NHS England

# Eye Health Network for London: Achieving Better Outcomes

# Acknowledgement

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The 'Eye Health Network for London: Achieving Better Outcomes' report describes a more co-ordinated approach to the commissioning and delivery of eye health and sight loss services to support the integration between services and pathways.
It particularly focuses on Outcome 2 of the UK Vision Strategy:

***'Everyone with an eye condition receives timely treatment and, if permanent sight loss occurs, early and appropriate services and support are available and accessible to all'.***

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 London Councils, Clinical Commissioning Groups (CCGs), Health and Wellbeing Boards, and working with the Eye Health Network; 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.

Interventions and services for small or specific groups of patients, those with rare conditions, or those with ocular and systemic co-morbidity, are at particular risk of being overlooked and thereby introduce inequalities in access to health and care.

Key priority areas have been highlighted by the VISION 2020 (UK) Ophthalmic Public Health Committee (OPHC), and so will have broader recognition and implications wider than just London. They are therefore of potential importance for all the other Local Eye Health Networks in England. Special thanks are necessary to Miss Parul Desai, Ophthalmologist and Consultant in Public Health at Moorfields Eye Hospital, who chairs the OPHC and has supported this strategy report from its conception.

Specific recommendations have been developed by a number of working groups with representation from primary care and hospital clinicians, commissioners, providers from the voluntary and charitable sector, patient groups and other partners across London. Thanks are necessary to everyone involved for their time and expertise; to Poonam Sharma for her reviews, Thomas Pocklington Trust for providing data on needs assessment and user feedback; and the College of Optometrists, SeeAbility and Guide Dogs for providing the images.

Members of the working groups are listed in Appendix 2.

**This report has been endorsed by the**

CLINICAL COUNCIL

FOR EYE HEALTH COMMISSIONING

**and**

**the VISION 2020 (UK) Ophthalmic Public Health Committee**

# Contents

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| | | |
|---|---|---|
| Introduction | | 1 |
| Foreward | | 2 |
| Context | | 3 |
| Improving Eye Health and Reducing Sight Loss / Five Year Forward View | | 5 |
| London Eye Health Needs Assessment | | 6 |
| Certificate of Visual Impairment Indicator | | 7 |
| Ensuring Better Outcomes | | 8 |
| Portfolio of Indicators | | 9 |
| Key Priority Areas | | 10 |
| Community Ophthalmology Model | | 11 |
| Integrated Pathways: | Age-related Macular Degeneration | 12 |
| | Cataract | 13 |
| | Children's Screening and Paediatrics | 15 |
| | Diabetic Retinopathy | 16 |
| | Glaucoma | 17 |
| | Low Vision | 19 |
| | People with Learning Disabilities / Dementia | 21 |
| | Urgent Care | 22 |
| | Improving Communications / Referral Feedback | 23 |
| Appendix 1: Portfolio of Indicators | | 24 |
| Appendix 2: London Eye Health Network working group members | | 27 |
| Appendix 3: Abbreviations | | 28 |

# Introduction



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**David Parkins: Chair of the London Eye Health Network**

David Parkins is the President of the College of Optometrists. He is Chairman of the Clinical Council for Eye Health Commissioning and a member of the VISION 2020 (UK) Ophthalmic Public Health Committee. His previous research into 'repeat measures' in glaucoma is a NICE proven QIPP case study on NHS Evidence. Currently, he is conducting doctoral research into clinical decision making and referral practice.

The London Eye Health Network has members with a wealth of national expertise and the potential to provide a strategic co-ordinating role across our population, given the number of commissioners, providers and organisations involved in eyecare across the Capital.

The Network seeks to work with key stakeholders on the further development of this London-wide strategy so that it can be shaped to include local priorities.

The focus has to be on maintaining quality care, and reducing service variation and inequalities. Given the current capacity issues in ophthalmology, the status quo is not sustainable and new innovative models of care will need to be tested at greater scale to have maximum impact.

It will require a co-ordinated approach, and London-wide and local leadership in order to achieve the goal of improving outcomes for patients. However, *"the answer cannot be one-size-fits-all, nor is it simply to let 'a thousand flowers bloom"* (NHS Five Year Forward View, page 17).

Service redesign in isolation leads to separate clinical service specifications and fragmented pathways of care, especially when the population it serves does not fully match the Trust's area.

Expert working groups have developed recommendations for specific integrated pathways (pages 12-23). These should be used as a basis for discussion between commissioners and providers. It is not intended to 'reinvent the wheel' but rather draw on evidence and good practice across London and rest of the country. To make real progress, there will need to be clear objectives with priorities for action, and this report provides guidance on how this can be achieved.

To support this strategy, it is envisaged that Eye Health Programme Boards at Strategic Planning Group level will be required to drive these recommendations forward in line with the NHS Business Plan 2015/16 and the Five Year Forward View.

**David Parkins**
**Chair - London Eye Health Network**

# Foreword



This strategy aims to minimise sight loss and reduce health inequalities for London's population. It is about focussing on delivering better value care across all the eyecare pathways. This not only means we look after individuals better but also means we look after more people because we cut out waste, reduce variation and make the resources go further.

This is vital because the main eyecare challenges nationally are to meet the needs of an ageing population and fund the increasing use of more advanced treatments. Some hospital eye services are already nearing capacity in trying to cope with increased demand for age-related macular degeneration treatments. This will become an even greater challenge as more treatments are introduced.

Issues with quality can often stem from poor information or communication issues, or the way the pathways themselves are put together; and also, what the NHS contracts clinicians to do. In too many cases, the system forces clinicians to work in a way that is not best for patients or for taxpayers.

User feedback is important to assess whether the system is working well. Commissioners may be looking at one particular service redesign issue, when patients are more concerned that they cannot read the appointment letters due to their failing sight and consequently fail to attend their appointments.

Fragmented pathways of care are not in the best interests of the users of the service, and lead to confusion and delay. The system has to evolve so there is greater integration between community and hospital services, and again between hospital and sight loss rehabilitation services. Stroke services also need be ensure vision problems are included in the pathway.

**User feedback on eye health and sight loss services at London Vision Strategy events:**

***'The doctors are too rushed to answer questions effectively."***
***'So many different appointments are confusing - different appointments at different hospitals clashed.'***
***'System is chaotic.'***
***'If you finally get to meet a senior member of the medical team (consultant) you get the information you require, otherwise not.'***
***'Poor communication about what's happening when you're there.'***
***'I had to phone up and go back to see them for further information.'***
***'First referral lost, then I had to call again to start the ball rolling."***
***'They sent me home with no support whatsoever. I was more confused after the appointment."***
***'No one guided me or advised me on rehab issues. They were good on medical issues."***

***Thomas Pocklington Trust***

# Context

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The commissioning and delivery of eye health and sight loss services is complex; pathways cut across borough boundaries and can involve many providers in a network of care. In London, the landscape includes over 30 NHS hospital ophthalmology departments / sites, private ophthalmology providers offering NHS services, several community provider organisations and nearly 900 optical / optometry practices and nearly 900 providers holding contracts to deliver primary care domiciliary services. In addition, there are borough based social care services for people with visual impairment, and a range of charity and voluntary organisations involved in sight loss services.

Pathways rely on a multi-professional workforce, which include: optometrists, ophthalmic medical practitioners, ophthalmologists, orthoptists, ophthalmic nurses, dispensing opticians, ophthalmic technicians, and GPs with special interest. For the vast majority of GPs and pharmacists in primary care, simple eyecare is considered to be a small part of their routine workload.

The commissioning process needs to ensure that eye care is delivered safely, by an appropriately trained workforce and compliant with NICE guidance. It should be evidenced-based and audited for outcomes and value for money. Roles and responsibilities in the processes of commissioning and provision of care do need to be clear, to ensure safe and effective care based on clinical need.

Nationally, accredited professional training and continuing professional development for extended clinical roles (optometrists, nurses, and orthoptists) for shared or co-managed care are gradually becoming available.

With the introduction of new models of community ophthalmology, workforce development will need to be considered alongside the wider strategy.

Across the London boroughs in 2013/14, there was a two-fold variation in spend in the Eye and Vision programme budget (Figure 1). However, it cannot be assumed that the lower spenders required more money. There was also a two-fold variation in the uptake of NHS sight tests across the capital[1].

