CLINICAL COUNCIL

FOR EYE HEALTH COMMISSIONING

Priorities for Delivering the NHS Long Term Plan for Eye Health

www.ccehc.org.uk

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Introduction

The eye health and sight loss sector has identified and highlighted the challenges facing current and future eye health and care services. The capacity pressures endemic in the wider NHS are also a core feature of eye health services. In addition, the processes for the commissioning and provision of eye health services across pathways of care are fragmented, with fragmented solutions for different parts of a pathway of care operating in silos. Collectively this results in inconsistency, delays, duplication, waste and unwarranted service variations, with governance and quality assurance issues at boundary hand-overs between steps along the care pathway.

The Clinical Council for Eye Health Commissioning (CCHEC www.ccehc.org.uk) has developed some strategic solutions for the transformational changes required to address these challenges culminating in the **S**ystem and **A**ssurance **F**ramework for **E**ye-health (SAFE), 2018, which broadly aligns to the ambitions of the NHS Long Term Plan (LTP) – ***Appendix1****: NHS Long Term Plan 2019 - Implications and Application to Eye Health.*

The LTP sets out the priorities for healthcare over the next ten years and how the NHS funding settlement will be used. It calls for a new service model for the NHS, different ways of working harnessing new technologies and interventions to improve care and outcomes for patients and population health; and to support healthy ageing across the life course.

Details on the application of the LTP and its delivery for eye health are provided in ***Appendix1:*** *NHS Long Term Plan 2019 - Implications and Application to Eye Health,* and ***Appendix 2:*** *Implementation of safe: The System and Assurance Framework for Eye-health,* respectively.

The CCEHC presents here the priorities for how the LTP can be delivered for eye health and care through the collaborative efforts of commissioners, service providers and clinicians.

1. System Improvement

LTP Chapter 1: *Integrated Care Systems (ICSs) are NHS England's preferred model for healthcare planning and provision and to be established by 2021.*

The Ask: Include eye health in the development of ICSs and their operating infra-structure for networked care, governance, quality assurance and health information.

How: Implement the **S**ystem and **A**ssurance **F**ramework for **E**ye-health (SAFE) to deliver the system[1] based transformational changes as outlined in the LTP, for eye health. SAFE provides evidence-based, optimal whole system pathways that have been developed by collaborative clinical leadership across the eye sector. (www.ccehc.org.uk).

SAFE presents what a good eye health and care service system[1] looks like and what is expected of it, to meet population eye health needs. (***Appendix 2****: Implementation of SAFE*)

Why: SAFE is operational at ICS level and supports planning and commissioning at this scale for the provision of systems delivering whole pathways of care based on risk stratification of a patient's condition and competencies of professionals providing care – so that services are provided in the most optimal settings based on need. It takes account of the perspectives of commissioners, providers, clinicians, managers.

Implementation of SAFE will ensure that eye health and sight loss services are more proactive and joined up, providing timely coordinated care and support to individuals.

Benefits:

- Provision of consistent, coordinated care across traditional boundaries, in settings appropriate to the patient's clinical status (risk); making best use of available expertise and resources, whilst avoiding waste and duplication and delays for care.
- Redesign of services delivering the system pathway to alleviate pressures on the hospital eye services (acute and chronic conditions, and emergency services)
- Shift in emphasis to whole pathways of care rather than its component stages so that the implications of a change or redesign in any one stage are considered both upstream and downstream along the entire length of the system pathway.
- Clarity in the roles and collective responsibility of all those involved in the planning, commissioning and provision of services across the system pathway.
- Overcomes the fragmentation and compartmentalisation of commissioning and provision that currently exist.

[1] ***A service system*** delivers a whole pathway of care which provides a range and continuum of services that are based on risk stratification of a patient's condition and the competencies of the professionals providing care. Delivery of the whole pathway may involve multiple providers and settings to address the health needs of a defined population**.**

2. Service Improvement

LTP Chapters 1 and 3:

The NHS will increasingly be more proactive, joined up, coordinated and differentiated in the services it provides and in its support offer to individuals.

Out-patient services will be redesigned.

2.1 New Service Models

The Ask: Eye health hospital care is predominantly an out-patient delivered service. Redesign to allow specialist out-patient care to be prioritised on diagnosis and active management and treatment, requires specific commissioning and organisation of patient flows into the system and for step-down ongoing management, support and care. This includes: service provision to improve quality of referrals (reducing unwarranted variation), monitoring and review of stable and low risk conditions, and support for patients with sight impairment.

