LETTERS

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THE WASTE IN NHS SIGHT TESTS

Ophthalmologists should be active in community eye care

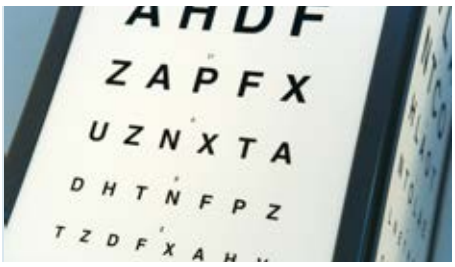
The views expressed by Clarke are his own and may not be shared by all ophthalmologists.[1]

Ophthalmologists are the only medically trained workforce with expertise in providing a holistic approach to the diagnosis and treatment, including surgery, of patients with eye diseases. However, the contribution that optometrists and GPs make to looking after the basic eye health needs of the population should not be underestimated.

Capacity within eye departments is seriously limited. An ageing population and newer treatments becoming available through advances in medicine and surgery and approval by the National Institute for Health and Care Excellence are putting immense pressure on existing capacity. Shared care programmes with optometrists, led by ophthalmologists, are one approach to dealing with this problem. There are several good examples of this across the country.

Clarke is right that inappropriate referrals can cause undue expense, be stressful to patients, and overload hospital eye clinics.[1] The answer lies in continuing education, training, and feedback to optometrists while providing an ophthalmologist led service. A joint endeavour to reduce the number of "unnecessary" referrals and constructive use of the optometrist workforce is the way forward.

The Royal College of Ophthalmologists is worried about the restricted practice in appointments to local eye health networks (LEHNs), the governance structure of these bodies, and the trend towards awarding eye healthcare contracts without the involvement of ophthalmologists. It must be recognised by all concerned that eye healthcare is not just about primary care. LEHNs and commissioning groups should include ophthalmologists in planning eye care services.



If we keep the patient's best interest at the centre, then all else will fall into place.

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Full response at: www.bmj.com/content/348/bmj.g2084/rr/693299.

1 Clarke M. NHS sight tests include unevaluated screening examinations that lead to waste. *BMJ* 2014;348:g2084. (19 March.)

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Bringing optometrists into the NHS would contain referrals

We agree with Clarke that current screening for intraocular pressure (IOP) would fail the Wilson criteria owing to high false positive rates for pneumatic tonometry as much as cost effectiveness.[1] In Oxfordshire (2013), 141/182 patients (77%) with raised IOP on pneumatic testing were normal when re-checked by applanation tonometry, and similar data are available from elsewhere.[2] Before the 2009 National Institute for Health and Care Excellence guidelines,[3] only 20% false positives were found in one hospital outpatient department.[4]

Perhaps optometrists exercised more professional judgment then, whereas now their professional bodies mandate adherence to NICE guidelines,[5] accepting that many patients will be normal but ignoring the opportunity costs. There is also inequity—opportunistic screening tends to omit those with physical disability or lower socioeconomic standing.

We should not blame optometrists. The government expects skilled professionals in high cost premises to provide expert examinations, yet the fee (£20.90; €25.50; $35.13) is derisory and requires profits from sales to subsidise these examinations. The prescribing and dispensing of drugs are financially separated for good reasons, but the same logic is not applied to lenses. If the government wants to contain escalating referrals, it should bring optometrists into the NHS culturally (with shared clinical protocols) and financially (with budgetary responsibility), divorcing the sale of spectacles from the aim of optimising eye health with finite resources.

We risk unintended consequences from a simple linear response to a complex challenge, and so must develop a system in which all professionals play their part. Despite little or no recompense, many clinicians have created admirable schemes where optometrists are key players in integrated services. However, while large chains of opticians can lobby parliament, it will take political bravery to change this national contract; but we ask that politicians join in. Is anyone for evidence based government?

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Author's reply

The number of responses to my article, on *The BMJ*'s website and on social media, shows that the problem of ophthalmology referrals is important and needs to be dealt with by commissioners and those responsible for screening within the NHS.

Fundamentally, the arrangements for the provision and remuneration of optometry services in the UK encourage opportunistic screening, which has not been evaluated in terms of public health benefit.

Shah and colleagues make the important point that, if this situation is to change, optometrists need to be brought culturally and financially into the NHS. This is, in my view, unlikely to occur as a result of government intervention, and I would suggest that clinical commissioning groups and NHS England need to hold the optometric profession to account for the use of NHS resources generated by tests performed in optometric practice.