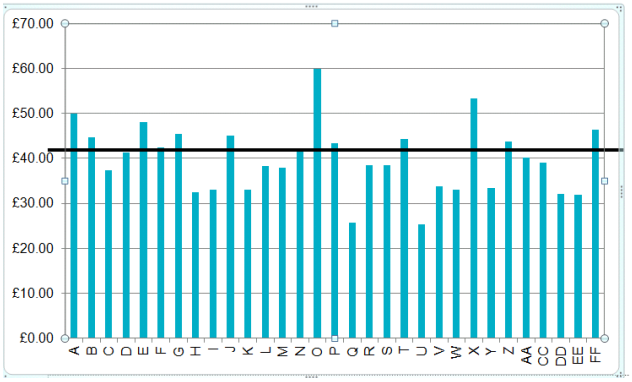


**Figure 1: Eye & Vision £ spend per person in each London borough (2013/14).**

Typically, services which are known to work are rolled out in some areas and not in others, often on a small scale. There have to be opportunities for greater efficiency by reducing the duplication of effort in commissioning, procurement and delivery through commissioning at greater scale, and the agreement of consistent and integrated eyecare pathways across London.

[1] RNIB's Sight Loss Data Tool http://www.rnib.org.uk/knowledge-and-research-hub-key-information-and-statistics/sight-loss-data-tool

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**Table 1: Epidemiological & Economic Model Sight Loss in the UK: 2010-20**
**Estimated number of affected adults in the UK**

| **Age-related Macular Degeneration (AMD) *** | **2010** | **2020** |
|---|---|---|
| Early AMD | 1,493,963 | 1,821,434 |
| Neovascular-AMD | 414,561 | 515,509 |
| Geographic Atrophy-AMD | 193,652 | 240,358 |
| Sight Impaired | 132,970 | 171,530 |
| Severely Sight Impaired | 90,254 | 120,452 |
| **Diabetic Eye Disease** | | |
| People diagnosed with Diabetes | 2,665,029 | 3,342,634 |
| Background Diabetic Retinopathy (DR) | 748,209 | 938,448 |
| Non-Proliferative DR | 66,037 | 82,827 |
| Proliferative DR | 19,447 | 24,391 |
| Diabetic Maculopathy | 187,842 | 235,602 |
| Sight Impaired | 40,982 | 46,473 |
| Severely Sight Impaired | 24,976 | 29,957 |
| **Glaucoma #** | | |
| Ocular Hypertension | 308,044 | 361,183 |
| Primary Open Angle Glaucoma | 265,973 | 327,440 |
| Sight Impaired | 57,646 | 71,806 |
| Severely Sight Impaired | 17,511 | 22,261 |

* assumed 75% of all eligible patients with wet AMD treated with intervention of equivalent efficacy as Lucentis.

\# estimated numbers of diagnosed cases, assuming current 50% detection rate.

Demand for eye care services is increasing. Estimates in sight loss in the UK for the main eye disease areas are also increasing in the UK[2] (Table 1).

There is anecdotal evidence of capacity issues and increasing waits for patients. Accurate and relevant performance data is sparse and partly results from the fragmented way in which eyecare is commissioned.

Significant amounts of data are collected through the sight test claims, but these are not designed for ophthalmic public health. Hospital Eye Service activity data by sub-speciality is just not reported to commissioners. The poor quality of data undermines the confidence in the information used to plan and commission services, assess quality and ensure effective use of resources.

[2] Minassian D, Reidy A, (2009). Future Sight Loss UK 2: An epidemiological and economic model for sight loss in the decade 2010-2020. EpiVision and RNIB.

# Improving Eye Health and Reducing Sight Loss: linking to the NHS Five Year Forward View



A consultation for improving eye health and reducing sight loss was conducted by NHS England in 2014. It focussed on a more preventative approach, early accurate detection by primary care services and more effective management in the community. Although primary care led, the whole scope of eye health and sight loss services was included.

Seven key themes emerged from responses by national organisations:

1. Improving IT & communications
2. Developing clinical leadership/changing organisational culture
3. Developing pathways
4. Making better use of skills
5. Reviewing General Ophthalmic Services / exploring new contractual opportunities
6. Improving case management
7. Improving accessibility to eye sight tests

The vast majority of respondents agreed that there was a need to make important changes to how eye care services are planned, whilst retaining the strengths of the current system.

Specifically, individual clinicians and organisations need to establish different ways of working; primary care providers need to collaborate at a much greater scale with one another, and with community and hospital providers to deliver 'wider primary care at scale' for their communities.

New models of care are needed, to explore how eye health can support the ambitions for primary care and work with other primary care contractors to provide joined up care for patients.


**The NHS Five Year Forward View** (FYFV)[3] makes the point we have to fundamentally change aspects of the way care is organised in order to give patients the sort of services they expect. It does not mention eye health specifically, but 'out of hospital care' and evolved primary care are themes that are embedded throughout the document.

Pooled budgets and co-commissioning[4] are possible options for eye health services and during 2015, CCGs have the opportunity to discuss eye health commissioning with their regional team and Eye Health Network but have no formal decision making role.

Some CCGs may want to take on a greater level of responsibility in the commissioning of eye health, and this is to be reviewed in 2016/17, with full and proper engagement of the relevant professional groups.

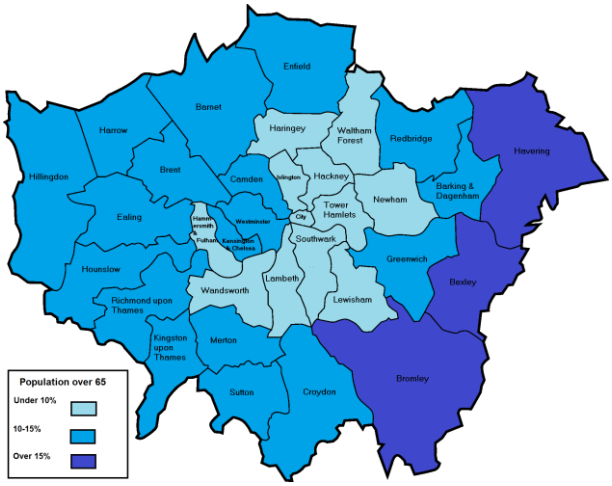
[3] NHS Five Year Forward View (2014). http://www.england.nhs.uk/ourwork/futurenhs/
[4] Next steps towards primary care co-commissioning ( 2014)

An Eye Health Needs Assessment and review of current pathways should be part of the commissioning process for each borough. For London's population of 8.6 million people, 40% live in inner London and 60% in outer London.

### Age:

22% of people are aged under 18
67% of people are aged 18-64
11% of people are aged 65 and over

Havering has the largest percentage of residents aged over 65 at 18%, and Tower Hamlets has the lowest at 6%.




**Map showing population of London boroughs aged over 65**

As age is the major factor in AMD, there should be greater access to AMD services in outer London areas.

### Ethnicity:

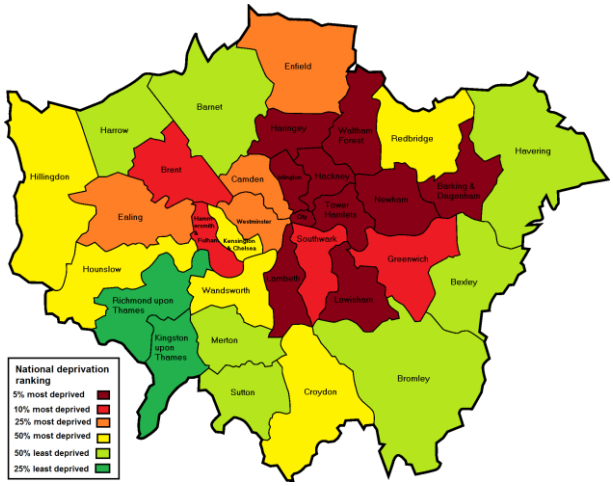
60% of residents are White
18% are Asian or Asian British
13% are Black or Black British

The borough with the largest White population is Havering at 88%. The borough with the largest Asian or Asian British population is Newham at 43%. The borough with the largest Black or Black British population is Lewisham at 27%.

These latter two ethnic groups have a higher prevalence of diabetic eye disease and glaucoma.

### Deprivation:

Nine London boroughs appear in the most deprived 5% of local authority areas [Hackney, Newham, Tower Hamlets, Islington, Waltham Forest, Barking and Dagenham, Haringey, Lambeth, Lewisham].