How: Apply the CCEHC Frameworks www.ccehc.org.uk which underpin the whole service system pathway (SAFE), to commission and provide:

i. ***Primary Eye Care Services*** (first contact care) which are commissioned consistently and delivered by primary eye health professionals (who have the necessary equipment in primary care settings), to improve quality of referrals to specialist services, and manage low risk conditions in primary care.

ii. ***Community Ophthalmology Services*** delivered by a community of multi-disciplinary eye health professionals to monitor patients with stable, chronic disease; or assessment and management of patients whose eye conditions are at low-risk of deterioration. This will include virtual clinics.

iii. ***Low Vision, Habilitation and Rehabilitation Services*** delivered in health and social care settings, should be available to support and maintain the mental health, independence and social inclusion for those living with sight impairment and sight loss.

Why: These Frameworks provide the architecture for how services are organised and delivered at different stages of the system pathway; with explicit requirements for their commissioning, provision and governance, to facilitate integration and continuity along the patient's journey along the course of the system pathway.

Benefits:

- Alleviates pressures on traditional services and supports redesign of some Out-Patient Services
- Improves patient flows and reduce delays for appointments along the whole system pathway.

- Connects primary eye care teams and multi-disciplinary eye health teams (MDTs) to specialist hospital eye services, whilst keeping GPs in the loop but not impinging on their time or resource.
- Enables primary eye care teams to provide care to the population served by the wider primary care networks
- Improves access to services for patients.

2.2. Screening Services

The Ask: Screening services should not be considered in isolation of related onward diagnostic and treatment services.

Why: The Diabetic Eye Screening Programme (DESP) is a mandated National Screening Committee (NSC) programme, and Vision Screening in children aged 4-5years is recommended by the NSC. Both are a significant source of referrals to eye health services for onward investigation and management, and avoidable duplication of service provision.

DESP has established quality assurance and monitoring standards and processes. Whilst service specifications and standards for quality assurance are available for vision screening for children aged 4-5years, there are significant variations in their application.

How: In addition to applying the respective quality assurance standards, specifically monitor the appropriateness and outcome of referrals from these screening programmes and their impact on onward specialist service demand and activity.

Establish OCT surveillance clinics as recommended by DESP for diabetic maculopathy not requiring treatment, to reduce referrals to specialist ophthalmic services and for monitoring stable for diabetic maculopathy.

Benefits:

- Avoids duplication
- Improves quality and effectiveness of screening services
- Improves patient experience
- Releases specialist ophthalmic capacity

3. Enabling Infrastructure

3.1 Digitisation and IT connectivity

LTP Chapter 5: *Technology will enable the NHS to redesign clinical pathways and support health and care staff to deliver joined up services.*

The Ask: Establish IT connectivity across primary eye care practitioners (primary care optometrists) to enable continuity of direct patient care between primary eye care and ophthalmology teams providing specialist care in hospitals.

How: Implement the review recommendations of the IT Connectivity Programme Board

Why: The primary eye care (first contact) professional responsible for the highest proportion of ophthalmology referrals is the optometrist. Access to the E-Referral (e-RS) with image transfer and commissioning of primary eye care services and community ophthalmology services (as per the CCEHC Frameworks), which are dependent on appropriate IT, are key to achieving transformational redesign of ophthalmic Out-Patient Services and development of networked care.

Benefits:

- Improve quality and tracking of referrals into hospital and their booking into appropriate clinic appointments
- Reduce burden on GP time
- Improved access to services for patients
- Facilitates good practice and shared learning through communication and feedback between ophthalmic specialists and primary eye care professionals.
- Enables primary eye care teams to be participate in the wider primary care network system

3.2 Health Information

LTP Chapters 3 and 6: *The NHS will reduce unjustified variation in performance*

The Ask: Regular, systematic review and monitoring of eye health and care at ICS level through a formal quality board (or equivalent structures) as these become established.

How: Adopt the Portfolio of Indicators for Eye Health and Care and implement SAFE service systems. These are available to use now by the structures and processes being put in place for this purpose for ICSs.

Why: To identify unwarranted variations in quality, outcomes and inequalities.

Eye health service provision is a high-volume NHS activity, but is not routinely reviewed at population level for unwarranted variation. The Portfolio provides the metrics for the SAFE system pathways to demonstrate populations at risk of poor eye health, and for monitoring access, availability and outcomes of key eye health and care services. NHS RightCare include SAFE and the Portfolio of Indicators in their Vision Toolkit[2] together with additional data on service activity and costs.

