CLINICAL COUNCIL

FOR EYE HEALTH COMMISSIONING

Strategy 2016 - 2018

Commissioning for the needs of the patients

Enhancing eye health services

WHO ARE WE?

The Clinical Council for Eye Health Commissioning (CCEHC) is the national clinical voice for eye health in England.

The Clinical Council brings together the leading professional, patient and representative bodies involved in eye health, providing collective expertise to commissioners, providers, clinicians and policy-makers on the commissioning of eye health services, including social care and ophthalmic public health in England.

The CCEHC's recommendation is provided in the best interest of patients, on the best evidence available and independent of any professional or commercial interests.

The CCEHC brings together the following organisations in the sector:

- Association of Directors of Adult Social Services
- Association of British Dispensing Opticians
- British and Irish Orthoptic Society
- College of Optometrists
- Faculty of Public Health
- International Glaucoma Association
- Macular Society
- Optical Confederation (including the Local Optical Committee Support Unit)
- Royal College of General Practitioners
- Royal College of Ophthalmologists
- Royal College of Nursing (ophthalmic section)
- Royal National Institute of Blind People
- VISION 2020 UK

The College of Optometrists and The Royal College of Ophthalmologists jointly act as the CCEHC's secretariat.

WHY IS IT IMPORTANT TO IMPROVE EYE HEALTH SERVICES?

- Demand for eye care services is increasing. Estimates in sight loss for the main eye disease areas are also increasing in the UK[1]. Almost two million adults in the UK have some degree of sight loss of which 12% have severe sight loss (blind) and 24% have moderate sight loss (partial sight)[2]. Without action this number is likely to double by 2050.

- In the UK people are still losing vision from avoidable causes. Sight loss has a devastating impact on people's lives and costs the UK economy almost £22 billion a year.

- About 2 in every 1000 children are living with moderate or severe sight loss and about 450 children are born or become blind each year[3]. For children, in whom serious eye disease is generally present at birth or manifest from early life, impaired vision has a significant impact on all aspects of their development and their education and subsequent employment opportunities[4].

- Increasing eye health needs due to the ageing population and availability of new treatments are generating severe capacity issues within the hospital eye service. With an increase of up to 30% in eye clinic attendances over the last five years, we can no longer ignore the pressure building up in ophthalmic services[5].

- Historically and currently, community and hospital eye health services have been commissioned, procured and operated as separate systems which means that services and pathways are often fragmented, inconsistent and frustrating for both clinicians and patients.

- At a time of great challenges and opportunities for the NHS, it is essential to make sure we deliver cost effective quality care to patients in England. Roles and responsibilities in the processes of commissioning and provision of care need to be clear to ensure safe and effective care to meet clinical need.

[1] 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. http://www.rnib.org.uk/knowledge-and-research-hub/research-reports/general-research/future-sight-loss-uk-2
[2] Future Sight Loss UK 1: Economic Impact of Partial Sight and Blindness in the UK adult population. Author: Access Economics, Publisher: RNIB, Year of publication: 2009. http://www.rnib.org.uk/knowledge-and-research-hub/research-reports/general-research/future-sight-loss-uk-1
[3] Solebo AL, Rahi JS (2014) Epidemiology, aetiology and management of visual impairment in children. Arch Dis Child. Apr;99(4):375-9.
[4] Rahi JS, Cable N et al (2003) Severe visual impairment and blindness in children in the UK. Lancet. Oct 25;362(9393):1359-65.
[5] The Royal College of Ophthalmologists. Increasing demand on hospital eye services risks patients losing vision. 16 March 2016.

WHAT ARE OUR STRATEGIC OBJECTIVES?

Eye health does not have a high enough profile within society and this deficit is reflected in the NHS. There is a need therefore for national leadership which brings together related groups in the ophthalmic sector so that, in relation to commissioning, there is one clinical voice in England supporting commissioners, providers and Local Eye Health Networks (LEHNs).

The CCEHC concentrates its activity on areas where collective action from its members has the biggest impact for commissioners and patients, mainly by:

1. Leading and influencing the commissioning and delivery of eye health services and eye care
2. Being an informed and evidence-based resource supporting government, policy-makers, LEHNs and commissioners
3. Initiating and responding to system developments, news, information and events relating to the above.

