CLINICAL COUNCIL

FOR EYE HEALTH COMMISSIONING

About Us

The Clinical Council for Eye Health Commissioning aims to offer united, evidence-based clinical advice and guidance to those commissioning and delivering eye health services in England on issues where national leadership is needed.

It is convened by The Royal College of Ophthalmologists and The College of Optometrists in partnership with the following organisations:

- Association of Directors of Children's Services/ Association of Directors of Adult Social Services
- Association of British Dispensing Opticians
- British and Irish Orthoptic Society
- Faculty of Public Health
- International Glaucoma Association
- Local Optical Committee Support Unit
- Macular Society
- Optical Confederation
- Royal College of General Practitioners
- Royal College of Nursing (ophthalmic section)
- Third Sector (represented by Royal National Institute of Blind People)
- VISION 2020 UK

The Clinical Council for Eye Health Commissioning would also like to thank the UK Vision Strategy for their contributions to this response.

Preface

The NHS eye health service covers all aspects related to the well-being of the eyes with the aim of preservation of vision, the correction of sight and assisting those with vision impairment in the context of the patient as an individual and not just the eye as an organ. Its remit includes the prevention of eye disease, primary care in the community, hospital specialist treatment and interventions, rehabilitation, care and support for the visually impaired and severely visually impaired so that all those in the pathway may live their lives gainfully and independently with dignity and confidence.

The range of services is wide and includes screening, case finding and early diagnosis of conditions to prevent visual impairment, prescription and provision of spectacles and/or contact lenses for the correction of refractive error; diagnosis and management of common and urgent eye conditions; specialised tests, treatments and interventions including surgery for the management of routine and complex eye diseases; provision of vision aids and other support to those with sight loss; and social inclusion and care as determined by individual circumstances.

The workforce delivering the eye health service is wide ranging and supports the various activities covered. This includes general practitioners, optometrists, orthoptists, ophthalmic nurses, dispensing opticians (including low vision opticians and contact lens opticians), ophthalmic medical practitioners, ophthalmologists, regional and national vision charities, patient support groups, social workers and carers and a host of individuals with special skills involved in the care of the visually impaired and severely visually impaired people.

Eye health services are delivered in a variety of premises in different locations in community settings such as community optical practices, general practitioner surgeries, and community centres; in hospitals, specialist centres and in patients' homes. The patients needing and accessing eye health services are of all genders and age, of diverse socioeconomic status and ethnicity, of different cultural and religious backgrounds.

In recent times a distinct stream of cosmetic intervention-related eye health services have emerged, which for administrative, planning and other reasons should only be included in the Call to Action because they impact on the mainstream eye health services for example in the treatment of adverse consequences and complications resulting from such activity.

Fundamental to the development of an efficient, cost effective, fit for purpose eye health service is acceptance and recognition that the entire range of services and the entire workforce, working in all locations, must be integrated horizontally and

vertically in the service of all patient categories with the patients' best interest at the core of the system. Integration does not mean being employed by the same employer, but it is about aligning the incentives in the system to deliver better outcomes.

The eye health service in all its facets must be underpinned by principles of clinical governance, continued professional training, education and development, research and audit, efficient communication and patient input and feedback. All individuals in the workforce should be given the opportunity to enhance skills and acquire competencies to contribute towards these common goals. Services should be delivered by the most appropriate professional in the most appropriate place so as to ensure quality, safety, timely access to services and cost effectiveness.

All of the requirements and recommendations apply to all eye health professionals and other providers of services whether in the NHS or private sector.

All the recommendations in this consultation response are aligned to the UK Vision Strategy. The UK Vision Strategy provides a framework for change and was produced following consultation with over 650 eye health and sight loss organisations and stakeholders.

Key Points

Key Points Summary

- Improve IT links across all sites where eye care is delivered (community optical practices, GP surgeries, community care centres, and hospitals) and the wider NHS and primary care to facilitate efficient and secure communication and sharing of patient information

- Address capacity issues in the pathway to save patients from unnecessary blindness and vision impairment

- Maximise the use of the skills in the eye care pathway by ensuring that patients are treated in the appropriate place by the appropriate professional at the appropriate time, whether in the community or in the hospital

- Restructuring of hospital and community delivery of services should ensure reduction in procurement and delivery costs whilst preserving quality. Savings should be reinvested in clinical care

- Improve communication and relationships between the multiple professions through better commissioning to achieve a more integrated eye care pathway and better patient care

Essential to improving eye health and reducing sight loss is the improvement of information technology (IT) in eye care. IT links between community optical practices and the rest of the NHS and primary care as well as improved systems in hospitals are key to improving care, outcomes and NHS efficiency not least through strengthening clinical performance through peer review. Improved IT will also enable the collection and effective use of data for epidemiological analysis, public health, service planning and research and will support patient information and participation.

The current lack of capacity in the hospital eye services must be addressed through effective eye care pathways into *and out* of hospital, ensuring that available capacity in primary care is used where appropriate. These pathways should maximise the professional skills currently available (be they held by ophthalmologists, GPs with special interests, optometrists, community nurses, pharmacists, opticians or orthoptists). Patient safety and outcomes in these pathways should be safeguarded by good clinical governance and enhanced training for clinicians where necessary, both requiring financial investment.

Financial investment

1. How can we secure the best value for the financial investment that the NHS makes in eye health services?

Eye health services should aim to minimise preventable sight loss, support those with unavoidable vision impairment, correct refractive error, and preserve or restore sight where possible, enabling people to live their lives as fully and independently as possible.

Eye health should not be considered in isolation of wider health and well-being. Public health has a key role in ensuring this through its role in Local Authorities, CCGs, Health and Wellbeing Boards, and working with Local Eye Health Networks; by providing objective dialogue and interpretation of eye health needs, information and intelligence in the context of broader population health and public health interventions for health improvement

Securing the best value for financial investment means that sight is preserved where possible, and that people are able to care for themselves, in their own home, for as long as possible. Loss of vision can contribute to depression[1], falls among the elderly[2] and can hinder a person's ability to look after themselves. Preventing sight loss significantly improves the quality of life of those who might otherwise be affected by the negative impact of visual impairment, providing the best value for financial investment in health and social care. Integrated working between health and social care supports the best use of resources as well as supporting patients and people to have better outcomes. Integrated systems between health and social care are essential.