Benefits:

- Quantify unwarranted variations and inform appropriate action
- Improve patient safety
- Monitor impact of service developments on access and outcomes

[2] **NHS RightCare Vision Toolkit** – expected to be published during 2019.

4. Prevention and Inequalities

LTP Chapters 1 and 2: *Stronger NHS action on prevention and health inequalities*

The Ask: Embed an eye health assessment in planned (and existing) service models for healthy ageing, dementia care, learning disability and autism, and include eye health in wider NHS activity for prevention of avoidable illness and inequalities.

How:

i. Promote the value of regular GOS NHS sight tests (and eye examinations where not entitled), recognise the relationship between overall health and maintaining good eye health, and include in planned public health messages and interventions for maintaining good health.

ii. Commission joined up low vision, habilitation and rehabilitation support services for people with poor vision of all ages, by applying the CCEHC Low Vision, Habilitation and Rehabilitation Services Framework (www.ccehc.org.uk) and including as integral components in a system pathway (as advocated by SAFE)

Why: All of the prioritised risk (lifestyle) factors in the LTP associated with the main conditions responsible for premature mortality are also associated with poor eye health. The factors associated with broader health inequalities are all applicable to eye health.

Assessing the needs for healthy ageing should include sensory health assessment (vision and hearing) which can contribute to the morbidity associated with dementia, frailty, mental health and dependency.

People with sight impairment and sight loss are at particular risk of falls (all ages), so mobility training and environment management at home is key here. It is also more difficult for them to join regular exercise classes for strength and balance, and may require additional support or special arrangements to enable their participation in these preventative activities to maintain their genera l health.

Low vision and rehabilitation services providing support and care for people of all ages with vision impairment are essential for the maintenance of their overall health and well-being. However, there is variation in the commissioning and planning for these services which are delivered across health and social care settings. Consequently, there is not only variation in the availability and quality of these services, but delays in accessing them as well.

Benefits:

- Add value to general health and lifestyle interventions
- Make every contact count more holistically.
- Prevent falls and accidents in an identifiable population at risk
- Maintain independence, social inclusion, and mental health of people with sight impairment and sight loss.

5. Workforce

LTP Chapter 4: *Tackling workforce shortages and supporting staff*

The Ask: Invest in the development of the eye health workforce

How: Health Education England should work with the professional bodies to take forward the Ophthalmology Common Clinical Competency Framework[3] for non-medical eye health professionals to deliver patient care within a multi-disciplinary team in a hospital setting; and the recommendations from the Royal College of Ophthalmologists for specialty training and workforce development. The needs of the eye health workforce working in other settings should also be supported.

Why: Eye health is a high-volume NHS activity facing the same challenges as the wider NHS with recruitment and retention of staff and workforce shortages, highlighted in the LTP.

The eye health sector has embraced multi-disciplinary team working, recognising the need for accredited training to acquire the skills and competencies required for extension of clinical roles to provide the additional capacity to the ophthalmology workforce delivering direct patient care.

The Royal College of Ophthalmologists' workforce census consistently highlights the shortage of consultant and specialty training posts required to meet the demand for specialist ophthalmic care

Benefits:

- Motivated, skilled workforce to meet population eye health needs
- Delivery of timely, effective care to patients
- Improve access to care

[3] **Ophthalmology Common Clinical Competency Framework** – Royal College of Ophthalmologists 2016. It provides standards and guidance for the knowledge and skills required for non-medical eye healthcare professionals to deliver patient care. https://www.rcophth.ac.uk/professional-resources/new-common-clinical-competency-framework-to-standardise-competences-for-ophthalmic-non-medical-healthcare-professionals/

Summary

The LTP is directly applicable to eye health.

Presented here are approaches for the provision of eye health service systems delivering whole pathways of care that can be applied to the development of networks of care within an ICS. Some of these are already happening but often commissioned and delivered in a piecemeal fashion overlooking their impact across the service system, thereby limiting their long-term effectiveness and sustainability. The transformational changes proposed and presented above would serve to address these whilst delivering the LTP for eye health and care.

APPENDIX 1

NHS Long Term Plan 2019 - Implications and Application to Eye Health (June 2019)

Eye Health and NHS-LTP-F.xlsx

APPENDIX 2

System and Assurance Framework for Eye-health (SAFE) – Implementation

Introduction

SAFE provides a systems-based approach, with tools and resources (including metrics), for the collaborative planning, commissioning and provision of eye health and care service systems. (***Figure 1- SAFE overview***) www.ccehc.org.uk

A SAFE service system is commissioned to deliver a whole pathway of care providing a range and continuum of services that are based on risk stratification of a patient's condition and the competencies of the professionals providing care. Delivery of the whole pathway may involve the contracting of multiple providers and settings to address the health needs of a defined population.