The CCEHC is focusing on two strategic objectives to improve the quality and efficiency of eye care:

1. To provide government, policy-makers, LEHNs and commissioners with prompt, informed and evidence-based recommendations and be an effective partner on eye health commissioning matters.

2. To develop models of care and guidance to support commissioners and providers in (re)designing local services to address growing needs, capacity issues and to improve the quality and cost-effectiveness of patient-centred care.

WHAT WILL WE DO?

1. Support the restructuring of commissioning and delivery of hospital and community eye health services.

   Why it is important: to secure efficiencies in commissioning and delivery costs while preserving and improving quality and outcomes.

2. Promote better use of capacity and resources.

   Why it is important: this will focus on the development of whole system pathways which offer timely and optimal care, streamline processes, improve access and convenience for patients, which are cost-effective and deliver high-quality, measurable outcomes at population and individual levels. Better use of capacity and resources will result in more timely care and reduce avoidable sight loss.

3. Call to improve data sharing and communication between providers.

   Why it is important: Clinical Commissioning Groups (CCGs) are unable to make informed strategic decisions on eye health services or properly understand their importance when they have inaccessible, hard-to-interpret or too little data.

HOW WILL WE DO IT?

1. By developing, as a priority, an overarching commissioning framework for eye health (See Annexes A and B) comprising interconnected frameworks to support commissioners in redesigning eye health and care services while maintaining quality, ensuring safe care, reducing service variation and improving equity of access, convenience and outcomes:

   - Primary eye care framework (July 2016)
   - Community ophthalmology framework (July 2015)
   - Low vision service framework (in work plan)
   - Hospital ophthalmology framework (linked to the Royal College of Ophthalmologists 'Way Forward')

2. By building relationships with and influencing government, policy-makers and commissioners, so that cost-effective eye care services that meet the need of local populations and patients and deliver high quality measured outcomes are commissioned across the whole of England

3. By working with and through LEHNs and other local networks and our memberships to achieve positive and transformational change at scale.

4. By promoting local evaluation and feedback to inform national and local pathway and systems developments.

HOW WILL WE MEASURE OUR ACHIEVEMENTS?

This is a long-term process that needs to be measured on a regular basis.

- How many commissioners are using the frameworks and with what effect for local populations and patients?
- Which services are being commissioned and transformed based on our recommendations and with what results?
- How many commissioners and providers are using the VISION 2020 UK Ophthalmic Public Health Committee's portfolio of indicators[6], to what ends and with what results?

Progress will be measured by an annual survey of CCGs and LEHNs.

