 50% from Optometrists. Of the 760 referrals per month, approx. 270 (36%) are triaged directly to hospital eye services and 490 (64%) are seen in The Practice clinics. Of the patients seen by the Practice, approximately 10% are onward referred to acute care.

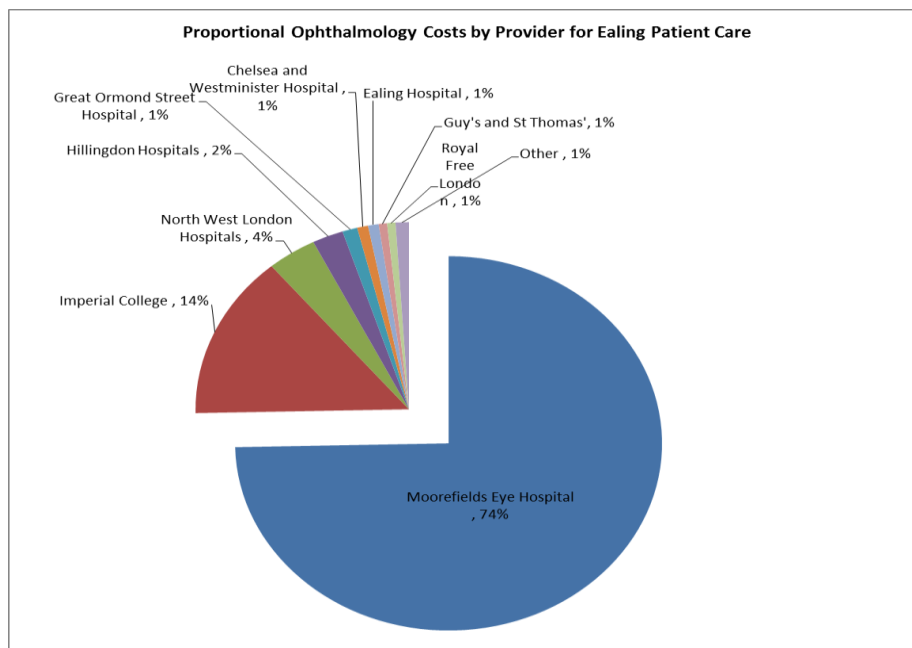


Hospital Based Services

People are referred to hospital based eye clinics or departments for diagnosis and treatment that cannot be provided in the community.

For Ealing patients who receive care from a variety of Eye Hospitals, the Moorfields Eye Hospital (MEH) provides the majority of care (Figure 14). MEH has a hub at Ealing Hospital and provides an ophthalmology service.