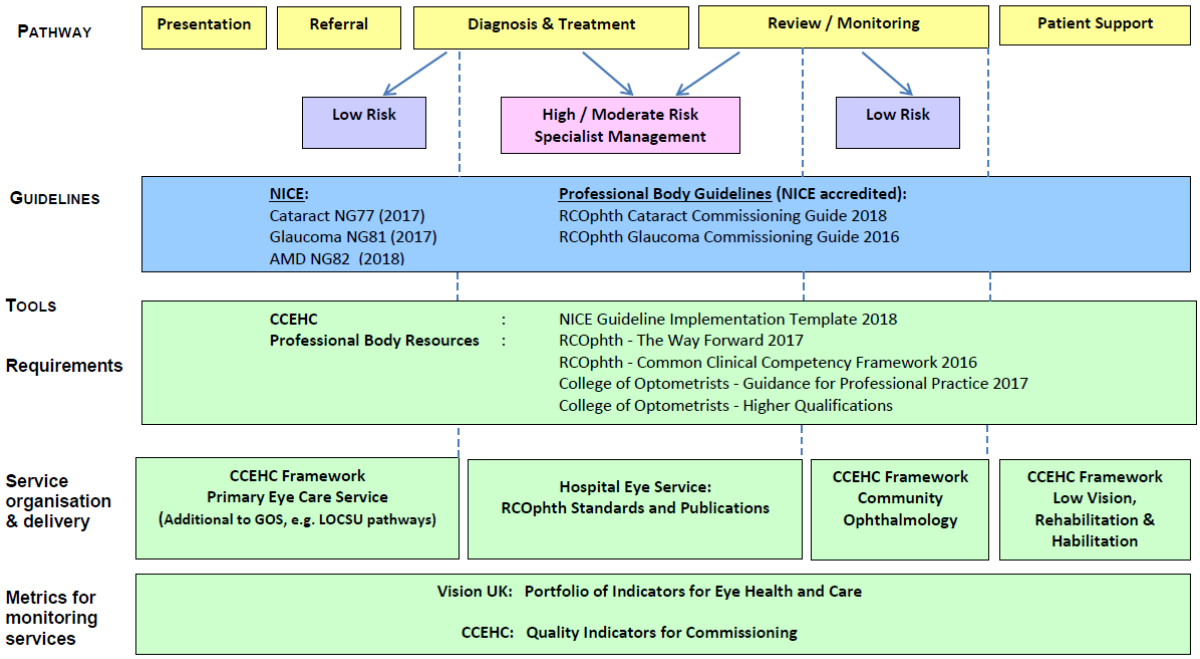
SAFE is operational at Integrated Care System(ICS) or equivalent scale or population level. Its implementation will enable "right commissioning" of services and provision of "right care", to facilitate and improve patient flows along the system pathway, improve access to services, avoid delays in care, support capacity management and reduce service variations. It will support patients being managed in the most appropriate setting by competent eye health professionals, prioritising specialist ophthalmic care for diagnosis and treatment, and management of high-risk patients or those with complex conditions (including comorbidities).

SAFE resources provide the evidence base for "*what should happen*" (NICE or NICE accredited guidelines). SAFE tools support "*making it happen*" and include requirements for services and clinical practice, how services are organised and delivered, and metrics for ongoing review and monitoring of service provision and outcomes. It can be applied to any condition or patient group, at any population level.

SAFE describes what a good eye health and care service system looks like and what is expected of it, to meet population eye health needs.

SAFE presents an innovative service model for NHS eye health and care, redesign of some current out-patient services, addresses unwarranted variation, and supports healthy ageing. In doing so it is fully aligned to the ambitions of the NHS Long Term Plan.

Figure 1. **Schematic Overview of the SAFE Service System**



Complete details of SAFE and the SAFE tools and resources presented above are available at www.ccehc.org.uk

IMPLEMENTATION OF SAFE WILL REQUIRE THE FOLLOWING:

1. Organisations (commissioning and providing services) within ICS geographic boundaries will need to:

1.1 Review and map current pathways, service provision, gaps and patient flows within the area.

Experience indicates that there will be gaps in what is known around availability of services and pathways, and who is providing what; that what is available is not joined up and patients may be at risk of falling between the interfaces between steps in the pathway; with multiple duplication and waste of resources.