When commissioning, clinical commissioning groups (CCGs) should ensure they commission a whole service which includes greater integration of, primary, secondary and tertiary care, supported by public health. Local Eye Health Networks (LEHNs) should have fully representative membership to enable them to act as a support to CCGs to ensure joined up commissioning. Consideration should also be given to how LEHNs may start to take a greater role in the commissioning process.

Best value is achieved when patients are seen in the appropriate place by the appropriate professional at the appropriate time, whether in the community or in the hospital. Practitioners therefore need to be suitably trained and experienced wherever they work in the system. The practitioners deployed should be the most effective and cost effective mix of ophthalmologists, orthoptists, optometrists, ophthalmic nurses, opticians and GPs with a special interest.

Services should be commissioned from, and coordinated across, all relevant agencies encompassing the whole eye health and care pathway[3,4]. This should be done with direct input and discussion with people with eye health issues, sight impairment and sight loss, and underpinned by standards for professional practice skills, competencies and accountability within the health and care systems[5].

Taking a step back, we also need to have an accurate understanding of the needs the system is trying to meet. In order to plan effective and appropriate eye care services to meet the needs of the population, we need appropriate epidemiological data. As a first step the existing data in the General Ophthalmic Services payments systems and hospital clinical systems needs to be collated and used, rather than discarded as currently happens.

Eye health does not have a high enough profile within the NHS. There is a need for national level leadership. National leadership will help to bring all the disparate groups together in order to make an integrated service that functions efficiently. The Clinical Council is ready to take on this role in partnership with NHS England at national level working with Local Eye Health Networks at local level. The Clinical Council would invite NHS England to use this body in the first instance for any advice on work plans resulting from the Call to Action.

Pathways, prevention and integrated services

2. How can we encourage a more preventative approach to eye disease to reduce the burden of blindness and vision impairment?

Secondary prevention: early detection of disease

Population-based screening

- Children : The UK National Screening Committee's (NSC) policy recommendation (December 2013) for a systematic population screening programme for vision defects in children, aged between 4 and 5 years, offered by an orthoptic-led service, should be implemented[6]. Implementation of a national programme could be readily supported by robust high level indicators such as population coverage of the screening programme; proportions offered

screening; proportion taking up screening offer, without posing great additional burden for data collection.

- Diabetic Retinopathy Screening - The national diabetic retinopathy screening programme was established in England in 2006, with supporting national quality standards and tools for implementation. Variation in coverage of the screening service exists[7], and the underlying causes for this should form the basis of regular local review and action, together with monitoring of its quality assurance and outcomes of referral for specialist care. The NSC shall be reviewing the current screening intervals and its recommendations when published should be implemented in full.

- Other conditions - Any new population-based screening activities for other eye conditions should be evidence-based and only be introduced with the approval and support of the NSC."

Capacity

We can encourage a more preventative approach to eye disease by ensuring that patients are seen in a timely fashion, which means easing capacity. Capacity issues in hospital eye clinics must be addressed to save patients from unnecessary sight loss and vision impairment. Eye clinics across England are struggling to meet demand and are insufficiently resourced. Hospital eye units are already missing key targets, meaning that people are not, for example, receiving injections to treat AMD to preserve their sight [8]. Long acting treatments for AMD are many years away and demand for this service is increasing - so something must be done to avert this capacity crisis. Improved community services should be geared to improving patient flows through the pathway and to make better use of the skills in the community ensuring that the right patients are seen in hospital eye services and only when required.

The intention is to manage capacity, for patients to be seen on time, and for follow ups not to be delayed by capacity issues. The target outcomes are more manageable waiting lists. Savings in the hospital system are likely to be achieved through well designed and commissioned pathways that focus on quality and manage the workload in the most effective way for the local population, conditions and resources. Technology advances and better treatments have increased the demand for treatment for some eye conditions, such as age-related macular degeneration (AMD) and diabetic maculopathy. This increase in work-load for the hospital eye service has not been met by an increase in capacity, even when

departments have made innovative uses of mobile units[9] or of working in multi disciplinary teams with nurses, optometrists and orthoptists. The chronic conditions, especially AMD, glaucoma and diabetic eye disease, lead to capacity issues due to long-term follow up measures being required for patients. While there is a referral-to-treatment target (18 weeks) for new referrals, and NICE guidelines for the review of patients with glaucoma, there is no such protocol for other follow-up patients. There is a very real danger that unnecessary delays in follow-up appointments will lead to preventable sight loss[10].

Hospital eye services should be places to treat patients with acute conditions, but the current eye care pathway means that hospital eye services must also treat those with long term conditions which have reached a stable or low risk state (such as stable glaucoma) because there is no other mechanism to monitor these patients. If we want to encourage a preventative approach to eye disease, we must ease the pressure on hospital eye units and allow them to focus on delivering sight saving treatments for acute and active conditions and monitoring long term or stable conditions where needed. A clinically (normally ophthalmology) led service, with trained clinicians (optometrists, orthoptists, ophthalmic nurses, opticians, etc) and good clinical governance can manage long term conditions outside the hospital safely and effectively[11,12].

To bolster the evidence on co-management schemes, services such as these should be further commissioned as pilot programs on a scale large enough to yield data on their effectiveness. Such services must be commissioned with the active engagement of all relevant professional and patient groups. NHS England should encourage CCGs to produce local eye health commissioning plans by March 2016 that are agreed by the local Area Team and subsequently the Board of NHS England. These plans should be co-commissioned with other CCGs to cover the catchment area of Trusts supported by their LEHNs, front line staff working in local eye clinics, patients and the public, the voluntary sector and other stakeholders in each area.

<u>Data</u>

There is an urgent need for better prevalence and incidence data relating to eye conditions. This crucial evidence will help commissioners understand local demand for eye care and identify any unmet need. (See our response to question six for further information.) Without high quality data, developing innovative approaches to preventing sight loss will be severely hampered.

To be effective, the plans to encourage a more preventative approach to eye disease to reduce the burden of blindness and vision impairment should:

- Review local needs (based on prevalence and incidence data including information contained within the local Joint Strategic Needs Assessments), particularly for at risk groups such as children in special schools, adults with learning disabilities, people living in deprived communities, African-Caribbean and South Asian Ethnic groups, people living with dementia and seldom heard groups such as homeless people.

- Ensure eye clinics are adequately resourced to meet service demand now and in the future.

