NHS England

Eye Health Network for London: Achieving Better Outcomes

Executive summary

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The report aims to deal decisively with eye health and sight loss, reduce health inequalities for London's population and deliver cost efficiencies by embracing the Five Year Forward Plan. It has been endorsed by the Clinical Council for Eye Health Commissioning for England and the Ophthalmic Public Health Committee of VISION 2020 (UK). 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'.

The commissioning and delivery of eye health and sight loss services can be complex; pathways frequently cut across borough boundaries and involve many providers in a network of care. By working together at a greater scale, there are many opportunities for greater efficiency in the commissioning, procurement and delivery by reducing the duplication of effort and the waste of resources.

Q. Why is this important to Patients?

Patient feedback is that the system is often seen as chaotic and rushed. We have to improve outcomes and the experience for patients, by streamlining and integrating the pathways. All clinicians need to be clear on referral thresholds for their patients and the most appropriate pathway. Patients also say that advice and guidance on how to access sight loss rehabilitation services is often lacking. Hence, the need for Eye Clinic Liaison Officers (ECLO) to be part of the service specification **(Recommendation 1: ELCO).** Eyecare services also need to be able to respond to individual patient needs; for example, when more clinic time is required (**Recommendations 9: People with Learning Disabilities, 10: People with Dementia).**

Q. Why should this be important to Clinical Commissioning Groups (CCGs) and Health and Wellbeing Boards (H&WBs)?

NHS England commissions General Ophthalmic Services (e.g. NHS sight test and CCGs commission community eyecare and the Hospital Eye Service (HES). This split can lead to a variation in the coverage of schemes and inconsistency in the referral pathways. Therefore, CCGs and H&WBs need to ensure that an Eye Health Needs Assessment is part of the commissioning process in order to provide data on the current performance of local services, and an assessment of present and future needs. However, accurate and relevant performance data is sparse. The poor quality of data can undermine the confidence in the information used to plan and commission services, assess quality and ensure effective use of resources.

Measurement of performance for wet age-related macular degeneration (AMD) treatments times and for delayed follow-up appointments in glaucoma are therefore included in the Portfolio of Indicators **(Recommendation 2)**. Minimising service variation and duplication of effort within pathways are essential. Commissioners need to develop a five year forward capacity plan to manage the increase in activity in these areas **(Recommendations 3: AMD, 7: Glaucoma).**

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Low Vision Services are delivered by the HES and through Borough Services. These would benefit from greater integration and improved links with rehabilitation services (**Recommendation 8: Low Vision).**

Q. Why is this important to Ophthalmology?

Hospital ophthalmology departments are very busy places and likely to be even busier in the future. It is therefore important that patients who need to seen there are appropriate, are seen promptly and any follow up appointments are not delayed. Patients who are assessed as low risk should have the option to be seen in a community setting. However, the aims for such community ophthalmology services need to be clearly defined, supported by a multi-professional workforce, and utilising imaging technology and virtual clinics (**Recommendations 3: AMD, 4: Cataract, 5: Children's' screening, 6: Diabetic Retinopathy, 11: Urgent Care).**

Q. Why is this important to GPs?

For the vast majority of GPs, simple eyecare such as treating conjunctivitis is considered to be part of the routine workload. However, without access to specialist equipment, it can be difficult to exclude other ocular co-morbidity. Access to Minor Eye Condition Schemes can often avoid urgent GP referrals to eye casualty departments **(Recommendation 11: Urgent Care).**

Most optometrist referrals to the HES still go via the GP; a greater use of direct referral would be a more efficient process, saving both time and effort for all involved.

Q. Why is this important to Optometry?

Optometrists are the primary referrer in about 90% of all ophthalmology referrals.HES feedback to optometrists is poor in many areas. Feedback to the referring optometrist following every referral they make would help to educate them in their referral decision making and improve the quality of future referrals they make **(Recommendation 12: Communications).**

There is potential for more to be done in Primary Care, as happens in some parts of England and through national Optometric contracts in Scotland and Wales. In London, similar arrangements could be applied to cover much larger areas, as about 20% of patients do not stay within their CCG area for their primary eyecare and therefore, may not access the services commissioned for their population (**Recommendations 4: Cataract,7: Glaucoma, 11: Urgent Care).**

Q. Why are Eye Health Services considered important compared to other NHS services?

Early detection, prompt access and treatment of eye problems are so important to achieve better outcomes for patients.

Activity within eye health and sight loss services is increasing. There were 12.7 million NHS sight tests conducted in England in 2013/14. This is an increase of 2.5 million more NHS sight tests than in 2005/06 (private eye examinations in 2013/14 were estimated at 5.5 million). Alongside this, ophthalmology has the second highest number of outpatient attendances for any speciality. There were 6.85 million outpatient attendances in 2013/14 (over 60% of all outpatients were aged 60 years and over, with 20% being over 80 years). This is an increase of over 1.75 million more appointments than in 2005/06. With an ageing population and the introduction of more advanced treatments, this is set to rise even further, especially in the medical retina and glaucoma sub-specialities. Reports of capacity issues in some areas suggest the status quo is not sustainable and more innovative, integrated models of care need to be tested at greater scale.

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