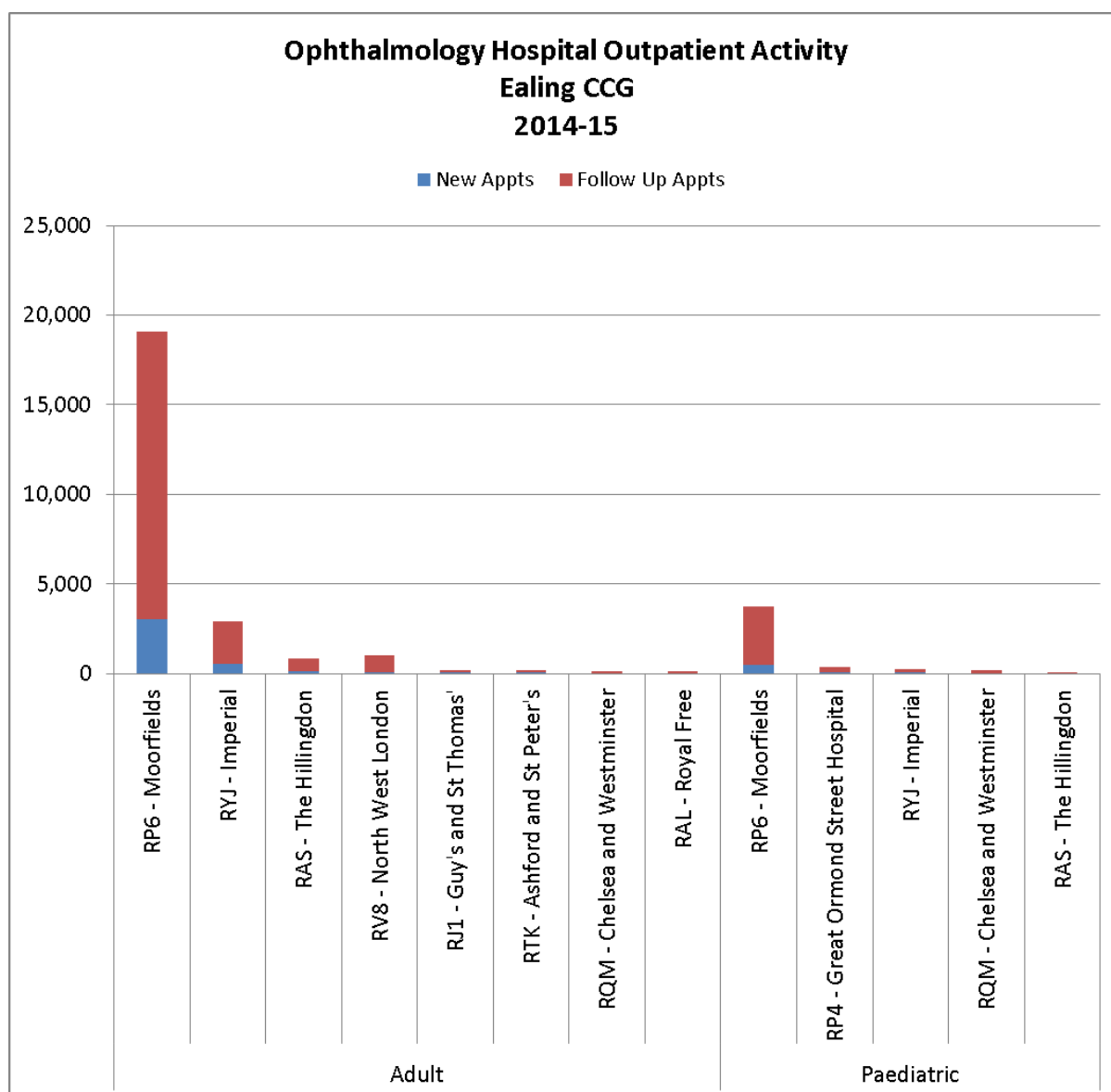
Figure 14. Proportional Cost by Provider for Ealing Patient Care



Specialities include:

- Cataract
- Glaucoma
- Medical retina
- General ophthalmology
- Strabismus (adult and children)
- Uveitis
- Eye Hospitals across providers are experiencing significant pressures due to increases in activity for age related conditions such as Cataracts, Glaucoma and macular degeneration.

Figure 15: Ophthalmology Hospital Outpatient Activity, Ealing CCG, 2014-15



As can be seen in the figure above majority of the ophthalmology hospital outpatient activity in adults in Ealing is at Moorefield's Hospital as follow up appointments.