- Ensure patient pathways are fit for purpose and include rapid referral systems (where relevant), access to Eye Clinic Liaison Officer (ECLO) services (please see question three for further information), and Certificates of Visual Impairment.

- Ensure CCGs and providers have clear, systematic processes for ensuring patient input to commissioning decisions, collecting patient feedback and collecting data to enable effective monitoring and reporting of outcomes.

- Adhere to national standards and guidelines - including national screening committee (see appendix A) NICE guidance - to reduce variations in accessing rapid diagnosis, high quality services, low vision services and social care. This will help reduce the postcode lottery for eye care which patients currently face.

- Support and promote implementation of the UK Vision Strategy and progress towards achieving its objectives for preventing sight loss and improving population eye health.

Raise general awareness among health and social care staff, and all community health care workers of the link between eye health and general health (see question four).

3. How do we encourage individuals to develop personal responsibility for their eye health and sight?

Properly evaluated public health campaigns are required to raise awareness of the need to look after eye health and to inform the public that sight tests can identify early stage eye disease, which can often be effectively treated. Currently, the sight test is perceived by many members of the public as only identifying refractive error followed by the supply of spectacles and not for identifying other causes of preventable sight loss.[13,14] Campaigns should be targeted at specific high risk groups, highlighting the links between sight loss and other public health issues such diabetes, smoking and falls (e.g. the link between smoking and developing wet AMD is as strong as the link between smoking and lung cancer[15]).

These public health messages should be supported and reinforced by local eye health providers including optometrists, opticians, ophthalmologists, orthoptists, GPs, vision screeners, school nurses, pharmacists and the voluntary sector. The campaign should also offer targeted messages to at risk groups and those who care for them (i.e. people from BME groups, people in care homes, and the professionals and family members who provide care to people with learning disabilities, stroke or dementia). Efforts should also be made to raise awareness of entitlements in relation to NHS funded sight tests and support to cover the cost of spectacles.
It is essential that eye health services are easy for people to access if we are to encourage individuals to develop personal responsibility for their eye health and sight. This is why it is essential to promote understanding and knowledge of optical practices as a core part of NHS primary care. Also, where necessary, new service models may be required to improve access and uptake in areas where there is a scarcity of provision.

A large proportion of patients attending hospital eye services would be classed as “at risk”. Augmenting hospital optometry services would enable opportunistic testing of this group of individuals which include a fair proportion of children.

Awareness campaigns are important, but more work needs to be done with patient groups and the wider public to understand their views on how individuals can be encouraged to develop personal responsibility for their own eye health and sight and the health of the eyes of their children and extended family. NHS England should work with Public Health England to undertake a public facing campaign to raise awareness of eye health.

An effective way to improve people’s responsibility for their own eye health could be to deliver appropriate education from an early age[16].Through better public education we now have a reasonable level of awareness about the dangers of sun with regard

to skin cancer, and we should aim to achieve the same level of awareness of the dangers relating to eye health from smoking, diabetes (related to obesity), and UV light –plus awareness of genetic factors.

Once eye disease has been identified and visual loss is anticipated or present, ECLOs are extremely useful in helping people understand how to care for themselves and protect their sight after a diagnosis. ECLOs play an essential role in providing practical and emotional support to people recently diagnosed with a sight condition. They help patients and carers understand the eye condition and their treatment, and link patients to support in the community including local patient groups and social care services (i.e. integrating services). They also have the time to spend with patients and carers following the ophthalmology consultation, which in turn helps to free clinicians' time so they can focus on treating patients.

There could be a greater role for ECLOs in both the hospital and community settings and this role should be standardised[17]. Further, we believe that every eye clinic in England should have access to an effective ECLO service and that ECLOs should be part of every eye care pathway. This includes those providing specialised ophthalmology services to patients. Additionally, self care help for patients with diabetes and glaucoma should also be promoted through ECLOs, as well as through diabetic nurses and dieticians. ECLOs should work closely with their local third sector organisations, and services should be jointly funded and commissioned by CCGs and social services as a costed element of NHS Trusts' ophthalmology contracts.

As well as face to face support, patients with sight conditions also need accessible information. Under the Equality Act, both public and private sector service providers should be making information available in accessible formats for blind and partially sighted people and people with learning disabilities. Patient experience tells us that this is not always the case.

NHS England is developing an Accessible Information Standard and must make sure that when it is agreed it is implemented across the health service (i.e. in primary, secondary and specialised services as well as initiatives like the Patient Academy). CCGs must ensure that commissioning contracts require Any Qualified Providers to offer accessible information to patients in their preferred format.

4. How can we increase an understanding of eye health amongst health and social care practitioners in the wider professional network, particularly amongst those who are working with groups at higher risk of sight loss?

A number of significant UK public health challenges such as low birth weight and prematurity, dementia, diabetes, smoking, and falls in the elderly are closely linked

with eye health. There is epidemiological evidence regarding the association between sight impairing conditions and systemic diseases responsible for premature mortality so any generic public health interventions (e.g. for smoking cessation, diet, obesity, physical activity), designed to modify risk of these will also have a beneficial impact on eye health and prevention of sight loss. Raising awareness of these associations is important and necessary for aligning key messages in health education and assessment of high risk and vulnerable groups in the population.

Local and national care pathways already exist for these concerns, but eye health is often not included. We must integrate relevant eye health provisions into existing care pathways and assessment protocols. Targeting practitioners with relevant information in areas where 'at risk' populations are represented and the use of multidisciplinary teams is a must. Pharmacists, GPs, care home staff, community health workers, health visitors, vision screeners and school nurses need greater training to understand the signs and symptoms, treatments and referral pathways for the leading causes of blindness. This includes the early diagnosis and treatment of amblyopia which can have significant implication for educational attainment and social inclusion as well as being a marker for other eye health conditions.

Pathways, prevention and integrated services

5. How can we ensure that all relevant NHS services identify and address potential eye health problems for patients with long term conditions where eye health problems are a known possible outcome?

Healthcare professionals and providers of services need to understand that being fit and well can help your eyes stay healthy. Any generic public health interventions (e.g. for smoking cessation, diet, diabetes, obesity, physical activity), designed to improve general health will also have a beneficial impact on eye health and prevention of sight loss. This is also touched upon in our answer to question four.

