How far is it possible to measure the impact of non-medical eye clinic support services?

This publication summarises findings from research conducted by Dr Graeme Douglas, Sue Pavey, and Professor Peter Spurgeon, University of Birmingham.

The main service given to patients in hospital eye clinics is medical diagnosis, treatment, and advice by ophthalmic and optometric professionals. Patients might also receive non-medical support and advice. In some eye clinics, this type of service is formalised into an Eye Clinic Support Service (ECSS) which may be staffed by, for example, nurses, rehabilitation workers, or volunteers.

The Royal National Institute for the Blind identified a need to investigate effectiveness of eye clinic support services. Thomas Pocklington Trust commissioned the University of Birmingham to carry such a study which was independent of service providers in this field.

This study found that:

- increased speed of access to other support services and patient throughput in eye clinics are two potential measures of ECSS impact.
- despite the general view of the likely positive impact of such services, there was relatively little objective evidence identified.
- ECSSs should seek to collect more detailed records of their work.
**Project methods**

The project team took two approaches: first, professionals associated with nine different eye clinics were interviewed in England (some with developed support services, others without). People were asked what impact they thought the support services had.

Secondly, 20 people (all over 50 years of age) who had been patients in three different eye clinics were interviewed. These patients were asked what they could remember about the support services they had received.

**What is the general picture?**

The interviews based around nine eye clinics in England revealed a complex picture. The services which were contacted differed from one another greatly. In terms of how the services worked: some had clear paths of referral within the eye clinic, others not; some had clear links with a single social services department (or equivalent), others had links with many; others had links with none; some services kept detailed records, others did not.

In terms of what the services did, all provided a ‘link service’ referring patients onto others beyond the eye clinic. Some provided additional services to a greater or lesser extent (such as providing information to patients). It had been assumed that two of the eye clinics had no support service in place – even in these two cases there were some mechanisms in place for providing non-medical support, in one case quite sophisticated.

**What do the professionals think?**

The professionals’ views were brought together and summarised. Below is a list of the ways they thought ECSSs had an impact:

- **Impact upon ‘patient pathways’** – this includes the following overlapping aspects:
  - access to social services (statutory and non-statutory) through referrals;
  - prioritising patients, e.g. highlighting to social services that a patient had an urgent need;
  - increasing speed of access to a service.
• Impact within the eye clinic – this includes:
  – increased patient throughput and cost effectiveness;
  – reduction in stress and clearer professional boundaries, e.g. being able to refer a patient onto someone who is able to answer their questions;
  – indirect impact upon the broader hospital, e.g. increased awareness of visual impairment issues has led to better hospital signage, staff training.

• Direct services to patients from the ECSS – this includes:
  – provision of quality information, e.g. about the medical condition, descriptions of services such as large print books, contact details of services / groups, description of the process of registration;
  – practical help, e.g. filling in forms, phone calls, supporting statements;
  – emotional support, whilst many interviewees emphasised the ECSS did not provide a counselling service, it was commonly recognised that services offered an ‘empathetic ear’ at a time of distress and difficulty for some patients.

• Indirect services to patients, through referral to a large array of organisations, professionals, and services, e.g. social services departments, rehabilitation workers (including those with knowledge of low vision aids), employment advisers, welfare rights officers, counselling services, Macular Disease Society, talking books, and various local societies for visually impaired people.

What did patients recall about the non-medical services they received?

The patients who were interviewed were able to recall some of the non-medical support they received in eye clinics. This suggests that this may be a possible method of measuring the impact of such services.

However, patients’ recollection was not always clear. For example, patients found it difficult to distinguish the impact of the ECSS from other services such as those provided by the local society for the blind generally. Also, patients may not be aware of some of the impacts of an ECSS (e.g. they may not realise or recall a referral was made on their behalf).
Conclusions

It is useful to consider what available data currently exists.

It is generally argued that the principle of the ECSS is a good one. Indeed, this position is reflected in the many services that have developed in recent years (and particularly funded by the voluntary sector), as well as in the recently published policy document Progress in Sight (ADSS, 2002).

The study highlighted that professionals tend have a positive perception of the impact an ECSS, but it proved very difficult to generate objective evidence of such impact. This is because in the majority of cases studied, detailed records of the patients using the support service were not kept.

This suggests that a more ‘purposeful’ study would be required – that is a study which specifically sets up methods to collect data. One such method might involve the systematic collection of patient experiences and even seek to assess whether the service had impact upon patient adjustment to their condition. Importantly, it might also involve careful patient tracking in order to generate data in relation to speed of access to support systems and patient throughput in eye clinics. However, such a study would be complex and expensive.

Nevertheless, there are more immediately practical implications of this exploratory study. The clearest recommendation is that support services should seek to collect more detailed records of their work. Whilst this is by no means straightforward, it could provide extremely valuable ‘case study’ evidence.

Reference

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How to get further information

A short report, in the form of an ‘Occasional Paper’, and the full report, both titled *How far is it possible to measure the impact of non-medical eye clinic support services?* by Dr Graeme Douglas, Sue Pavey and Professor Peter Spurgeon are available from:

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**Background on Pocklington**

Thomas Pocklington Trust is the leading provider of housing, care and support services for people with sight loss in the UK. Each year we also commit around £300,000 to fund social and public health research and development projects.

Pocklington’s operations offer a range of sheltered and supported housing, residential care, respite care, day services, home care services, resource centres and community based support services.

A Positive about Disability and an Investor in People organisation, we are adopting quality assurance systems for all our services to ensure we not only maintain our quality standards, but also seek continuous improvement in line with the changing needs and expectations of our current and future service users.

We are working in partnership with local authorities, registered social landlords and other voluntary organisations to expand our range of services.

Our research and development programme aims to identify practical ways to improve the lives of people with sight loss, by improving social inclusion, independence and quality of life, improving and developing service outcome as well as focussing on public health issues.

We are also applying our research findings by way of pilot service developments to test new service models and develop best practice.