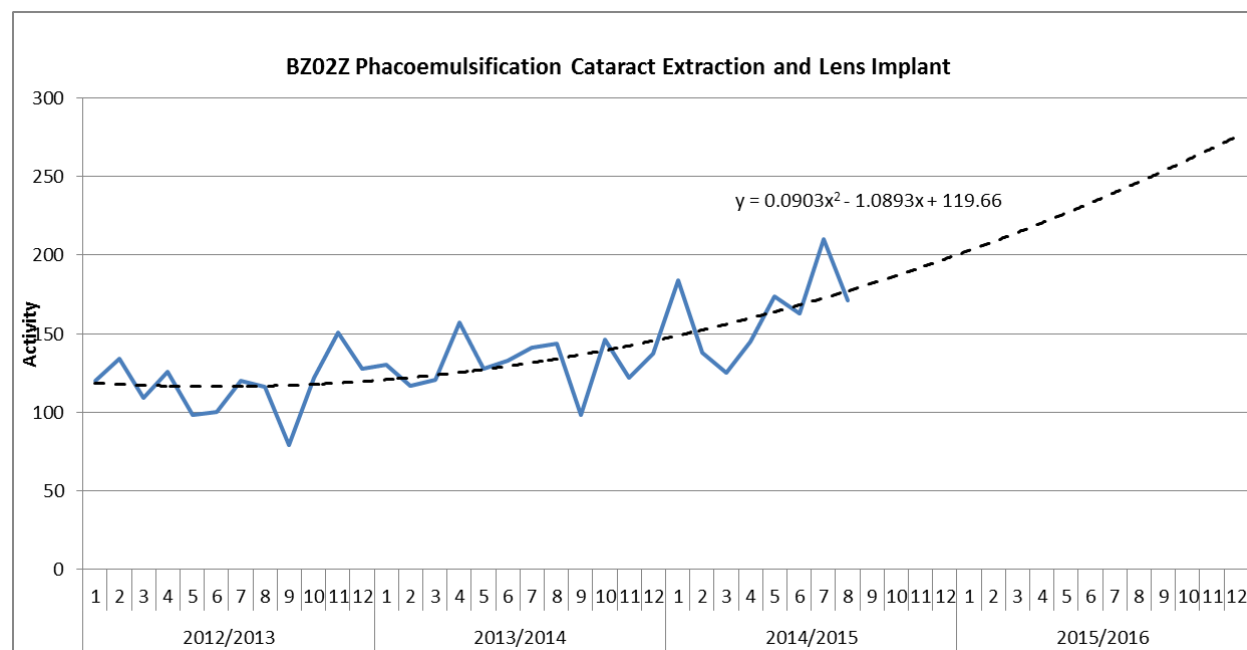
Cataracts

Cataracts are the most common cause of vision loss in people over 40 years old. In Ealing, 42% of patients having this surgery are over 75 years of age. We expect the demand for cataract interventions to increase in line with an aging demographic.

Over the last 16 months there has been a noticeable increase in cataract procedures for Ealing (Figure 16) Cataracts are attributable for 20% of the total ophthalmic activity and 56% of inpatient activity (cataracts procedures are done as a day case.) This poses a significant cost pressure in the coming financial period if this trend continues.

There are 3 primary procedures for cataract interventions; the most common (93%) of these is phacoemulsification cataract extraction and lens implant (BZ02Z.) In 13/14 Ealing CCG spent £1.3 million on these procedures; there has been no noticeable trend over the last 32 months in the other two cataract procedures: Enhanced Cataract Surgery and Non-Phacoemulsification Cataract Surgery. Therefore, this demonstrates that there has not been a shift in procedures between these three codes.