Practically, we must ensure that eyes are part of the relevant NICE pathways, such as the recommended eye screening in the NICE pathway for diabetes and congenital abnormalities such as Down's syndrome. Currently, eye health is part of the NICE falls pathway, but does not feature in the dementia pathway or the smoking pathway (the latter despite substantial evidence linking smoking and blindess[18]). Frailty assessments[19] should also include an assessment of visual capacity as part of a patients overall health.

There should be a NICE clinical guideline and quality standard developed for diabetic eye conditions. Diabetes is one of the leading causes of blindness[20], affects the working age population and is projected to increase. Currently guidelines and

standards are planned for Glaucoma, AMD and cataract but diabetic eye conditions have been missed out.

6. How do we develop an approach to commissioning that makes the best use of the skill mix that is available in hospital and community resources?

Better quality data across eye care pathway is essential. Clinical Commissioning Groups cannot make strategic decisions on eye care or properly understand its importance when they have too little data.

Hospital episode statistics

Hospital episode statistics data represent the national record of this type of activity and are used as proxies for need, for service development and commissioning decisions. We must:

- ensure that International Classification of Diseases (ICD) and Office of Population and Census Statistics (OPCS) codes are provided for both admissions and out-patient attendances; (this is particularly important as much of eye health care is out-patient based)

- ensure quality begins at source i.e. at the hospital and individual department level, and that further measures are taken to support and facilitate the processes to affect this;

The Health and Social Care Information Centre (HSCIC) is responsible for monitoring the quality of data returns and should be commended for its recent suspension of access to Hospital Episode Statistics data due to consistent non-compliance with data quality standards by several providers.

Community eye health service data (e.g. optometrists and orthoptists)

Early interventions can improve the outcome for patients with a number of sight threatening pathologies. However at present the lack of infrastructure and connectivity leads to a degree of duplication as optometrists have almost no information about previous referrals or their outcomes. In consequence, community eye health services frequently operate in technological isolation from the rest of the NHS and care system. The lack of connectivity between primary eye care and the rest of the service builds inefficiency into the system at all points and is a major barrier to improving eye health efficiency and outcomes. Please see question 12c for further information.

Proper investment in IT would improve the quality and effectiveness of referrals from community optical practices and other primary carers by enabling electronic transfer of data and images. Funding for investment in IT and the sharing of risk needs to be resolved. Please see appendix B for more information on the benefits of an improved electronic referral and feedback system.

Certificates of Visual Impairment (CVI)

Certification of visual impairment forms an important population eye health indicator and some specific causes (diabetic retinopathy, glaucoma and AMD) are included in the Public Health Outcomes Framework.

There is an immediate risk to the ongoing data collection and collation of certifications of vision impairment, as the funding for this currently provided by charitable sources ceases in January 2015.

In the medium to longer term there is a need for mainstreaming this national data collection and its management as a national data repository e.g. by the Health and Social Care Information Centre (or equivalent) ensuring ongoing collection and availability of this data.

The importance of completing CVI forms, (where clinically relevant and in agreement with the patient) should be recognized as part of every pathway. This should not be an ad hoc process as this both connects patients to vital social care services and collects key outcomes data.

The primary purpose of CVI is to inform patients about the opportunity to avail social care and to trigger this interaction with social services. The patient has the choice to accept or decline. If the CVI forms are to become a means of gathering useful data for public health measures, a re-think on the purpose and content of the form will be needed.

National Eye Health Epidemiological Model (NEHEM)

The NEHEM was developed by the optical professions in 2008 (by means of a development grant from the Central (LOC) Fund). It filled a void in public health data for health planners, commissioners and providers and, being free and open to all, was an altruistic investment from the eye health community for the public good.

The model provides prevalence data by health and social care area for the four UK countries for cataract, glaucoma, age-related macular degeneration and low vision.

It does not include diabetic retinopathy as, at the time, the Department of Health was investing in modelling tools for diabetes and it was anticipated that these would already cover this.

The model was constructed in a transparent and dismantle-able way so that anyone using or working on it could see the evidence base used, the assumptions made and how the prevalence estimates had been built up. It was also designed to enable local commissioners to insert more up-to-date local data and model various scenarios for their own commissioning purposes.

The model has been widely used in the development of eye health assessments and equity profiles across the country. However the model now needs updating, for which funding is required.

7. Can we develop more widely the integrated role of eye health professionals in primary care in the identification and management of chronic or acute disease?

A more integrated eye care pathway including multiple professions requires improved communication and the information technology to enable it (see question six). In addition to information integration there also needs to be a culture of working as an integrated whole to look after the care of the patient.

Currently, there is no evidence on the cost effectiveness of shared care in the community. However, the capacity issues outlined in question two mean that other models of care, including shared care in the community, should be considered as part any future eye care pathway. Any changes to the current arrangement do need to be reviewed to avoid unintended consequences. Hospital tariffs are artificial constructs and loss of some more lucrative routine patients for hospitals might mean that other tariffs need adjusting if the hospital eye service department is to remain financially viable.

<u>Independent Acute Sector Units</u>

Of ongoing concern to NHS based ophthalmologists is the question of routine quality control and ‘cherry picking’ of low risk ophthalmology patients by Independent Acute Sector Providers, destabilising the tariff and making traditional NHS units unviable. Audit should be integral to service delivery by these units and it would be reasonable to expect the use of standard audit methodologies and protocols by all providers. Concerns regarding case mix have been expressed and it is of interest that the ability to risk adjust can now provide comparable outcomes from units where selection of low risk cases is thought to be occurring. Consideration should be given to more sophisticated contractual arrangements than tariffs, which are essentially an

activity based contract. Capitation, or payments based on population, may be better for patient outcomes.

The Healthcare Quality Improvement Partnership (HQIP) has funded and tasked the Royal College of Ophthalmologists to develop a national database to audit cataract surgery. All providers of cataract treatment to the NHS are expected to participate in the continuous audit. Independent sector treatment centres (ISTCs) are subject to Care Quality Commission (CQC) inspection. CQC should monitor participation in the national cataract audit during their inspections.

8. What can we do to relieve pressures in ophthalmology departments because of difficulties in discharging patients back into the community?