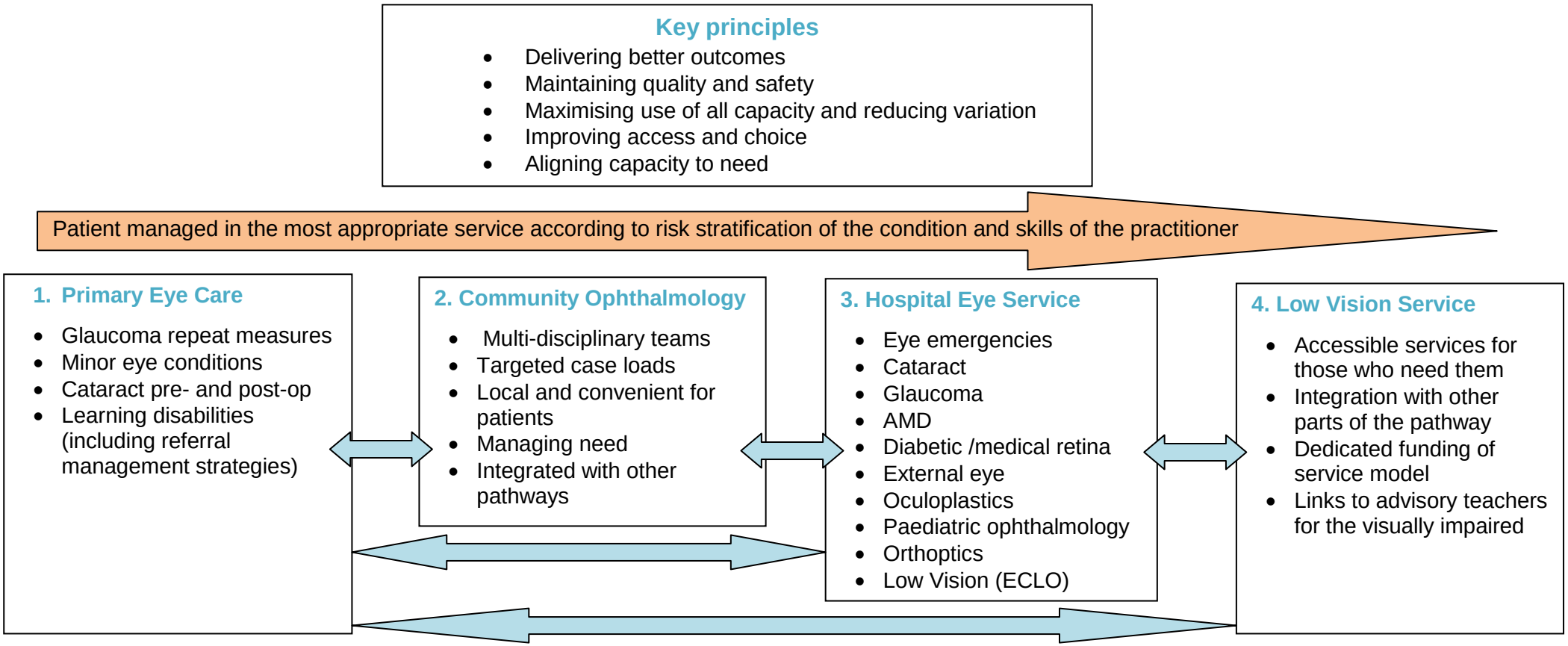
[6] This includes progress against the national ophthalmic public health indicators.

Annex A

Principles for the framework design for the delivery of safe and effective eye health services

Eye conditions such as age-related macular degeneration (AMD) and glaucoma will increase as the population ages. The number of patients receiving treatments for wet AMD in the Hospital Eye Service (HES) is already nearing capacity and those patients with glaucoma require life-long follow up. This means that the current service model is becoming unsustainable. To support commissioners and providers in meeting this challenge, the Clinical Council is bringing together groups of experienced clinical leaders and patient advocates to design a series of four interconnecting frameworks.

These will comprise **1)** an integrated primary eye care model, **2)** a community ophthalmology model using the multi-specialty community provider or integrated primary and acute care systems promoted in *The Five Year Forward View*, **3)** an efficient and effective Hospital Eye Service that is seeing and treating the patients who need to be seen on time in that setting, and **4)** prompt access and support for those patients who require Low Vision and Rehabilitation Services.



Annex B

Work plan 2016-2018

At a time of great challenges and opportunities for the NHS, it is essential to make sure we deliver cost effective quality care and support with optimal outcomes for patients and populations in England. Roles and responsibilities in the processes of commissioning and provision of care need to be clear to ensure safe and effective care based on clinical need and the CCEHC will aim always to make these explicit.

Eye health does not have a high enough profile within society or the NHS. There is a need for national leadership to bring all the interrelated groups together to support the development of integrated services that function efficiently at local level.

Both Government and NHS England have welcomed the CCEHC taking on this role in partnership with NHS England at national level and Local Eye Health Networks at regional level.

We have identified the following main issues to ensure high quality primary eye care services are consistently available to patients at the point of need:

- Addressing the current and future capacity issues in hospital eye service clinics and across primary and secondary care to meet need
- Maximising the use of capacity and skills across primary, community and hospital care (including the voluntary sector)
- Optimising outcomes and maximising value through all eye care pathways
- Restructuring commissioning and delivery of hospital and community of services while increasingly preventing eye disease in the first place, intervening as early as possible to prevent deterioration and impairment and supporting individuals with eye disease or impairment both emotionally and practically from the point of diagnosis to maximise their quality of life.

To address these priorities, the CCEHC has already developed a community ophthalmology framework and a primary eye care framework.