**Map showing Indices of Multiple Deprivation ranking for London boroughs**

Deprivation often links to people not attending for regular eye examinations and presenting late with treatable eye conditions.

### Urgent care:

While 24 hour eye emergency services are available in central London, a number of urgent access eyecare services in outer London close at 4.00pm. This is resulting in large spikes of attendances for the 24 hour service in the early evening.

A strategic review of opening times by commissioners would help to improve access issues.

# Certificate of Visual Impairment (CVI) indicator



The CVI indicator in the Public Health Outcomes Framework measures the number of people who are certified sight impaired or severely sight impaired, and the number of those who have lost their sight from one of the three major causes of preventable sight loss: glaucoma, age-related macular degeneration (AMD) and diabetic eye disease. Tackling these three conditions is the primary public health challenge in eye care. They are the biggest causes of certifiable blindness in England but with the right care, at the right time, in the right place, people can be treated effectively and in many cases their sight saved. Currently certification still requires patient consent.

The crude rates of sight loss in London are[5]:

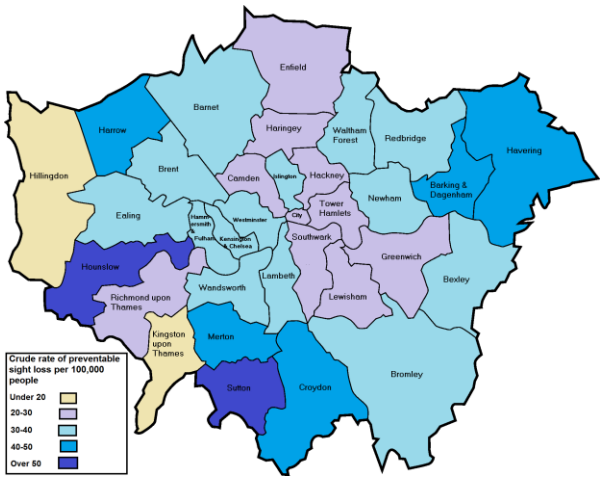
AMD = England rate of 123.1. The lowest rate of 42.3 is in Kingston upon Thames and the highest rate of 194.7 is in Sutton.

Glaucoma = England rate of 12.5. The lowest rate of 6.0 in Greenwich and the highest rate of 24.5 is in Hounslow.

Diabetic eye disease = England rate of 3.5. The lowest rate of 1.9 is in Bromley and the highest rate of 6.8 is in Lambeth.

The crude rate of sight loss certifications per 100,000 population for England is 42.3. The lowest rate of 16.4 is in Camden and the highest of 63.5 is in Sutton.

There is clearly variability in the CVI rate across the boroughs. But what this can only say, is that there is variability in the numbers of individuals being put in touch with social service departments in need of support of help for their visual loss. Therefore, the higher numbers indicate need.




**Map showing Public Health Outcomes Framework crude rate of preventable sight loss for London boroughs**

The variation in rates might be real and if it were, we would need to look at factors responsible for such variability, but variation in rates might also be due to variation in coverage of certification. This highlights the need for audits of coverage *(Can be monitored by Portfolio Eye Specific Indicator 6).*

Some hospitals have Eye Clinic Liaison Officers (ECLOs) who promote the value of certification and registration. Some do not. This is an important role for making sure patients and their carers receive the support they need and are signposted to the correct services.

### Recommendation 1

The important role of the Eye Clinic Liaison Officer (ECLO) should be included as part of the service specification *(Can be monitored by Portfolio Eye Specific Indicator 9).*

[5] http://www.phoutcomes.info/public-health-outcomes-framework

The current pathways are inefficient, both for clinicians and patients - minor changes or small schemes will only promote the maintenance of the status quo. Commissioners and providers need to build on current good practice, and extend the schemes and services that deliver better outcomes. Change should not be seen as just about moving a percentage of activity into the community. The focus needs to be on developing more integrated pathways supported by cross-sectorial working.

Providers should ensure that they use best evidence in making decisions about the care of individual patients and avoid wasteful duplication of effort along pathways.

Changes in the commissioning landscape provide an opportunity to develop more integrated eye care services across London, with care brought closer to the patient as appropriate.

The aim should be a move to an 'outcomes-based' strategy rather than 'activity-based', and thereby create patient focused integrated services. In order to deliver optimum value and outcomes, every provider involved will be required to apply 'Right Care' principles for their part of the pathway.

The whole strategy requires a change of culture, greater standardisation in terms of process and data collection to be able to measure outcomes. There needs to be greater use of multi-professional staffing, greater use of imaging technology and virtual clinics, the elimination of paper and move to electronic referrals and audit.

Services should be coordinated across all relevant agencies encompassing the whole eye health and care pathway, with direct input and discussion with people with eye health problems, sight impairment and sight loss.

An integrated approach including all service providers and service users regarding the provision of services is fundamental to the delivery of quality care to people with sight impairing conditions, and for all levels of prevention (primary, secondary and tertiary) of sight loss.

The collation of quality data along pathways of care needs to be a key requirement of each provider. It is impossible to deliver patient centred care without such data. Ophthalmic data, as collected by optometrists, ophthalmologists and other clinicians will have a key role in measuring and improving care, and ensuring that care is appropriate for the population and is of good value. There should be a requirement that all eyecare providers above primary care level, use an electronic clinical management system to record activity and outcomes at a patient level.

Part of the move to electronic systems should include the setting up and use of secure NHS mail for community optometrists to communicate with hospitals and GP practices, and especially for community and secondary level feedback to the referring optometrist / GP on referral outcome. Electronic referrals will allow the transfer of photographic images and ocular coherence tomography (OCT) scans to enable the use of virtual clinics and be ready for the NHS e-referrals system.

A Portfolio of Indicators[6] has been developed by the VISION 2020(UK) Ophthalmic Public Health Committee to review and monitor population eye health and wellbeing at a national and CCG level.

Consultation with eye health and sight loss sector stakeholders demonstrated positive engagement and support with broad agreement on the relevance, application and utility of the indicators.

The Portfolio has received endorsement by the Clinical Council for Eye Health Commissioning in February 2015. The next step is to pilot the tool in order to address the current gaps in eye health service information, and as a first step to embedding the eye health perspective in the use and interpretation of mainstream Outcome Frameworks.

The portfolio contains :

- Eye health indicators covering care across all sectors that provide the specialty-specific granularity to the broader Outcomes Framework indicators identified below (Appendix 1).
- Indicators identified from the existing NHS, Public Health and Adult Social Care Outcomes Frameworks that demonstrate broad overall change (if any) at population level in those areas identified as being relevant to eye health improvement, prevention of sight loss, and living with sight impairment.

Whilst these indicators are not currently supported by the national data collection infrastructure, they could serve as key core standards for local clinical audit and service reviews. They could be incorporated in service contracts to facilitate local data collection and review by providers and commissioners to ensure good practice, outcomes and quality of services.

In the longer term, demonstration of their local utility would form the basis of their inclusion in the broader Outcomes Frameworks.

**Recommendation 2**

The VISION 2020(UK) portfolio of indicators is piloted across London as a tool to demonstrate improvement within the eye health and sight loss pathways, aligned to the principles of the NHS Five Year Forward View.

[6] http://www.vision2020uk.org.uk/news.asp?newsID=6157&section=000100050006

The **first priority** is to develop a set of London-wide whole system pathways, incorporating the recommendations in this document, that offer good patient care, streamline processes and are cost-effective.

The **second priority** involves the acceptance that the commissioning of eyecare and sight loss services is complex and cuts across many organisational boundaries. Consequently, commissioning and procurement for the delivery of eye care services needs to be done at a larger scale to have greater impact and save costs. Resource needs to go to front line services. There should be a number of Eye Health Programme Boards established covering each Strategic Planning Group within London with representation from commissioners, providers and service users.

The **third priority** is the need for better data e.g. Hospital Episode Statistics for eye care. These routine operational data are generated from the provision of NHS care in hospitals (admissions and outpatient care). The quality of these data for outpatient attendances is incomplete, inconsistent and inaccurate, yet these data represent the national record of this type of activity and are used as proxies for need, for service development and commissioning decisions. Improving the quality of data on outpatient attendances coded by diagnosis and procedure should be a reasonable and deliverable short to medium term action. In addition, as more services are delivered in the community, there should be data flows for national aggregation along the lines of Hospital Episode Statistics. The infrastructure to provide this is not insignificant, but unless addressed there is no information on value and potential of the activity provided in this sector either for NHS General Ophthalmic Services or other enhanced, shared or co-managed care.