1.2 Review workforce and infra-structure to identify the available skill-mix and the requirements for additional training and upskilling to acquire the necessary competencies for different ways of working across the system pathway. The enabling infrastructure to deliver services will include estate, equipment for clinical assessment, and IT connectivity and training to use it. IT connectivity for primary eye care will be a major enabler for making the transformational changes required for system pathways; as will the development of EMRs and patient administration systems to hold data on all primary referrers (GP and optometrist) to allow for effective communication, feedback and continuity of patient care.

1.3 Consolidate current status into a whole system pathway. Applying the findings from the reviews above -

- Use the CCEHC Frameworks providing the architecture for the organisation and delivery of services across the whole pathway, to establish the service system.
- Undertake risk stratification of the patient population (existing and new) to re-direct patient flows to the most appropriate setting for service provision along the system pathway.

1.4 Prioritise chronic disease management and high volume service activity: glaucoma, age-related macular degeneration, diabetic eye disease and cataract

2. Actions for "Right" (*skill-based*) Commissioning

2.1 Use the Primary Eye Care Service Framework to commission and provide an integrated Primary Eye Care service across the ICS, with consistent protocols, governance and quality assurance processes, to:

- improve quality of referrals using filtering within existing primary care
- manage low-risk eye conditions
- allow for pre- and post-operative cataract surgery reviews

2.2 Use the Community Ophthalmology Services Framework to re-align existing services, and to commission and provide consistent, quality-assured, step down care across

the ICS which is delivered by a community of multi-disciplinary eye health professionals in appropriate settings making better use of technology for service delivery, to:

- manage eye conditions referred appropriately from Primary Eye Care Services
- monitor stable low risk ocular hypertension (OHT) and suspect glaucoma patients
- monitor retinal disease -
    - Age related macular disease (AMD) - early AMD, late dry AMD, and patients with wet AMD discharged from hospital (secondary care) following treatment
    - OCT surveillance of diabetic retinopathy as an adjunct to the routine screening service
- include virtual clinics

2.3 Use the Low Vision, Habilitation and Rehabilitation Services Framework to address the current fragmentation in commissioning and provision of these services, and the delays and inequalities in the availability of these services, which should be integral components in a system pathway. This Framework can be applied to align commissioning and provision between health, social care and education funded services for children and adults with vision impairment and sight loss across the ICS, to maintain the following throughout their life course -

- independence
- social inclusion
- mental health

This framework may inform services provided by charities and voluntary services and their alignment with health and care.

2.4 Apply Metrics for Right Commissioning

2.4.1 SAFE Quality Indicators for Commissioning - these are a series of statements focusing on the quality of the commissioning process for ensuring that structures and process are in place for safe and effective service provision .

2.4.2 SAFE: Portfolio of Indicators for Eye Health and Care

The Portfolio provides the metrics for the SAFE system pathways to demonstrate populations at risk of poor eye health and for monitoring access, availability and outcomes of key eye health and care services.

a. *Broad Population Portfolio Indicators*

These include the following from the Public Health Outcomes Framework, which serve to identify population groups at particular risk to their eye health; inform eye needs assessments and local eye priorities; and identify opportunities for alignment with broader health priorities and health improvement interventions.

Health Improvement Domain

PHOF 2.12 % of adults (aged 18+ years) classified as overweight or obese

PHOF 2.13 Proportion physically active and inactive adults

PHOF 2.14 Prevalence of smoking in adults

PHOF 2.17 Estimated diabetes diagnosis rate

PHOF 2.24 Emergency hospital admissions due to falls in people aged 65 and over

Healthcare and Premature Mortality Domain

PHOF 4.12i-iv Preventable sight loss- certification of vision impairment : AMD, Glaucoma, Diabetic eye disease, All-cause new certifications

b. ***Eye Specific Portfolio Indicators***

Indicator 4i Number (and %) of CCGs in England (or by defined commissioning body) procuring a Glaucoma Referral Filtering Pathway for (a) repeat measurement service, or (b) enhanced case finding service

Indicator 4ii Number (and %) of participating practices in Glaucoma Referral Filtering Pathways for (a) repeat measurement, and / or (b) enhanced case finding; by CCG (or defined commissioning body).

Indicator 5 Has a Cataract Referral Pathway been commissioned ?

Indicator 6 Has an AMD Referral Pathway been commissioned?

Indicator 13 Has a Monitoring Pathway been commissioned for low risk or stable OHT and suspect COAG?