Pressures on hospital eye departments are immense and growing (see question two). Capacity in the hospital sector is limited both in terms of:

- workforce – current demand for specialist medical ophthalmology services is higher than supply[21] (a number of sight threatening conditions require medical intervention, which is non-surgical. Such treatment is provided by specialist ophthalmologists who are described as medical ophthalmologists);

- physical capacity – the pressures on eye units and the costs already incurred in major re-developments which will continue to constrain capacity progress for years to come.

On the other hand, the skills of optometrists, orthoptists, opticians, ophthalmic nurses and others in the community, with necessary training to up skill where appropriate, create a more flexible and ready workforce. The market system is dependent to a certain extent on surplus capacity which can be harnessed for the benefit of the NHS.

There need to be incentives for primary and secondary care (and in some cases the voluntary sector) to collaborate to deliver better integrated care. Perverse incentives should be removed. An example of a perverse incentive is where a follow up tariff is paid for patients being monitored in hospital, where the care could be delivered in primary care.

Integrated services could involve hospital based clinicians spending some of their time delivering and/or overseeing services in the community. This could apply not only to ophthalmologists, but also to clinicians such as orthoptists, ophthalmic nurses, opticians and optometrists with higher qualifications and specialist skills gained in the hospital environment.

A clinically (usually ophthalmologist) led model with robust clinical governance and increased training as required for optometrists, orthoptists, and ophthalmic nurses would enable patients to be safely discharged from hospital into appropriate community schemes for management and monitoring. Increased training should be provided through a universally recognised national system of further qualifications for each profession to provide assurance to both the patient and the clinician discharging the patient (usually an ophthalmologist). A universally recognised national scheme for each profession would also provide a standard level of competencies across England, reducing variation by post code as well as making the qualification portable. Importantly, such a system would save time and resources locally, by removing the current scope for the repeated creation, operation and maintenance of multiple local variations of this, which is inefficient, inconsistent and illogical. The skills and competences of all professionals must be kept up-to-date. It will be of no use to the NHS if patients are inappropriately discharged or have to be referred back because of lack of services or skills in the community.

Telemedicine should also be considered as part of integrated services. Applications for use include image capture and transfer for diagnosis, monitoring of ongoing conditions (e.g. glaucoma, retinopathy, AMD screening), and ophthalmologist support to other clinicians. The solution here is, once again, IT connectivity and capacity. However, further research into the quality and patient safety implications of remote eye care is required[22,23.]

Access

9. How can we appropriately increase access and uptake of timely routine sight tests for the general population, including for people at higher risk?

In order to appropriately increase access to routine sight tests for the general population, including for people at higher risk, we must ensure that high quality eye care is easily accessible to all; in ways, locations and at times that suit the patient.

The majority of optical practices are open Monday to Saturday, with many open evenings and/or Sundays and they are generally well located for public transport links and have access to parking.

Work needs to be done to ensure GOS is universally accessible to groups who have particular needs (see our response to Question ten), possibly through Level 3 – enhanced services (now known as community services) as they were originally intended to be deployed.
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- A national service should be commissioned to ensure people with learning disabilities have universal access to GOS[24].

- A national service should also be commissioned to make GOS more accessible for children in special schools or those with special educational needs. Access to GOS for this group could be simplified by designating schools for children with special needs as “Day Centres”.

- Some flexibility is required to improve access to GOS for homeless people, gypsies, travellers and sex workers.

- ‘At risk’ groups who are not currently entitled to an NHS funded sight test such as people of African, Afro-Caribbean and South East Asian descent who are under 60 should be targeted.

Although all community optical practices provide NHS sight tests and high quality spectacles within NHS voucher values, the challenge is to encourage those at risk or outside the system to take up the service. These do not need to be in traditional premises (although this is desirable because of the higher standards of equipment) but outreach services can be provided in church halls, schools, mobile units and other community facilities as they are, for example, in some parts of Scotland and other rural areas. Also, flexibility regarding the location and type of premises may help to make the sight test more accessible[25].

CCGs, through their Local Eye Health Networks, should identify need and consider where such services might be commissioned and establish pilots to assess whether improved access, better eye health and identification of higher levels of preventable sight loss are achieved. NHS England can designate any premises as GOS premises for these purposes and, with appropriate local leadership and encouragement, many high street practices will be willing to provide outreach services on this basis. In some cases it might be sensible to co-locate sight testing and case-finding services in GP practices or other health care facilities.
The current NHS sight testing service is heavily subsidised by the sale of spectacles, contact lenses and other optical products. Without significant public investment, this is likely to remain the case for the foreseeable future. However the business model that has accrued as a result of the need for subsidy of optical services by providers may inhibit some patients, especially those on low incomes, from accessing the service even though the service and spectacles are free to eligible groups. As above, Local Eye Health Networks should consider these issues and work with the Local Optical Committee and other eye care providers to see how they could be addressed.

LEHN should consider what role they have to play in their local area to increase access.

10. How can we improve timely access to eye health treatments and sight loss services for vulnerable or seldom heard groups?

There exists in eye care an established primary care (optometric and GP) service providing opportunistic case detection of disease (early stages or otherwise) and primary prevention through health education on modifiable risk factors. Making better use of this service, informed by epidemiological evidence on high risk groups (including vulnerable groups such as older people in care homes, those with learning disabilities etc.), for more consistent, targeted availability of these primary care services, would improve quality of care and patient experience, contribute to preventing sight loss and raise public awareness.

There are estimated to be over one million people in the UK with a learning disability. People with learning disabilities may not know they have a sight problem and may not be able to tell people. Adults with learning disabilities are 10 times more likely to be blind or partially sighted than the general population. An estimated 96,500 adults with learning disabilities (including 42,000 known to the statutory services) are blind or partially sighted. Six in 10 people with learning disabilities need spectacles and often need support to get used to them. Because people with a learning disability are less likely to report problems, it is particularly important they are monitored on a regular basis, including a sight test. Much like with people with a physical disability who find it difficult to travel, those with learning disability may be more comfortable being examined in familiar surroundings[26]. The use of home visits for this group of the population may be helpful in picking up problems earlier and providing a more accessible service. It would also be advisable to ensure that national screening committee recommendations for school screening are followed (see Appendix A).

Carers and relatives as well as other health professionals like GPs, community nurses and social workers are more likely to come into contact with this group. Raising their awareness and educating them to help them recognise that the effects of sight loss could prompt increased and timelier referral to eye services. This could be accomplished by allocating more time for eye health into the undergraduate medical curriculum and the nursing curriculum.