The **fourth priority** is the need for better sharing of data and information for direct patient care. Good communication and secure sharing of relevant information between health and care professionals, and their patients, at each stage of the patient's pathway, facilitated by electronic patient records and underpinned by community optometric connection to N3 and NHS mail, to support:

- Patient self-management, particularly for chronic diseases
- Care pathways across sectors and co-management (where applicable and appropriate)
- Feedback on referrals
- Education - greater awareness of impact of eye health (risks, management, well-being) amongst health and care professionals, improve quality of referrals and patient care
- Avoiding patients being lost in the system due to poor communications between hospital and rehabilitation services

The **fifth priority** is around equality, diversity and inclusion. This should be a core part of 'normal business'. Nevertheless, it is included in this section to ensure it remains high on everyone's agenda. The values that support this are:

- Respect the dignity, privacy, confidentiality and cultural diversity of all
- Championing vulnerable people through equity, fairness and the integration of health and social care

There needs to be better accessibility and communication of services for all patients in line with the Equality Act 2010, and targeted services for 'hard to reach' groups along with provision of eyecare for the homeless within the community.

Some community ophthalmology services have already been commissioned in response to the increase in demand. New models need to be tested at scale but it is important that there is a common framework around each one and we do not continually reinvent the wheel.

A framework has been developed by an experienced group of clinical leaders and patient advocates under the Clinical Council for Eye Health Commissioning. Representation included:

Royal College of Ophthalmologists
The College of Optometrists
Royal College of General Practitioners
Royal College of Nursing (ophthalmic)
Faculty of Public Health
British and Irish Orthoptics Society
LOCSU
VISION 2020(UK)
International Glaucoma Association
Patients

The broad components of the community service should provide assessment and management of patients whose eye conditions are at low risk of deterioration, who are either referred by primary care for assessment or discharged from secondary care for monitoring.

Schemes that are supplementary to the NHS sight test in primary care, that are undertaken prior to the decision to refer e.g. glaucoma repeat measurements, minor eye conditions, learning disabilities and cataract pre-assessment, should not be considered as community ophthalmology but commissioned with separate service specifications. In Scotland and Wales, optometrists are funded for repeat measurements, follow-up appointments and the management of minor eye conditions through their main national contract.

The community ophthalmology service should be distinct from primary and secondary care services and defined by the functions it performs and its composition, such as the use of multidisciplinary teams with a targeted case load. Not all aims listed may be relevant in all areas.

**Common aims of a Community Ophthalmology Service:**

1. The provision of timely care by appropriately trained and competent professionals.
2. The delivery of high quality clinical services ensuring patient safety with a positive patient experience.
3. The provision of education and training for the development of the future workforce.
4. The reconfiguration of patient flows to make best usage of available resources and skills mix.
5. The embedding of comprehensive governance structures into the service.
6. The provision of services in a setting closer to home or work.
7. The reduction of referrals to secondary care to reduce waiting times for secondary care outpatient appointments and/or enable greater capacity for the care of higher risk patients in secondary care.
8. The delivery of feedback to GP and optometrist referrers and patients to support integrated care.

# Integrated Pathways: Age-related Macular Degeneration 12

Lead: Rahila Zakir

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Age-related Macular Degeneration (AMD) is a long term condition which is the leading cause of sight loss in the UK. Risk factors are advancing age, ethnicity, family history; smokers are at 2-3 times higher risk of developing AMD than people who have never smoked. Sight loss often occurs quickly with the wet (neovascular) form of AMD but can be stabilised or improved in most cases with prompt treatment and timely monitoring. The 'dry' form of AMD occurs slower but is not treatable, and patients will need support and access to appropriate Low Vision services (page 22).

Patients with wet AMD need ongoing treatment for their vision to remain stable. Monthly or bi-monthly monitoring appointments depending on the treatment option may be required for a considerable time; the length of time patients are in treatment can vary from several months to several years.

The biggest challenge for an AMD service is to ensure there is sufficient capacity for patients to have their follow up appointments on time. Innovative service models across the UK are meeting this challenge in different ways. However, even with the most efficient use of resources, AMD services will need to continue increasing capacity until longer-acting treatments or treatments that do not require regular intra-vitreal injection become available.

Strategic decisions are required to manage the expected future growth in this area, to avoid delays in initial assessment and subsequent treatments.

NICE has approved treatments for retinal vein occlusion (RVO) and diabetic macular oedema (DMO) and existing capacity issues may impact on their full introduction.

**Recommendation 3: Age-related Macular Degeneration**

- A forward capacity plan for the next five years.
- Consistent use of a London-wide suspect wet AMD urgent referral guidance.
- Full coverage across London of best practice fast track referral pathways from optometrists and GPs which minimise avoidable delays to starting treatment.
- Secure electronic referrals to be introduced to improve the speed and quality of referrals. In some areas, faxes are still being used for transfer of urgent information from optometry / optical practices to the Hospital Eye Service.
- Treatment of confirmed wet AMD to start within 2 weeks of diagnosis and for timely review and re-treatment appointments to occur on time *(Can be measured by Portfolio Eye Specific Indicator 8).*
- Separate clinics for monitoring stable wet AMD.
- Ensure that optometrists and GPs, particularly locums receive regular support / training to recognise the symptoms and signs of wet AMD and are familiar with the local process for urgent referrals.
- Ensure that all patients who have visual loss have access to an ECLO service and services which provide support and visual rehabilitation.

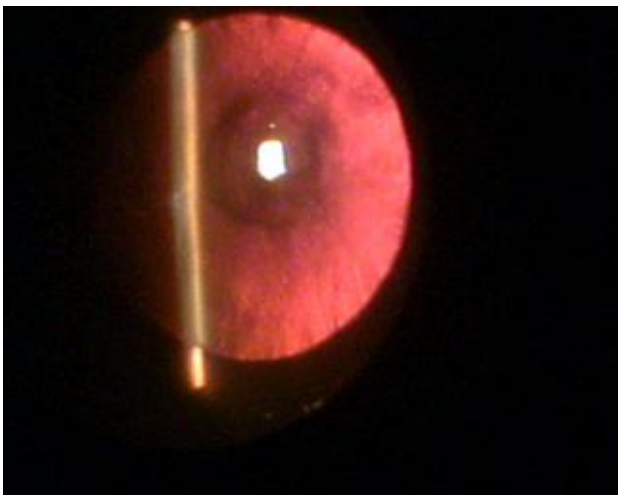
Lead: Poonam Sharma

**********

Cataract extraction accounts for a significant proportion of the surgical workload of most ophthalmologists and cataract surgery continues to be the most common elective surgical procedure performed in the UK. There is a threefold variation in the number of people having cataract surgery across England, with rates ranging from 285 to 804 per 100,000 population[7].

There is evidence to suggest that where direct cataract referral services exist, it reduces the over-referral of patients for possible cataract extraction. Some CCGs have commissioned either pre or post operation assessments in the community. These services appear to be at individual CCG level leading to variation in patient access to the pathway. In a few areas, Hospital Trusts are contracting optometrists directly to provide these services.

Cataract surgery may be performed primarily to aid the management of other eye conditions, for instance to facilitate surveillance or treatment of diabetic retinopathy or to improve intraocular pressure control in primary angle closure glaucoma.



In 2011, there was broad agreement on criteria for cataract surgery (The London Cataract Criteria) which has subsequently been adopted by the Royal College of Ophthalmologists. This took account of clinical advice as well as the evidence base and implications for population health.

**The London Cataract Criteria**

1) Cataract surgery to be considered for patients with a best corrected visual acuity of 6/9 or worse in either the **first or second eye**, ***AND*** have impairment in lifestyle such as substantial affect on activities of daily living, leisure activities, and risk of falls.

2) Surgery is indicated for management of ocular co-morbidities such as control of glaucoma and view of diabetic retinopathy.

3) Patients with cataract having visual acuity better than 6/9 does not imply automatic exclusion. In this circumstance, where there is a clear clinical indication or symptoms affecting lifestyle, surgery should still be considered.

NICE guidance for the diagnosis and treatment of cataract is in development for release in 2017.

[7] The NHS Atlas of Variation in Healthcare (2010).