Indicator 14 Has a Monitoring Pathway been commissioned for early AMD, late dry AMD, and patients discharged from hospital (secondary care)?

Indicator 15 Has a Post-op Cataract Pathway been commissioned and provided within the Hospital Eye Service, Community or both.?

Indicator 16 Has an Eye Care Liaison (ECLO) Service commissioned and provided within the Hospital Eye Service, Community or both?.

Indicator 17 Have Low Vision, Habilitation, and Rehabilitation Services (LVHRS) been commissioned and provided within the Hospital Eye Service, Community or both.?

3. Actions for Provision of "Right" Care

3.1 Risk stratification of the patient population in hospital-based ophthalmic out-patients

Prospectively review and risk stratify the *current* patient population (Attenders and Non-Attenders) to identify those who would be suitable for step-down care, to release capacity in specialist, active management clinics; and continue to do so on an ongoing basis.

Completion of Actions 1 and 2 of NHS England Elective Care Transformation Programme: Transforming Elective Care Services: Ophthalmology, should provide assurance that failsafe processes have been put in place to avoid delays, and should have identified the scale of the *backlog* of cases awaiting review (including risk stratification).

3.2 System Quality Assurance.

Establish processes to identify unwarranted variation (e.g. through audit) and embed these in the developing infrastructure for regular review and appropriate action across the ICS. During the transition to ICS ensure this is effected through existing processes such as Trust/ CCG clinical quality review groups; Trust contract monitoring groups etc.

3.3 Apply Metrics for Right Care

3.3.1 SAFE – Portfolio of Indicators for Eye Health and Care

The Eye Specific Portfolio Indicators provide the metrics for monitoring access, availability and outcomes of key eye health and care services, and support review of observed variations.

a. *Service Outcomes*:

Indicator 2i Proportion of those offered diabetic eye screening who attend a digital screening event (all ages). [Diabetic Eye Screening Programme (DESP) performance indicator DES-PS-7]

Indicator 2ii % children and young people (CYP) aged 12-24 years diagnosed with diabetes that are screened. [Uptake in CYP is poorer than older age groups and can be masked by the overall uptake indicator (DES-PS-7)].

Indicator 7 Visual Acuity outcomes of Anti-VEGF therapy at baseline and at one year after starting treatment for: (i) wet AMD; (ii) Diabetic Macular Oedema (DMO); (iii) Retinal Vein Occlusion -Central (CRVO) and Branch (BRVO).

Indicator 8 Visual Acuity outcomes of Cataract Surgery: (i) Visual acuity at time of surgery (pre-operative); (ii) Visual acuity at 4-6 weeks post-operative assessment .

Indicator 12 Audit of certification of visual impairment (CVI): (i) where the primary cause of vision impairment in Adults is due to AMD, Glaucoma and Diabetic Eye Disease; (ii) in Children by primary cause.

Indicator 18 Registered blind and partially sighted persons (local authority data of persons in need who are known to social services)

b. *Service Quality and Safety*:

Indicator 9 % of Urgent (R3A M0 and R3A M1) Diabetic Eye Disease seen within 6 weeks of screening event. [DESP performance indicator: DES-PS-12]

Indicator 11 % Hospital appointments that occur within 25% of their intended follow up period, including rescheduling of hospital initiated cancellations and non-attendance

This indicator has been adopted by –

i. NICE Quality Standards for Serious Eye Disorders (QS 180, February 2019): process statement (c) for quality standards 4 and 5. https://www.nice.org.uk/guidance/qs180

ii. NHS England Elective Care Transformation Programme: Transforming Elective Care Services: Ophthalmology (2019)

3.3.2 *Referrals to Specialist Ophthalmic Services*:

a. *False-positive referrals from*-

- Diabetic eye screening programme
- School vision screening
- Primary eye care services e.g. for minor eye conditions, suspect glaucoma
- Community ophthalmology services e.g. for urgent eye care, suspect wet AMD , glaucoma

These indicators provide information on the quality of these services, and their impact on onward specialist care.

b. *Quality / appropriateness of referral*: % discharge at 1st ophthalmology out-patient appointment

Observed , potentially unwarranted variations in this indicator serve to highlight differences in the availability of appropriately commissioned services (i.e. primary eye care services for repeat testing and referral refinement prior to referral), and differences in the quality of referrals; all of which have an impact on the delivery of onward specialist ophthalmic care.

3.3.3 *NHS Right Care Vision Toolkit -* for data on service activity and costs, to allow for review and appropriate benchmarking. (*publication pending*)