User involvement

11. How do we best involve service users and their carers in the development, design and delivery of NHS services for eye health?

We suggest that when considering the voice of service users and their carers (where relevant) in the development, design and delivery of NHS services for eye health it is important to engage with three main groups; people with eye conditions living with sight loss and their carers (if relevant), people attending hospital clinics/receiving treatment for eye conditions (but not visually impaired) and the wider public who have accessed, or may need to access, eye health services. LEHNs have a leadership role to support the involvement of service users and their carers as well.

It is important to work with patient groups set up by charities supporting patients with particular eye conditions and/or sight loss. Examples are the Macular Society, International Glaucoma Association, RNIB, Seeability, Childhood Eye Cancer Trust, Fight for Sight and Guide Dogs. It is also important for CCGs to engage patient representatives of both national and local societies in their area.

Local Healthwatch has a key role to play as have patient advisory groups that many CCGs have set up.

An important consideration when consulting patients with sight loss is how information is presented, to ensure it is in an accessible format. Patients should be asked which format they prefer to receive information in.

Low vision services need to integrate well with other eye care services. The majority of low vision patients are referred into the service as part of their treatment for an underlying eye condition, such as AMD, glaucoma or diabetic retinopathy. However, integration needs to be much broader than that. People may be referred to low vision services by optometrists, GPs, social workers, rehabilitation workers and others. Furthermore, it is very common for people with low vision to have other long term conditions or disabilities. Well integrated services should consider the connections between those other conditions and vision. For example, there are low vision devices to help people with diabetes to measure their blood sugar levels and draw up their insulin. If someone has a visual impairment as a result of another medical condition (e.g. stroke) the use of low vision aids and adaptation may assist with their rehabilitation. Sight loss is one of the major causes of falls so low vision services should integrate with falls prevention services[27]. Learning disability health facilitation teams can help raise awareness of sight loss issues and help integrate services[28].

An important aspect of low vision services, particularly in the hospital setting, is the availability of an ECLO (see question three).

Correspondence from the low vision service should be shared with the service user but also with other teams involved in their care (such as the GP, falls team, visual impairment specialist in social services, care teams within the voluntary sector, specialist education services) and vice versa.

Helping carers to understand the patient's eye condition and its impact on vision and lifestyle can also be valuable and carers themselves may need emotional support. This can be provided as part of a low vision service.

All patients and carers should have the opportunity to discuss their diagnosis, prognosis and treatment. They should be provided with information on their condition, its implications and prognosis for their vision. Patients should also be told about the timeframes in which they should be treated, plus what to expect at every stage of their journey. For glaucoma patients, they should understand the importance of adherence with eye drop use, potential side effects and the need for lifelong monitoring. At risk family members may wish to be tested and should be advised accordingly. Written and face-to-face information regarding quality of life should be provided and patients should be made aware of available support including sight loss services, ECLO services, mental health services and carers' groups. Health care professionals should be familiar with latest DVLA guidance and must advise patients to contact the DVLA when appropriate.

If possible, patients should be treated at a place convenient for them. Health professionals should be aware of factors which could prevent patients with ocular hypertension or chronic open angle glaucoma seeking care including patients fearing what they may find out, stigma surrounding hereditary sight threatening conditions, cultural issues and perceived costs of sight tests.

Given that more than half of glaucoma cases are undetected in the community, there is a need for NHS staff including GP nurses and/or receptionists to remind patients and family members about their need and the conditions under which some are eligible for regular free NHS sight tests.

12. In stimulating debate about the potential for transferring more elements of eye care from hospitals to the community we want your views on:

a) What is the evidence base to support the suggestion that providing more eye care in the community will prevent eye disease and reduce unnecessary expenditure elsewhere in the health and social care system?

When considering the evidence base for community eye care services it is important to look at the success of services that have already been commissioned by many CCGs in England to better utilise the skills of community optometrists and opticians. We should also learn from the success of models of primary eye care services that have been implemented in Scotland and Wales.

Local variation of services in England means that where evidence exists of effective eye care in the community, the evidence refers to individual schemes of modest size. However, while it is acknowledged that more should be done to expand the evidence base for the efficacy and cost-effectiveness of these schemes (and research has been commissioned and funded by organisations in the sector[29]), there are examples of effective eye care in the community.

It is extremely important to acknowledge the value of services that reduce the volume of unnecessary referrals to secondary care as well as considering pathways and services that enable the transfer of more elements of eye care from hospitals to the community. There is an evidence base to support the commissioning of community services for minor eye conditions, glaucoma repeat readings, cataract referral refinement and post operative assessment, and low vision, all of which utilise core skills of optometrists and opticians (see appendix C). There is some evidence to support the commissioning of Ocular Hypertension Monitoring. Unpublished data from various schemes also exists within the sector[30].

A major disadvantage of commissioning community eye services at CCG level is that this fosters fragmentation. Evidence of successful community services from around the country should be the basis of future services, which should be up-scaled appropriately to reduce procurement and commissioning costs and direct more resource to clinical care.

In addition to services that utilise the core competencies of optometrists and opticians a number of different models of shared care glaucoma monitoring have been trialled and implemented in some areas. However there is minimal data available from the commissioned services. For instance, the Cambridge community Optometry Glaucoma Scheme is a community based glaucoma screening program and it has been found to be a safe and effective way of evaluating glaucoma referrals in the community and reducing false positive referrals for glaucoma into the hospital system[31].

In order to create more capacity in the hospital system, the parts of the eye care pathway which can be delivered safely in the community should be delivered in the community with the appropriate clinical governance, professional oversight and assessment through pilots.
Local schemes foster fragmentation and consideration should be given to a service which covers a large population. Several pieces of ophthalmic diagnostic equipment are required to deliver an efficient service. Installation of such equipment at multiple sites would require a balance between usage and cost.

Two way communications (upstream and downstream) among all components of the pathway is extremely important. This should relate to quality and outcome of referrals, which in turn would inform audit. Anecdotal evidence from Moorfields Eye Hospital at Bedford has shown that quality of referral has improved where audit and feedback has happened.

This is about access to high quality services. As identified above, the hospital eye service is over-burdened and this will only get worse with the ageing population and new technologies, but could be partly offset by improvement in quality of referrals. More care in the community will increase access – and as identified in our response to question nine – especially for at risk and seldom heard groups. These are the groups most vulnerable to eye disease therefore early intervention is essential. It is important not to lose perspective that for quality to improve the whole pathway has to be improved. For example if only community services were enhanced and capacity issues in the hospitals not addressed, patients identified with problems in the community will be denied (delayed) access to appropriate treatments that can be delivered in hospitals only.