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**Recommendation 4: Cataract**

- Use of and development of community based dilated assessment and direct referral by accredited optometrists* to reduce the number of false positive referrals for cataract surgery.
- Patients should only be referred in line with the London criteria, following counselling on the risks and benefits of surgery. Significant co-existing eye disease and patient related complicating factors should be considered before direct referral for cataract surgery.
- All direct cataract referral pathways should incorporate an informed decision making tool.
- The provider is required to follow the Royal College of Ophthalmologists, Cataract Surgery Guidelines (2010).
- Following uncomplicated cataract surgery, the patient is reviewed by an accredited eye health professional for post-op examination and refraction. There should be schemes where the community based professional provides feedback on the post-op clinical, visual acuity and refractive data to the unit where the surgery took place and to refer the patient back to the unit if complications are found.
- A standardised training and accreditation programme for post-operative cataract care is required, however until then the accreditation should include, a local hospital ophthalmologist to formally sign off the eye health professional. Regular review of clinical competence is necessary.
- Ensure that the cataract pathway caters for every individual's need e.g. dementia, learning difficulties or where general anaesthetic is indicated.

***London's ambition***

Equitable access to treatment and best possible visual outcomes, so that patients requiring cataract surgery are able to access surgery with the minimum number of hospital appointments, leading to a positive patient experience through consistent pathways across London.

* The LOCSU Cataract Referral pathway is an accepted and evidence-based pathway.

# Integrated Clinical Pathways: Children's Screening and Paediatrics



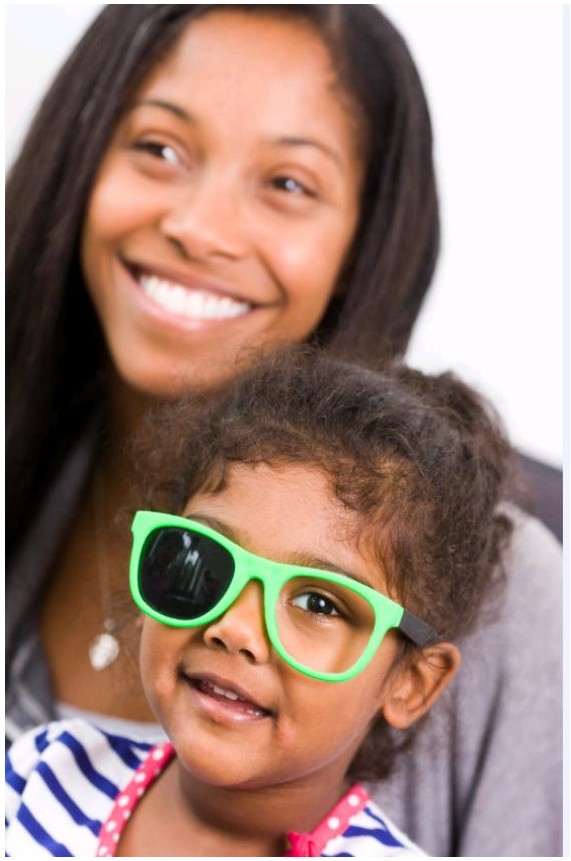
Lead: Liz Tomlin

The UK National Screening Committee recommends systematic population orthoptic-led vision screening at school entry[8]. This should be commissioned pan London so we create equality of care and access for everyone. There should be screening of all children between 4-5 years to detect visual problems. Early detection is essential for improving the provision of care and outcomes for children with eye disease, especially amblyopia[9].

It is imperative that this is total population screening, including children in private/home education, special schools, travelling communities and other hard to reach groups who currently may be missing out.

Referrals from the primary screening service should ideally be to a community service using a multi-disciplinary team of orthoptists and optometrists reducing false positive rates, treating refractive error and mild to moderate amblyopia (to protocol) with access to hospital services when necessary. Joint orthoptist / optometrist community clinics offer a high level of care and combined expertise at a one stop shop. To enable greater collaboration, the development of this service may be achievable through commissioning hospital eye services and community services to provide a multi-disciplinary team approach.

The information from the screening should be entered into the appropriate local software to ensure rigorous child safeguarding is maintained. This will enable health and social care professionals have access to this information. Feedback to the schools should be provided to allow information to be included in the health and wellbeing section of the Ofsted report.



**Recommendation 5: Children's screening**

There should be London-wide orthoptic-led screening of all children between 4-5 years to detect visual problems as recommended by the UK National Screening Committee *(Can be monitored by Portfolio Eye Specific Indicator 1).*

8 UK National Screening committee (2013)

9 Barnes GR, Hess RF, Dumoulin SO, Achtman RL, Pike GB, (2001).The cortical deficit in humans with strabismic amblyopia. J Physiol-London 533:281–97

# Integrated Clinical Pathways: Diabetic Retinopathy 16

Lead: Rahila Zakir

**Diabetic eye screening programmes (DESP)** and improved glycaemic control have reduced the incidence of sight loss in people of working age[10]. However, they have led to an increase in referrals to Hospital Eye Services of patients with suspect diabetic maculopathy.

The new common pathway includes the surveillance of higher risk patients through digital surveillance but at present the use of Optical Coherence Tomography (OCT) is out with the pathway and has to be commissioned separately from screening by CCGs. It is envisaged that CCGs across London will locally commission digital surveillance with OCT.

Re-procurement of DESP across London in 2015 will see the streamlining from 17 to 6 programmes. The intention is to reduce the variation in service provision, accessibility, uptake and quality.

Primary care has an important role in ensuring those diagnosed with diabetes attend their screening, especially children and young people aged 12-18 years *(Indicator 2).*

## Patient Education

A proactive prevention education programme is needed to encourage patients to lead a healthy lifestyle to maintain good eyesight. A healthy balanced diet and regular exercise are to be encouraged.

**Sharing of information between DESP and Hospital Eye Services:** The division of commissioning between the DESP and Hospital Eye Service often results in lack of timely information sharing on the management of patients with diabetic retinopathy referred to hospital. CCGs have agreed to strengthen contracts and to work closely with NHS England (London region) commissioners in monitoring improvements. Improved IT systems are needed to facilitate data sharing and enable the Hospital Eye Service to access the screening images.

Hospital Eye Services in meeting these requirements require dedicated administrative roles to ensure failsafe and data reporting is complete.

### Recommendation 6: Diabetic Retinopathy

- The ambition for London should be for all patients with diabetes to be able to access a diabetic eye screening service which has Optical Coherence Tomography surveillance clinics and which is integrated with all health services.
- Clearer reporting requirements within Hospital Eye Service contracts and closer working between CCGs and NHS England (London region) commissioners and providers in monitoring improvements.
- Hospital Eye Services to ensure adequate administrative support to be able to deliver the DESP reporting requirements.

[10] A comparison of the causes of blindness certifications in England and Wales in working age adults (16–64 / years), 1999–2000 with 2009–2010. *BMJ Open* 2014;**4**:e004015

# Integrated Clinical Pathways: Glaucoma



Lead: Poonam Sharma

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Glaucoma is a common sight threatening disease that affects the optic nerve. If not diagnosed, monitored and treated correctly, glaucoma can result in severe loss of vision or blindness. Approximately 10% of UK blindness registrations are related to glaucoma. Vision lost due to glaucoma is not recoverable. Fifty percent of glaucoma in the community remains undiagnosed, previously undetected cases are largely identified at routine sight tests by community optometrists. The classification of stable glaucoma is often time limited.

Glaucoma is a high volume and resource demanding disease and the NICE guidelines on the management of glaucoma[11] have had a considerable effect on glaucoma services. More patients are being referred as suspect glaucoma and Trusts have to ensure they are monitoring patients in line with the NICE guidelines. Widespread use of a repeat measurement scheme has been shown to reduce the number of suspect glaucoma / ocular hypertension (OHT) referrals[12].

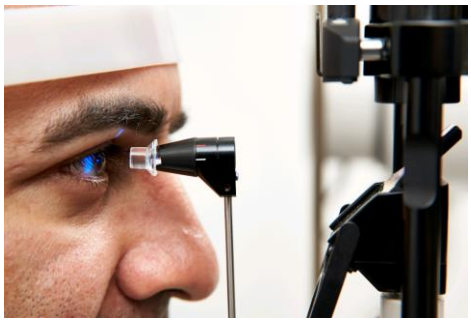
It is evident that hospital eye departments will struggle to continue to provide high quality care for glaucoma patients as the population ages and the prevalence continues to increase. Over 30% of glaucoma related NHS outpatients attendances are related to OHT and suspected glaucoma, and much of this workload could be commissioned in the community with an appropriate governance framework.