Dua comments on the failure of many local eye health networks (LEHNs) to engage constructively with ophthalmologists, and it would be

regrettable if LEHNs became mere lobbying groups for enhanced remuneration for optometrists. There is currently an opportunity to use the professional expertise of both optometrists and ophthalmologists, acting through LEHNs, to improve the quality and efficiency of the delivery of ophthalmic services in the NHS.

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Competing interests: I am clinical director of a hospital eye department.

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NEW GROUP B MENINGOCOCCUS VACCINE

No evidence for political manipulation…

Isaacs and McVernon assert that, in recommending the introduction of Bexsero into the national immunisation programme, the UK government and its advisory committees bowed to political and public pressure.[1] There is no evidence that the scientific advisory process was subject to political manipulation. The Joint Committee on Vaccination and Immunisation (JCVI), the UK government's advisory committee on vaccines, has not performed a U turn, even if the press and some medical journals find it serves their purposes to say so. It is worrying that the relevant deliberations have been so unjustly characterised.

The committee sought and used the best available evidence on which to make its recommendation, as it was urged to do.[2-4] Of course, politicians consider the impact of their policies on voters and there is more to their decisions than scientific evidence. This is surely not unique to this particular decision.

Isaacs and McVernon also warn of the potential detrimental backlash from a public averse to even short term self limiting problems related to immunisation and further challenge the wisdom of implementing the vaccine because of uncertainties about its effectiveness. For any vaccine, full knowledge of its impact must await introduction, and until this time assessments of efficacy and safety always contain uncertainties.

Recommendations about vaccine use have often been adjusted on the basis of such knowledge. With the recommendation proposed by the JCVI's 2+1 schedule and the excellent surveillance capacity of Public Health England, final assessment of Bexsero's effectiveness and its potential for herd immunity will be definitively assessed.

There is no reason why, if adopted, this policy should not be subject to review.

JASON LEE/REUTERS/CORBIS

Meantime, there has been a need to prevent meningococcal disease through immunisation for decades, and that imperative has not changed.[5]

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Full response at: www.bmj.com/content/348/bmj.g2415/rr/693945.

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Cite this as: *BMJ* 2014;348:g2929

…or conspiracy regarding group B meningococcus vaccine

Isaacs and McVernon highlight the importance and complexity of policy decision making for a group B meningococcal vaccine based on cost effectiveness.[1]

The health economic analysis for a group B meningococcal vaccine is difficult because of uncertainties about critical parameters that determine whether the vaccine meets the required threshold for cost effectiveness. Indeed, the first health economic model made available to the independent scientific committee that advises the UK Departments of Health—the Joint Committee on Vaccination and Immunisation (JCVI)—showed that a vaccine programme for such a rare disease would be cost effective at around £10 (€12.1; $16.8) per dose.[2] Further revisions of the parameters used in the model resulted in an interim statement by the committee in July 2013, which showed that the vaccine was unlikely to be cost effective even at £0 per dose.[3]

After a period of formal stakeholder consultation, the robustness of the model was improved by including a more plausible range of incidence and updated evidence, and the JCVI found that the vaccine could be cost effective at a low vaccine price.[4] It is important to note that the stakeholder consultation was initiated by the committee to improve the robustness of the model data "before" the public outcry rather than "in response to it," as incorrectly suggested by Isaacs and McVernon.

These three iterations of the model, which were run without prejudice about the possible outcome of the analysis, consistently showed that the vaccine's cost effectiveness is borderline in the UK epidemiological setting. They do not therefore represent a major change of direction by the JCVI; the final recommendation is that the programme will be cost effective only if the Department of Health can negotiate a low vaccine price. This process is a far cry from the conspiracy proposed by Isaacs and McVernon, but it is easy to see that their speculation makes more compelling news.

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Competing interests: AJP has conducted clinical trials of capsular group B meningococcal vaccines on behalf of Oxford University funded by the Wellcome Trust, Novartis Vaccines, and Pfizer but has no personal pecuniary or other interests with any vaccine manufacturer. AR was lead editor for a Royal College of Paediatrics and Child Health eLearning package that was sponsored by Novartis. MR has no competing interests.
Full response at: www.bmj.com/content/348/bmj.g2415/rr/693907.

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