Funded clinical leadership is required across both the hospital and community sector so that their remit covers the whole pathway. Further training and education may be needed for some professionals and the level of competence should be agreed. In some cases this may require optometrists, opticians, orthoptists or GPs with a special interest (GPSIs) acquiring appropriate and enhanced education and training including acquiring higher qualifications where appropriate, to diagnose, treat and manage patients within competencies. Working closely with community ophthalmologists would augment delivery of community care and reduce risk to patients.

As in all clinical services, the key issue is to ensure that standards are measured through clinical governance and audit in any appropriate contract. To maintain public trust and confidence and for quality assurance all schemes need to be externally assessed and monitored, appropriate to the level of clinical work undertaken in those premises. Currently optometry practices are not subject to CQC inspection but have other inspection procedures in place. All such monitoring should be standardised and transparent and outcomes published in the public domain. Such inspections should cover the entire pathway and not just individual components. We also must ensure appropriate volumes of patients to maintain clinical skills, effective use of investment in capital and supporting consultant advice when required.

While there is evidence of high patient satisfaction with services out-of-hospital, there is only limited evidence on their cost effectiveness. It is essential therefore that they are planned as part of joined-up local thinking across the hospital and community sector. This requires a transformation in clinical culture with a focus on the needs of patients and populations rather than institutions. The challenge therefore is for clinical leadership to make this happen, and sufficient and quality controls governance and audit to be put in place to guarantee patients' safety and maximise outcomes. The Clinical Council would be very keen to work with NHS England and Local Eye Health Networks/CCGs to pilot this whole system approach and to evaluate effectiveness and outcomes. Any pilots should be across large enough areas to make evidence gathering and outcomes worthwhile. Eye health services in England needs baseline data and a whole system review, not just tinkering with various schemes (refer to question six).

b) What are the workforce implications (development / re-structuring / training) to ensure safe and effective services for patients, and how would these be delivered?

See question eight for further information regarding training.

One of the benefits which operate in favour of eye health is the fact that community optical practices, optometrists and dispensing opticians operate in an open market-driven system which is much more flexible than traditional institutions. This means that if there is demand, the market will respond. The challenge in moving services safely to the community is to ensure that the normal time-lags in market responses are shortened and do not inhibit necessary progress. Clarity from NHS England about the direction of travel will encourage community eye health providers (including optometrists but also ophthalmic nurses, orthoptists, and dispensing opticians) to make the necessary investments in work-force training, development and facilities to take up the demand created by system re-design.

c) What are the IT requirements to support more community care?

A key to greater efficiency, from our perspective, is for IT systems in optical practices, school health services and community eye services to be closely linked to, and ideally integrated with general medical practice and hospital systems. Communicating electronically to all clinicians involved in the patient's care should be the norm rather than the (currently) very rare exception.

Investment in IT links and information governance support for community optical practices is required to support secure and efficient exchange of data between

primary and secondary care providers and to integrate community optical practices with the NHS 'any to any' e-refer project. See question six for further information.

Data collection must be well thought through and undertaken accurately so that when data are analysed a true and representative picture of practice is formed. The results must be carefully interpreted and any changes to practice implemented with full agreement of those involved. Re-audit at a later time completes the audit cycle and should affirm adjustments to practice implemented in the earlier cycle(s).

There are four specific IT requirements that need to be addressed:

- Infrastructure - integration of optical practices in the new NHS e-Referral Service (ERS) being launched to replace the current Choose and Book service.
- Technology - ensuring each community optical practice or other primary care setting is equipped with the technology necessary for submitting General Ophthalmic Service (GOS) claims electronically to capture the epidemiological and health data claims contain and to streamline and reduce the cost to NHS England of administering claims and payments system but Secure feedback- providing an NHSmail2 account to all of the 5400 community optical practices or other primary care setting[32]. A secure system is required to transfer patient information between NHS providers.
- Connectivity - providing a suitable N3/N4 connection to each community optical practice or other primary care setting. An electronic highway compatible with the NHS is essential for allowing community eye care systems to connect to other NHS bodies.
- Governance - supporting each community optical practice or other primary care setting to become Information Governance (IG) compliant to level 2. IG compliance is an essential requirement for connecting to the NHS IT infrastructure. This should be complemented with appropriate measures to ensure compliance with confidentiality and data protection legislation.

d) What are the information requirements to support more community care?

- Provide access to NHS number

- Develop an evidence base (please see questions two and 12a)
- Update the National Eye Health Epidemiological Model (please see question six)
- Improve Certificate of Visual Impairment data (please see question six)

The NHS number should be used across all primary eye health care service providers to ensure accurate tracking of patients and eliminate duplication. Community optical practices need to be integrated with NHS IT systems to enable GOS records and claims to be automatically populated with the patient's NHS number via the "look up" system (please see question 12c).

An integrated, national system for electronic eye health records and referral data should be the ultimate objective.

e) How do we ensure timely and appropriate access to out-of-hours services?

There are issues regarding the mechanism for funding acute care. It needs to be recognised that General Ophthalmic Services (GOS) does not provide for an emergency service. Each CCG should develop a suitable out of hours and seven day care strategy and commission accordingly, working with other CCGs or NHS Local Area Teams as appropriate to reduce costs. Services provided in a community setting should be subject to the NHS standards contract. However, there are examples of innovative systems for urgent conditions:

NHS Grampian[33]

Formation of the Grampian Eye Health Network

The walk-in service at Aberdeen's eye department was increasingly being used by the public for non-urgent eye problems. The level of walk-ins was at 6,000 annually and increasing. This led to long travel times and waits for patients, a chaotic environment and specialist resources being used to treat non-urgent cases. An audit demonstrated that only 9% of patients coming to the eye department required referral to the hospital eye clinic; over 90% could have been treated by someone other than a hospital doctor.

Improvements

Following input from all stakeholders (Local Board Advisory Groups, Community Health Partnerships, Community Forums) and to enable partnership and patient involvement, the Grampian Eye Health Network was formed which includes all optometry practices in Grampian and Shetland.