To assist commissioners in ensuring they improve the value of their service, the Royal College of Ophthalmologists and the College of Optometrists, jointly published commissioning guidance on glaucoma[13].

***London's ambition***

1) Referrals to secondary care for glaucoma are of high quality in London with a London-wide repeat measurement scheme in place.

2) Those patients who are diagnosed with glaucoma and deemed to be of low risk can be appropriately seen in the community allowing the acute trusts capacity to see the more complex and high risk patients. This will ensure follow up appointments for patients with glaucoma are not delayed.



[11] NICE guidance 85 for the diagnosis and management of chronic open angle glaucoma/ocular hypertension (2009).
[12] Avoiding unnecessary referral for glaucoma: use of a repeat measurement scheme. NICE Proven case study - NHS Evidence (updated 2014).

[13] Glaucoma: Commissioning better eye care: Clinical commissioning guidance from the College of Optometrists and The Royal College of Ophthalmologists (2013).

**Recommendation 7: Glaucoma**

- Commissioners should ensure providers have processes in place to prevent delay in follow up for patients with glaucoma as advised by the NPSA alert (2009) *(Can be monitored by Portfolio Eye Specific Indicator 5).*
- As set out in the NICE Glaucoma Quality Standard (QS7) Quality Statement 2: Referral, London-wide repeat measurement schemes by community optometrists should be in place. There is sufficient evidence demonstrating that a repeat measures service can significantly reduce false-positive referrals into the Hospital Eye Service. However at present individual CCGs are commissioning this and the costs of procuring this service at local CCG level can far outweigh those for providing the service itself *(Can be measured by Portfolio Eye Specific Indicators 4i& 4iii).*
- Applanation tonometry is not a requirement of the NHS Sight test, however it is core competency for optometrists. The Glaucoma working group therefore asks NHS England to explore if the existing GOS framework of additional and enhanced services could be used to implement a single service across London.
- NICE Quality Standard (QS7) Quality Statement 1: Referral, recommends implementation of local Glaucoma Referral Refinement (GRR) services. At present there are a few GRR services commissioned within London, again with local variations. The Glaucoma working group, therefore recommends current GRR services to be formally evaluated and then to use that information to develop a standardised pathway which should be piloted, possibly within the community ophthalmology model *(Can be measured by Portfolio Eye Specific Indicators 4ii & 4iii).*
- Implementation of an OHT monitoring scheme - Sharing the care of patients at relatively low risk of progression between the Hospital Eye Service and suitably trained community providers has the potential to release capacity and reduce costs but needs shared clinical information between hospital and community, the correct infrastructure and protocols that follow the NICE guidance.
- Commissioners to ensure that any service model incorporates support and counselling at diagnosis and for those who have suffered significant visual loss from glaucoma, including support for patients who find it difficult to administer eye drops themselves.
- Commissioners to implement the recommendation of the joint commissioning guidance on Glaucoma.
- Funded clinical leadership be considered across the whole Glaucoma pathway.

# Integrated Clinical Pathways: Low vision



Lead: Phil Ambler

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Low vision affects every aspect of someone's life, including reading, writing, shopping, taking medication, cooking, checking 'sell-by' dates, personal hygiene, watching television, driving, crossing roads, social engagement and recognising faces. Older people with low vision are more likely to be depressed and to fall than their sighted peers.

The primary aim of low vision services is to enable people with loss of vision to regain or maintain as much independence and autonomy as possible.

Low vision services achieve this through a wide range of tools depending on individuals' needs including: rehabilitation, provision of optical and non optical aids, and resources and training in their use, emotional support and advice, by linking in with other agencies that can provide ongoing support such as access to work, and local and national charities. They also improve the person's ability to self medicate and monitor other health conditions.

There is a changing world of low vision aids and equipment. This is notable in the increasing value of digital magnifiers and hi-tech equipment for sight impaired people alongside the decreasing cost. If digital aids were part of the strategy, it would be a great leap forward as in many cases digital aids are better than anything an optical device can do.

Patients need to be provided with information on how to take advantage of common digital devices such as smartphones and tablets. These devices can be easily adapted and used by people providing the advantage that they are relatively affordable and no different from their peers.

Traditional health-funded low vision clinic models only provide optical magnifiers while social care provide and fund digital aids. It is likely that clients would receive a better service and economies could be effected across both health and social care if funding was pooled and access widened.

An Eye Clinic Liaison Officer (ELCO) provides a vital service, increasing the efficiency of clinical staff through enabling them to focus their time most appropriately. This is achieved through reducing the time clinical staff need to spend with distressed patients, signposting to valuable follow on support services, assisting with the administration of CVIs, providing information on patients' eye conditions and providing emotional support. The cost-effectiveness of an ELCO service has been assessed[14].

[14] https://www.rnib.org.uk/economic-impact-eclo

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**Recommendation 8: Low Vision**

- Low vision services should not only be open to people who meet visual acuity thresholds or who register as sight impaired or severely sight impaired. Low vision services can mitigate the practical, emotional and occupational or educational impacts of sight loss for people who do not meet the criteria to register as sight impaired.
- Access to low vision services should be prompt and flexible. Early intervention is key to getting the best outcomes. Flexibility means service users can access the service from multiple routes and should be entitled to reassessments as their vision changes.
- Integration is particularly important for low vision services. Effective low vision services need to adapt to individual needs and work as seamlessly as possible with other services, including hospital eye units, education, social care, voluntary organisations and stroke, learning disability, rehabilitation and falls teams. There should be an ECLO service in every eye clinic in order to facilitate this *(Can be measured by Portfolio Eye Specific Indicator 9).*
- Providers should ensure low vision services have dedicated funding within the programme budget and explore the possibility to jointly fund and provide the service using health, local authority and voluntary sector resources. Consideration should be made for a domiciliary low vision service.
- Low vision services should be commissioned in line with the Royal College of Ophthalmologists' and College of Optometrists' joint publication Commissioning Better Eye Care: Adults with Low Vision (November 2013) *(Can be measured by Portfolio Eye Specific Indicator 10).*
- Where possible, some part of the service should be commissioned as a community based service and thus avoid unnecessary demands on secondary ophthalmic services.
- Referrals to low vision services should be as easy as possible and allow for self-referral especially those who have existing conditions and need a reassessment.
- Local low vision services should be monitored by the eye health programme boards.

# Integrated Clinical Pathways: People with Learning Disabilities / Dementia



Lead: Liz Tomlin

**Children with learning disabilities** are significantly more likely to have refractive error and visual impairment than the normal population[15]. A study funded by SeeAbility and RNIB found that prevalence of visual impairment amongst children with learning disabilities is 28 times greater[16] than amongst the general population of children[17].

For children of vision screening age 4-5 years, appropriate commissioning should ensure London-wide equality of access. Equality of care can be achieved by commissioning a multi-disciplinary team, e.g. an orthoptist and optometrist /ophthalmologist to conduct primary vision screening in special schools and main stream schools with specialist units to ensure equality of access for complex children.

**Adults:** SeeAbility have good evidence for visual problems being much higher in people with learning disabilities. Therefore commissioning for these groups should include local well publicised services giving longer community optometry appointments.

There should be commissioning of transition clinics between children's hospital services and adult specialist ophthalmology, and specialist clinics for those with learning difficulties, dementia, co-morbidities and other adults who need a longer appointment and higher staff ratios.

A tri-borough pilot of a LOCSU Learning Disabilities eye care pathway in London, found that 21% of patients needed spectacles for the first time and 33% had a new eye health issue identified[18].

**Recommendation 9: People with Learning Disabilities**

- To improve the quality of eye services for people with learning disabilities.
- To improve access within the community to eye examinations for people with learning disabilities across London boroughs.
- To decrease the disparity between the eye health of people with learning disabilities and that of the general population within the Capital.

**Dementia and sight loss** are both more frequent in older age. Quite often they occur together. People with dementia still require eye examinations and frequently need longer appointments and therefore, similar extended services should be available. Reduced vision from cataract can be easily missed by carers and their symptoms put down to dementia.

**Recommendation 10: Dementia**

- To improve access within the community to eye examinations for people with dementia across the London boroughs.

[15] Das M ; Spowart K; Crossley S ; Dutton, G (2010) Evidence that children with special needs all require visual assessment. Archives Of Disease In Childhood, (2010) Vol.95(11), pp.888-892.