Figure 16. Increase and Cataract procedures



Source: Ealing CCG

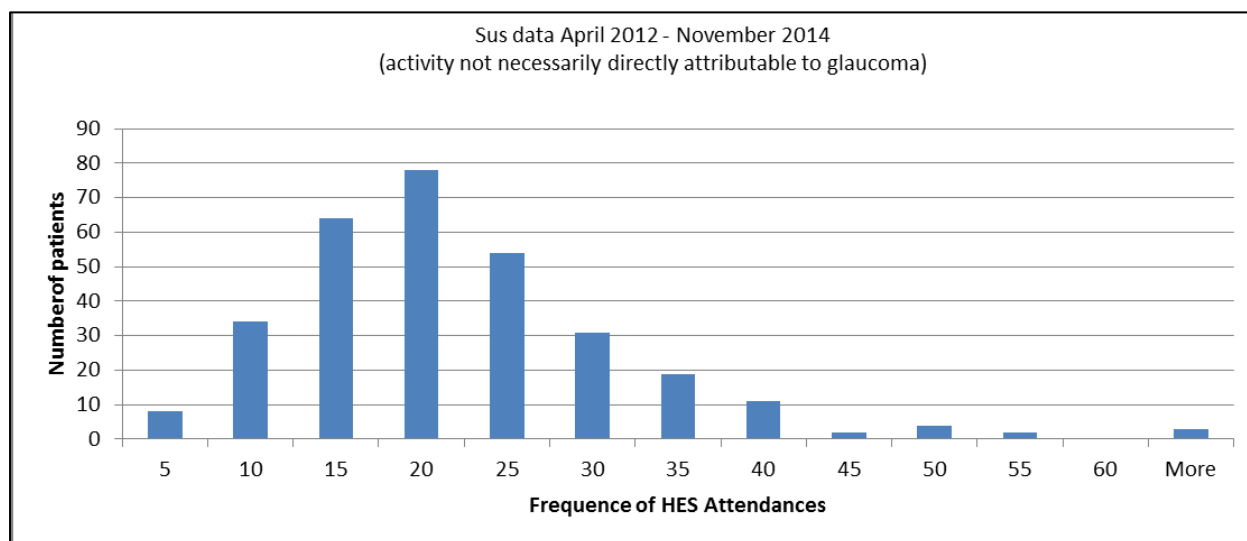
Glaucoma

Glaucoma is again a major cause of vision loss as a result of raised intraocular eye pressure; those patients with diagnosed Glaucoma or elevated ocular hypertension require intensive monitoring dependant on the level of risk associated with future vision loss. Although the total numbers are low, patients require frequent monitoring over a number of years, causing pressure on Hopsital Eye Services (HES) outpatient clinics.

Clinical evidence shows that 80% of Glaucoma cases are stable and could be managed in the community due to the tests required. It is difficult to quantify total costs attributed to Glaucoma care and treatment due to the on-going nature of care and the way SUS data is recorded.

Figure 17 is an attempt to reflect the number of times a patient who has Glaucoma accesses the HES over a 3 year period. This activity is not solely Glaucoma related (12% of patients who have Glaucoma have also had cataract surgery). However, it does demonstrate the frequency of activity related to the patients with Glaucoma.

Figure 17 Glaucoma frequency of HES attendance of patients with a primary diagnosis of Glaucoma



Source: Ealing CCG

Services for people with a visual impairment team

The services for people with a visual impairment team (SVIP) work with people of all ages with a visual impairment who live in the borough, primarily those who are registered as blind or partially sighted. We also provide a service to people with a significant sight loss that meet the criteria for registration. SVIP also offers a service to those with a dual sensory loss (Deaf Blind). The team is made up of a senior practitioner, rehabilitation officers and assistants.

SVIP have good links with health and voluntary organisations, which complement our specialist services. It is important that these links are maintained and strengthened to provide a rounded and joined up service.

Services may include:

- full specialist visual impairment assessment
- training in orientation and mobility, daily living, communications and managing low vision
- specialist equipment to aid independence, which has been identified from an assessment
- group work
- emotional support
- welfare rights advice
- specialist education advice
- supported employment
- all aspects of registration

Access to support is most often triggered by a Certificate of Vision Impairment issued by an ophthalmologist when treatment or correction of the sight loss is not possible. The CVI is sent to the local authority which is responsible for contacting the person and invites them to be

registered (as sight impaired or severely sight impaired) and / or have their needs for support assessed.

Local organisations

Ealing Association for the Blind (EAB) offers a range of support to people affected by sight loss.

Ealing Social Club for the blind (ESCB) provides social support and informative talks.

Ealing talking newspapers (ETN) is where volunteers record articles from the weekly local paper for the blind and visually impaired persons.

Hearing Impairment

Ealing has an adult service dedicated to providing a comprehensive hearing healthcare service for people in and around the London Borough of Ealing. Ealing CCG has extended choice of provider for adult hearing care and this means it is available in community settings as well as hospital. Monitor, the NHS regulator, found 7 out of 10 people wanted a choice of hearing care provider, but only 1 in 10 were given one⁴⁶.

Local organisations

deafPlus provides services for deaf and hard of hearing people living in the borough of Ealing.

Environmental aids

- Hearing Aids
- Interpretation and lip reading support

Other organisations

Next Generation Text Relay

This is the only national telephone relay service, which enables deaf, deaf blind, deafened, hard of hearing and speech-impaired people to communicate with hearing people. It is run and funded by BT.

Service user feedback

The Ealing Vision Strategy Group Consultation took place at the end of 2013. Over 50 registered blind or partially sighted Ealing residents attended the event to provide feedback on services and their experiences relating to the following areas:

- Promoting eye health and preventing sight loss
- Diagnosis and treatment

⁴⁶ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/409273/Adult_hearing_services_-_Monitor_s_report.pdf

- Follow up services and support
- Independent Living

Please see Appendix 1 below, for a summary report from the consultation.