A 24 hour telephone Eye Health Network Clinical Decision/Support Line was established, staffed by specialist nurses and doctors. Afternoon consultant-led eye-assessment clinics were established and optometrist-led support sessions were formed to ensure continuous learning, high quality care. Using Patient Group Directives enabled more efficient prescribing of medications.

Outcomes

- There has been a significant shift of care in to the community
- Only patients who require referral to the hospital eye clinic are booked into the eye assessment clinic
- Patients are now seen as locally as possible reducing travel time
- Lengthy waits are avoided
- NHS Scotland resources are now used more effectively

Wales's PEARS (Primary Eye care Acute Referral Scheme) Model[34]

Optometric primary care intervention service to facilitate the early assessment of acute ocular conditions.

Patients are seen within 24hrs of making an appointment and are self-referred or directed to the service by a GP. Optometrists are paid under an enhanced services contract to detect, and in some cases manage, urgent conditions. Most GPs lack the equipment, experience and skills to diagnose and treat eye conditions so taking advantage of community optometrists' expertise can enable patients to remain in primary care and potentially free up some GP resources.

Prompt, accurate diagnosis and triage are vital to minimising harm and sight loss from urgent eye conditions. They can improve the value of the pathway by separating out acute, emergency problems from comparatively simple cases. Diagnosing all but a small number of urgent conditions requires a slit lamp and the skills to use it.

The availability of slit lamps will therefore play a fundamental role in shaping local services. Expertise in the use of the slit lamp is **not** widespread outside community optometric practices and hospital eye departments; although a small number of GPs have an interest in ophthalmology and some hospital accident and emergency departments possess a slit lamp.

GPs do however provide first contact care for many urgent eye conditions without a slit lamp. Also optometrists who are not prescribers often refer patients to GPs for prescriptions. GPs have welcomed schemes that allow them to refer patients to optometrists for urgent, same day appointments rather than only having the opportunity to refer to the hospital eye service.

A facility for 24/7 access to assessment by an ophthalmologist is necessary for a small proportion of ophthalmic emergencies.

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Appendix A - Screening

Screening is an important part of reducing the burden of blindness and vision impairment. The UK National Screening Committee's policy recommendation (December 2013) for a systematic population screening programme for vision defects in children, aged between 4 and 5 years which should be offered by an orthoptic-led service should be fully implemented[6]. Implementation of a national programme could be readily supported by robust high level indicators such as population coverage of the screening programme; proportions offered screening; proportion taking up screening offer.

Further, the national diabetic retinopathy screening programme was established in England in 2006, with supporting national quality standards and tools for implementation. However, in 2011 there was considerable variation across PCTs in England in the percentage of the diabetic population receiving screening for diabetic retinopathy[35]. We feel that the current coverage levels should be reviewed and the underlying causes for any persistent variation should form the basis for immediate local action.

Glaucoma, of which chronic open angled glaucoma is the most common (COAG) is usually asymptomatic and depends on a series of optometric checks to be detected. The requirement for a National Screening Policy for Glaucoma should be reviewed. This may only apply to at risk groups (e.g. family history, Afro Caribbean etc. – no indication that this should be a generally screened condition).

The NSC shall be reviewing the screening intervals and its recommendations (due 2015) should be implemented in full.

Appendix B – Referrals

Two way communication links are currently inefficient or non-existent between ophthalmology departments, orthoptic departments, school health and optometrists. It has been shown that improving two way communication using IT services reduces waiting times and DNA rates[36]. More importantly, electronic referrals significantly improve the quality of referrals, for example those containing retinal images have been shown to reduce unnecessary consultations by 37%[36]. Another study found that the use of existing IT infrastructure improves communication between primary and secondary care[37]. This promotes more effective use of limited outpatient capacity by retaining patients with non-progressive, asymptomatic pathology in the community, whilst fast-tracking patients with sight-threatening disease.

As technological advances are made in the development of diagnostic equipment, many of these findings are no longer transferable other than electronically. This results in extra time and resources being needed in hospital clinics to undertake examinations which have often already been done in the community.

Information sharing is a two-way process. For the quality of optometry referrals and school screening to improve, the level of feedback also has to increase. In 2011 /2012 there were 6.3 million ophthalmology outpatient episodes, of these, 1.66 million were first attendances. The majority will have been referred from optometry and this represents a huge number of patients for whom current HES status and clinical outcomes are either fully or partially unknown to their original referring optometrist or dispensing optician. Studies have shown that ophthalmologists responded with feedback to the original referring optometrist in only 29% of cases, this means that the majority of new patient episodes resulted in no feedback to optometry[38]. Other studies found only 13% of referral letters received feedback[39].

Connecting optometry to the NHS would facilitate feedback to the original referring clinician (to report on outcomes or when discharging a patient) which is essential to improve the overall delivery of care to patients, and to enable a better understanding of when and what to refer to develop between community optical practices and

ophthalmology. Through ERS, major improvements to the ability to access previous referrals and their outcomes are also possible.

Additional benefits of a true two way flow of data mean it would be possible to confirm referral acceptance and to even arrange the clinic appointment for the patient in real time. This protects both the patient and the practitioner, avoids duplication and ensures patients do not fall through the cracks in the system.

The current NHS reforms have resulted in fragmentation of commissioning of primary and secondary sector eye health services, with immediate implications for care pathways and ongoing social care support.

Arrangements for an optometrist to refer a patient to hospital currently differ from one area to another, but to ensure the best use of skills in the hospital and community, optometrists should be able to direct refer to hospital. In some places, optometrists must refer to a GP, who then refers onto a hospital. This creates an unnecessary step in the process, particularly given that both optometrists and GPs have been found to have good agreement with ophthalmological diagnosis[40].

Referrals should be improved through an agreed standardised test (e.g. Perform visual fields with one type of machine and only if IOP high or optic discs cupped or if patient is symptomatic) to lower false positive and unnecessary referrals saving cost to the service.

Quick, reliable and comprehensive two way flow of referral information would

- help avoid unnecessary admissions and repeated clinical tests
- allow timely delivery of care by the most suitable means at the most cost-effective point
- avoid the risk of a referral getting delayed or lost in the postal system
- Track vulnerable and at risk children's care
- enable feedback from ophthalmology departments to community optical practices and other providers, and
- ensure patients are discharged for routine management or follow-up to the community optical practice of their choice.

Appendix C – See attachment