[16] Emerson and Robertson (2011). The estimated prevalence of visual impairment among people with learning disabilities in the UK

[17] SeeAbility: Children in Focus, the story so far (2015). www.seeability.org/childreninfocus

[18] Kensington & Chelsea, Hammersmith & Fulham and Westminster LOCSU LD eye care pathway report (2015)

# Integrated Clinical Pathways: Urgent Care



Lead: Seema Verma

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In London, there is a 9% year on year increase in the number of ophthalmic casualty attendances with the largest unit, Moorfields, seeing 95 000 patients annually[19]. Patients present to casualty partly because they perceive their eye problems as sight-threatening and partly because there is very little in terms of alternative pathways.

Approximately 30% of patients attending casualty departments have non-sight threatening / non-urgent problems[20]. New pathways to help divert patients with non-urgent problems from attending casualty would go some way in alleviating the pressures.

For any new integrated pathway to work requires the dedication and determination of all stakeholders involved. All parties need to be committed to whichever pathway is ultimately rolled out. This is certainly the case wherever a local Minor Eye Conditions Scheme (MECS) has been successful. It has required commissioners, GPs, optometrists and ophthalmologists to all work together to divert the non-sight threatening conditions away from the Hospital Eye Service. Further strategic planning of the urgent eyecare pathways and further training may allow even more conditions to be dealt with out of the hospital setting.

**Recommendation 11: Urgent Care**

- Accessibility and the 'urgent service need' to be evaluated across London, including :
  - Uptake of any new scheme by local optometrists and GPs
  - Out of hours availability
  - Patient choice
- Accreditation training must be clinically led by professionals with experience and expertise in the management of acute and emergency eye conditions.
- The scope and case mix of the eye conditions that will be seen in any new scheme must be carefully agreed by professionals with experience and expertise in the management of acute and emergency eye conditions.
- Governance and accountability arrangements must be included and specified in the service specification.
- Funding for time to gain on-going experience in eye casualty units to be included in the service specification.
- Given the size and variability of the London population, onward assessment and evaluation of safety, efficacy and cost-effectiveness of any new integrated service is necessary wherever it is piloted.

[19] Smith H B, Daniel C S and Verma S. (2013). Eye casualty services in London. Eye; 27**:**320–328

[20] Hau S, Ioannidis A, Masaoutis P, Verma S. (2008). Patterns of ophthalmological complaints presenting to a dedicated ophthalmic accident & emergency department: inappropriate use and patients' perspective. Emerg Med J; 25: 740–744

# Improving Communications / Referral Feedback



Leads: Wendy Newsom / David Parkins

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Many community optometrists and GPs are unlikely to see the full range of eye pathologies on a regular basis. Many practitioners often work in isolation and can benefit from advice and support when trying to decide whether they need to refer a patient with an eye condition or not. Also, it is not always communicated to primary care practitioners which conditions the hospital wants to see.

Secondary care / ophthalmology clinic staff are in the ideal position to feedback and provide support to those who refer to them. Audit has shown that secondary care clinicians write back to the GP in 99% of cases following a referral but as little as 12% of optometrist referrals result in a letter being copied to the optometrist[21].

**Recommendation 12: Communications**

To ensure there is feedback to the referring optometrist following every referral they make; this helps to educate the optometrist in their referral decision making and improves the quality of future referrals they make.

Enablers:

Develop more robust and consistent communication links between primary and secondary care. An advice line, which a referring practitioner can use to contact an eye care clinician in secondary care, has the potential to deflect avoidable referrals before they are written. Hospital optometrists can provide peer support to their community colleagues via an advice line.

Regular education for community optometrists, including what information is most useful in a referral letter, current treatments for eye conditions and referral timescales for acute eye conditions. Improved referral letter information enables triage of the patient into the appropriate specialist eye clinic at the first visit without the need to be seen in a general ophthalmology clinic or other referral refinement scheme in the first instance. This reduces the number of appointments for the patient, improving the efficiency of the pathways.

***Sharing of patient information between healthcare professionals: A joint statement from the Royal College of Ophthalmologists and the College of Optometrists (2015).***

*'People using health and social care services are entitled to expect that their personal information will remain confidential. However, people also expect professionals to share information with other members of the care team. Good sharing of information, when sharing is appropriate, is as important as maintaining confidentiality. Optometrists, as registered professionals, are part of the healthcare team so it is usually in the patients' best interest for ophthalmologists to share clinical information with the referring optometrist. This will improve the care of the patient, and that of future patients, by providing useful feedback about the diagnosis and management. It will also reduce duplication of tests, and possible unnecessary re-referrals. Unless the hospital policy specifically prohibits sending copies of letters to optometrists, ophthalmologists will routinely send copies of GP letters to the referring optometrist after confirming consent by the patient. The consent should be recorded in the notes. Optometrists can help to ensure that they receive feedback by always including their name and contact details clearly on the referral letter'.*