An event was organised in 2014 in Ealing which aimed to explore the experiences, good and bad, of local residents who suffer hearing loss problems. The event was designed to gather feedback on their use of the local GPs, Hospitals, Dentists and Social Care Services, and to identify any gaps in these services. In addition, the intention was to develop ideas for improving the experiences of people with hearing loss, deaf and deafblind in Ealing.

Full findings from the event can be found [here](#)⁴⁷. A follow up event with commissioners has been planned for mid-October 2015 with London Borough of Ealing Commissioners and Ealing CCG on how to take forward issues raised and involve the deaf and hearing loss community in planning and monitoring service experience

Identified Gaps

- Lack of public awareness campaigns in Ealing focused on visual impairments and sight loss. Evidence shows that health campaigns that highlight the risk between sight loss and smoking increase the number of people who quit. In addition, control of diabetes and Diabetic retinopathy screening can help limit the development of diabetic complications.
- Lack of awareness about hearing loss and the impact unsupported hearing loss can have on individuals and the community
- Ealing council has not signed up to the British Sign Language Charter
- Lack of understanding amongst staff across council and NHS about the needs of people with sensory impairments
- Issues with accessing services amongst people with sensory impairments
- Poor communication arrangements across all NHS services and council (not just social care as such but all council services) - for e.g. Significant issues around pharmacists/hospital /GPs on lack of explanation to people who are blind on taking medication safely

Recommendations for Commissioners

- Develop Public Health messages and campaigns to promote eye and hearing health
 - Public health to provide Making every contact count training to opticians so that they are able to advice patients about healthy lifestyles and the links to eye health

⁴⁷ Healthwatch Ealing. “Talk to Healthwatch Ealing”. Community Event for Hearing Loss, Deaf and Deafblind Residents of Ealing - Event Report **September 2014 (accessed October 2015)**

- Integrate eye health messages into smoking cessation activity to create a more compelling case for quitting in particular targeting more deprived areas in the borough. Evidence shows that people living in socio-economic deprivation are more likely to smoke and are also less likely to access primary eye care services and are therefore at a greater risk of avoidable sight loss
 - Raise awareness on the risk factors, signs and symptoms of undiagnosed diabetes and referral for treatment of care targeting BME groups at a higher risk of diabetes in particular South Asian Communities
 - Raise awareness about hearing loss – especially in older age – and the benefits of hearing care and support. This can reduce the risk of social isolation and loneliness.
- Ensure GPs and other health and social care teams are aware of hearing loss and range of local services. In particular, choice of provider and how to complain about services – e.g. lack of follow-up care and support.
 - Social services team in the council to review process for maintaining disability registers to ensure that it accurately captures everyone with a sensory impairment
 - Work to raise awareness of deaf and blind residents amongst staff across the council, NHS and other providers, to enable them to work with and understand the needs of people with sensory impairments. (A couple of training sessions have taken place in 2015/16 with social workers and the adaptation teams but should be rolled out more widely)
 - The council to review the communication skills of front line contact centre staff and consider signing up to the BSL charter
 - The Care Act 2014 requires that Deafblind people are able to access specifically trained one-to-one support workers, if they are assessed as requiring one. To address this, the council should continue to assess the need for specialist input to assessment, care planning, including staff suitably qualified to carry out complex assessments
 - Ensure that teams across the council take into account reasonable adjustments that need to be made to support people with sensory impairments. For e.g. Adjustments made to houses for people with visual impairment
 - Develop an information strategy to consider what more can be done to improve accessibility and reduce digital exclusion – allow access to information and advice service to people with sensory impairments and develop staff knowledge of how to provide information in a range of accessible formats
 - Ensure that health and social care information is accessible and aligned with the NHS England ‘ accessible information standard’

APPENDIX 1:

Ealing Vision Strategy consultation feedback report

Date: 6 December 2013 Prepared by: Phil Ambler, Thomas Pocklington Trust

Background

On 21 November 2013, a consultation event was held in Ealing to discuss issues relating to services used by people in the borough who are blind or partially sighted.