[21] Wendy Newsom - Moorfields at Bedford (2014) personal communication

# Appendix 1 - VISION 2020 (UK) Ophthalmic Public Health Outcome measures



| | Indicator | Minimum Standard | Achievable Standard | Reporting Frequency | Data Source Data Collection | Evidence/Policy Base | Purpose / Application | Domain and Population Group |
|---|---|---|---|---|---|---|---|---|
| **Primary Care** | | | | | | | | |
| 1 | % of school entry children (4-5yrs) screened | 80% | 95% | Annual | Data Source: Local Authority, CCG, Service Provider. Data Collection: Locally through Orthoptic Audit in Trust or Service Provider. BIOS monitor and review nationally | National Screening Committee: Screening Vision defects in 4-5 year old children. http://www.screening.nhs.uk/vision-child | Monitor implementation of National Screening Committee recommendations. | Prevention Children |
| | | | | | | | | |
| 2 | % children and young people aged 12-18 years diagnosed with Diabetes that are screened | >=70% | >=80% | Annual | Data Source : Local Authority / DESP / CCG. Data Collection : Local Trust / Service Provider Audit. | DESP Quality Assurance Standards-Aug 2014 (England). http://diabeticeye.screening.nhs.uk/standards | Diabetes is rising in children together with lowering of age of onset. Duration of diabetes is critical to risk of diabetic retinopathy rather than age | Prevention Children and Young People |
| | | | | | | | | |
| 3 | Uptake of sight tests in age groups: 0-15 years of age / 60 years of age and over | Establish locality baseline | Establish locality baseline | Annual | Data Source: GOS data held at the Health and Social Care Information Centre. Reported as estimated numbers of sight tests /100,000 population. | Routine NHS service data collection | Review & monitor uptake rates. Encourage regular review & scrutiny of data quality - batches & small samples analysed; excludes non-GOS (private) sight tests. Stimulate data quality improvement. | Effectiveness - General Ophthalmic Service NHS Children and Older Age Adults. |
| | | | | | | | | |
| 4i | 4i. Number (and %) of CCGs procuring a repeat (IOP) measurement service - by defined locality (Region, England or other local health economy) | Establish locality baseline | Establish locality baseline | Annual | Data source : locally CCG / LOCSU. LOCSU monitor and review nationally and make findings publicly available. Data Collection through Service/Contract specification | NICE Glaucoma Quality Standard - to gauge implementation in practice https://www.nice.org.uk/guidance/qs7 | Review and monitor service procurement and any variations in commissioning. Monitor implementation of NICE QS. Requirement for this service could be included in Glaucoma Service /Pathway Contract Specification. | Appropriate referral. Accessibility of service. Adults. |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 4ii | 4ii. Number (and %) of CCGs procuring a referral refinement service (IOP, discs and Fields) - by defined locality (Region, England or other local health economy) | Establish locality baseline | Establish locality baseline | Annual | Data source : locally CCG / LOCSU.<br>LOCSU monitor and review nationally and make findings publicly available.<br>Data Collection through Service/Contract Specification | NICE Glaucoma Quality Standard- to gauge implementation in practice https://www.nice.org.uk/guidance/qs7 | Review and monitor service procurement and any variations in commissioning.<br>Monitor implementation of NICE QS.<br>Requirement for this service could be included in Glaucoma Service /Pathway Contract Specification. | Appropriate referral.<br>Accessibility of service.<br>Adults. |
| 4iii | 4iii. Number (and %) of participating practices in each of these services (repeat measurement and / or referral refinement) - by CCG | 70% | 90% | Annual | Data source : locally CCG / LOCSU.<br>LOCSU monitor and review nationally and make findings publicly available.<br>Data Collection through Service or Contract Specification. | NICE Glaucoma Quality Standard- to gauge implementation in practice https://www.nice.org.uk/guidance/qs7 | Review and monitor coverage of these services locally.<br>Monitor implementation of NICE QS. Requirement for these services could be included in Glaucoma Service /Pathway Contract Specification | Appropriate referral.<br>Accessibility of service.<br>Adults. |
| | | | | | | | | |
| Hospital Eye Service | | | | | | | | |
| 5 | % Hospital appointments that occur within 25% of their intended follow up period, including rescheduling of hospital initiated cancellations | 85% | 95% | Quarterly | Data Source: Local Trust or Service Provider.<br>Data Collection : Local Service audit | RCOphth Quality Standards. https://www.rcophth.ac.uk/standards-publications-research/quality-standards/<br>NPSA alert for Glaucoma | Would address delays in continuity of management and losses to follow up, arising from capacity issues (clinical and administrative).<br>This could be included in Service / Pathway Contract Specifications for review through clinical audit. | Safety, Effectiveness, Experience.<br>All Ages |
| | | | | | | | | |
| 6 | Audit of certification of visual impairment (CVI) where the primary cause of vision impairment is due to AMD, Glaucoma and Diabetic Eye Disease | Review and monitor Trust practice - establish local benchmark | Review and monitor Trust practice - establish local benchmark | Annual | Local Trust.<br>Local Service Audit/Review | Public Health Outcomes Framework (PHOF) in England and RCOphth Quality Standards | Local application of PHOF.<br>Could be included in Service Contract Specifications | Outcome.<br>All Ages |
| | | | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 7 | Clinical Outcomes: Visual Acuity outcomes of Anti-VEGF treated following initial "loading course of 3-4 injections" and at one year after starting treatment for wet AMD. Also consider for DMO, CRVO and BRVO. | To meet benchmarks set by relevant RCT evidence base | To meet benchmarks set by relevant RCT evidence base | Annual | Data source : Local Trust OR Service Provider.<br>Data Collection : Local Service Audit/Review | NICE Technology Appraisals for anti-VEGF Treatment:<br>AMD - https://www.nice.org.uk/guidance/ta155/chapter/1-guidance<br>RVO - http://www.nice.org.uk/guidance/ta283<br>DMO - https://www.nice.org.uk/guidance/ta274 | Quality assurance of high volume activity for Provider and CCG review.<br>Could be included in Service / Pathway Contract Specifications.<br>Could inform development of subsequent mainstream RCOphth national audits. | Outcome-Effectiveness.<br>Adults |
| | | | | | | | | |
| 8 | % of R3A M0 and R3A M1 Diabetic Eye Disease seen within 2 weeks | 60% | 95% | Quarterly | Data Source : Local Trust or Service Provider.<br>Data Collection: Local Service Audit / Review. | DESP Quality Assurance Standards-Aug 2014 (England). http://diabeticeye.screening.nhs.uk/standards | Provision of timely consultation of screen positive high risk patients. | Prevention.<br>Service delivery.<br>Potentially all Ages |
| | | | | | | | | |
| Interface / Community | | | | | | | | |
| 9 | Eye Care Liaison (ECLO) Service. Every Commissioning Organisation (e.g. CCGs in England) to have commissioned an ECLO Service to be provided within HES, community or both. | | 100% | Annual | Data Source: Service Contract Specification.<br>Data Collection : Local Trust or Service Provider Audit Nationally RNIB reporting. | RCOphth/CO : https://www.rcophth.ac.uk/wp-content/uploads/2014/12/Low-vision-guidance-25-11-13-2013_PROF_263.pdf ;<br>LOCSU, RNIB, UKVS | Raises profile of this Service and need for its inclusion within Care Pathways. | Patient Support .<br>All Ages |
| | | | | | | | | |
| 10 | Low Vision Service (LVS). Every Commissioning Organisation (e.g. CCGs in England) to have commissioned a LVS to be provided either within HES , community or both. | | 100% | Annual | Data Source: Service Contract Specification.<br>Data Collection : Local Trust or Service Provider Audit | RCOphth /CO : https://www.rcophth.ac.uk/wp-content/uploads/2014/12/Low-vision-guidance-25-11-13-2013_PROF_263.pdf ;<br>LOCSU, RNIB, UKVS | Raises profile of this Service and need for its inclusion within Care Pathways.<br>Risk that LVS may not be considered as part of traditional "treatment" pathway or recognised as a relevant part of patient management. | Patient Support .<br>All Ages |

# Appendix 2



# London Eye Health Network working group members

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| | | |
|---|---|---|
| Susanne Althauser | Consultant Ophthalmologist | Royal Free London NHS Foundation Trust |
| Phil Ambler | Director of Policy | Thomas Pocklington Trust |
| Chris Bentley | Consultant Ophthalmic Surgeon | Central Middlesex Hospital & Imperial College Healthcare NHS Trust |
| Katy Binstead | Senior Optometrist | Moorfields Eye Hospital NHS Foundation Trust |
| Mike Brace CBE | Chair | Havering Vision Strategy Group |
| Salvatore Camilleri | Optometric Advisor | NHS England (London) |
| Janet Carlton | Dispensing Optician | Carlton - Dispensing |
| Claire Daniel | Consultant Ophthalmic Surgeon / A&E Service Director | Moorfields Eye Hospital NHS Foundation Trust |
| Parul Desai | Ophthalmologist / Consultant in Public Health | Moorfields Eye Hospital NHS Foundation Trust |
| Lisa Donaldson | Optometrist | City University London |
| Jon Doyle | General Medical Practitioner | Clinical lead - NHS Bromley CCG |
| Elizabeth Frost | Optometric Advisor | NHS England (London) |
| Eyall Gelbart, | Optometrist - LOC Chair | Merton, Sutton and Wandsworth LOC |
| Helen Gibbons | Clinical Nursing Lead (Education and Research) | Moorfields Eye Hospital NHS Foundation Trust |
| Fran Hibbert | Chief Officer | Merton Vision |
| Gordon Ilett | Optometrist - LOC Chair | Bexley, Bromley and Greenwich LOC |
| Jignasa Joshi | Optometrist - LOC Chair | Barking & Dagenham LOC |
| Stephen Kill | National Manager - Eye Care and Vision | SeeAbility |
| John Lawrenson | Professor in Optometry | City University London |
| Karon McCarthy | Orthoptist | Kings College Hospital NHS Foundation Trust |
| Wendy Newsom | Lead Optometrist | Moorfields Eye Hospital NHS Foundation Trust |
| Karen Osboun | Chief Executive Officer | Kent Association for the Blind |
| Abi Page | Dispensing Optician | Page and Small Opticians |
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| Mala Rao | Public Health Lead | Public Health England (London) |
| Patti Richards | Care Pathway Redesign Manager | NHS Bromley CCG |
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| Mike Woolston | Head of Services - London | Guide Dogs for the Blind Association |
| Rahila Zakir | Consultant Ophthalmic Surgeon | Western Eye Hospital, Imperial College Healthcare NHS Trust |

# Appendix 3 Abbreviations



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| AMD | Age-related Macular Degeneration |
| BIOS | British and Irish Orthoptic Society |
| CCG | Clinical Commissioning Group |
| CO | The College of Optometrists |
| DESP | Diabetic Eye Screening Programme |
| DMO | Diabetic Macular Oedema |
| ECLO | Eye Clinic Liaison Officer |
| FYFV | Five Year Forward View |
| GRR | Glaucoma Referral Refinement |
| LOC | Local Optical Committee |
| LOCSU | Local Optical Committee Support Unit |
| LVS | Low Vision Service |
| MECS | Minor Eye Conditions Scheme |
| NHS | National Health Service |
| NICE | National Institute for Health and Care Excellence |
| NPSA | National Patient Safety Agency |
| PHOF | Public Health Outcomes Framework |
| GOS | General Ophthalmic Services |
| OCT | Ocular Coherence Tomography |
| RCOphth | Royal College of Ophthalmologists |
| RNIB | Royal National Institute of Blind People |
| RVO | Retinal Vein Occlusion |
| SPG | Strategic Planning Group |
| UKVS | UK Vision Strategy |

# Eye Health Network for London: Achieving better outcomes

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