Just over 50 people attended on the day, the vast majority of whom were blind or partially sighted, and were split across six different groups. Whilst there was a mix of different ethnic backgrounds, there was limited representation for people under the age of 50 and no children were present.

The following report provides a breakdown of responses. The raw data can be viewed on request.

Due to the numbers attending and make up of the group, the issues raised may not be fully representative of the borough as a whole and should be viewed with that in mind. However, each point should be reviewed and considered as to whether further action or research needs to be taken.

Theme 1: Promoting eye health and preventing sight loss

- 1.1 There was a large discussion around engagement with GPs and their awareness judging by the majority of comments on this theme. This is likely due to the high proportion of those attending who have been living with sight loss for many years.
- 1.2 There was a strong sense that GPs need improved awareness on sight loss and how to best meet the needs of a patient who is blind or partially sighted.
- 1.3 Recommendations were made about provision of disability awareness training to GPs and reception staff.
- 1.4 More was felt needed to be done to promote awareness of sight loss to the general public. A lack of available information about eye health in Ealing was cited and the need to promote amongst specific communities (note – communities not identified).
- 1.5 A suggestion was made to use Ealing Health Trainers to spot issues early to help improve prevention.

Theme 2: Diagnosis and treatment

- 2.1 It was felt that good information is provided at point of diagnosis and this is followed up with good written information.
- 2.2 One group reported that waiting times were good whilst other groups reported long waiting times of on average of up to four hours.
- 2.3 Communication between services was indicated as being poor leading from the optometrist to the eye clinic, then on to the sensory service team. Time between diagnosis and treatment/support was cited as a concern.

- 2.4 People reported that accessing hospital was difficult with transport being highlighted as an issue by one group. A suggestion was made of providing community services to address this need.

Theme 3: Follow on services and support

- 3.1 The local voluntary sector was recognised as providing good levels of support.
- 3.2 Several concerns were raised about the considerable length of time some people had to wait for rehabilitation services to be provided.
- 3.3 There was a positive comment about changes made whereby patients can now access services themselves, which previously required social worker's 'permission'.
- 3.4 One group advised that the eye clinic liaison officer (ECLO) service works well. (Note: current ECLO has resigned, but the post is still in place)
- 3.5 Having everything in one building at Ealing Council was commended as good practice.
- 3.6 Some people are unaware of what follow on services and support is available for them and there is no clear path to services.
- 3.7 People said there is a lack of mobility training, difficulties getting the right equipment and support in using it.
- 3.8 People would welcome more social activities for both younger and older age groups as this is felt to be lacking in Ealing.

Theme 4: Independent living

- 4.1 Shopping in stores such as Morrisons and Sainsburys was thought to be good in terms of accessibility, especially where some stores now have lifts. Ealing Broadway shopping centre was felt to be generally accessible.
- 4.2 Ealing Broadway itself, particularly around the station, was felt to be very inaccessible for blind and partially sighted people, with one table describing it as a 'death trap'.
- 4.3 The condition of pavements across the borough was raised as an issue with blind and partially sighted residents at risk of tripping and falling, where there were uneven surfaces and potholes, especially in icy conditions. It was noted that there is good tactile paving in Ealing.
- 4.4 Overhanging trees and 'obstacles' at head height were mentioned as issues.
- 4.5 Housing was seen to be an issue for some groups. Housing associations are seen to have no experience of sight loss issues. More work could be done in considering adaptable changes which can be made in houses, such as improved lighting for example.
- 4.6 There were several issues reported about buses and bus drivers. In particular, reference was made to bus drivers pulling up too far away from the kerb or opening doors opposite obstacles such as trees or lampposts, which people walk in to. Bus drivers did not always lower the ramp.
- 4.7 Whilst some people felt that Dial-a-ride provides a good service, others felt that it was unreliable.

- 4.8 Taxis were a problem for some. It was said that some taxis did not take Taxi Cards and some taxis had problems with taking guide dogs.
- 4.9 One group highlighted issues around lack of provision in the area for activities for young people in Ealing who are blind or partially sighted.