Planned further frameworks are:

1. Low vision and living with sight loss
2. Hospital Eye Service

1. Primary eye care framework

Action	Timescale	Responsibility	Method / Notes
Working group assembled	Jan-Feb 2016	CCEHC secretariat	The CCEHC members will be formally invited to participate. Chair and Facilitator identified and nominated at first meeting of the Group.
Face-to-Face meeting	2 Feb 2016	Chair of WG, CCEHC secretariat	A first face-to-face meeting to agree on the Working group's governance, terms of reference and the key principles of the expected outcomes.
Teleconferences – every fortnight	March-April 2016	Chair of WG	The group will mainly work on a virtual basis.
Face-to-Face meeting – initial draft framework ready	5 May 2016	Chair of WG, CCEHC secretariat	A face to face meeting to agree the key principles of an initial draft and direction of the final report.
Finalisation of draft framework	May-June 2016	Chair of WG, CCEHC secretariat	The group will finalise the content of the report and approve it. It will be then designed.
Final Framework presented for endorsement by the CCEHC	9 June 2016	Chair of CCEHC	Final version of the report will be presented to CCEHC for approval. A two week float will be factored in to accommodate any final amendments or additions.
Stakeholders consultation	Throughout July-August 2016	CCEHC members, CCEHC secretariat	Once approved, the CCEHC may decide to consult any relevant stakeholders. The goal is to fully match the needs at local level and our proposed recommendations
Dissemination of report and communication	September 2016	CCEHC members, CCEHC secretariat	The final report will be disseminated to the stakeholders through the CCEHC secretariat and through its membership. All members will be invited then to advertise the report to their own contact and to communicate on this when possible.
Follow-up	October 2016 onwards	CCEHC secretariat	It is important to ensure a follow-up as the goal is to have our recommendations implemented. Follow-up emails, phone calls and meetings considered.

2. Low vision framework

Action	Timescale	Responsibility	Method / Notes
Working group assembled	Aug-Oct 2016	CCEHC secretariat	The CCEHC members will be formally invited to participate. Chair and Facilitator identified and nominated at first meeting of the Group.
Teleconferences – every fortnight	Nov-Dec 2016	Chair of WG	The group will mainly work on a virtual basis.
Face-to-Face meeting – initial draft framework ready	December 2016	Chair of WG, CCEHC secretariat	A first face to face meeting to agree the key principles of an initial draft and direction of the final report.
Teleconferences and potential face-to-face meeting – finalisation of draft framework	Jan-Feb 2017	Chair of WG, CCEHC secretariat	The group will finalise the content of the report and approve it. It will be then design.
Final Framework presented for endorsement by the CCEHC	Feb-March 2017	Chair of CCEHC	Final version of the report will be presented to CCEHC for approval. A two week float will be factored in to accommodate any final amendments or additions.
Stakeholders consultation	Throughout April 2017	CCEHC members, CCEHC secretariat	Once approved, the CCEHC may decide to consult any relevant stakeholders. The goal is to fully match the needs at local level and our proposed recommendations
Dissemination of report and communication	May 2017	CCEHC members, CCEHC secretariat	The final report will be disseminated to the stakeholders through the CCEHC secretariat and through its membership. All members will be invited then to advertise the report to their own contact and to communicate on this when possible.
Follow-up	June 2017 onwards	CCEHC secretariat	It is important to ensure a follow-up as the goal is to have our recommendations implemented. Follow-up emails, phone calls and meetings considered.

Annex C

Communications plan 2016-2018

What	Audience	Method	When	Notes
1. General information • Strongly promoting the CCEHC and its role to government decision makers, commissioners and the eye health front-line • Regular updates on its activities **2. Achievements** • Community ophthalmology framework • Primary eye care framework **3. Current work** • Low vision framework **4. Suggested topics** • Hospital Eye Service	**Target audience** • Department of Health • NHS England, • LEHNs chairs • CCGs • Hospital Eye Service managers and clinical leads • Directors of Public Health • Local Optical Committee chairs • Member organisations and the professions • Patients • Third sector partners **Secondary audience** • Wider healthcare sector • MPs • Public	**Target audience** • Website (if resources can be identified) • Mail out to include letter and report • Follow-up emails, phone calls and meetings • Opportunity at conferences and meetings (LEHN assembly, National Optical Conference, Optometry Tomorrow, etc.) • Articles in specialised media **Secondary audience** • APPG • Coverage in newsletters and social media • CCEHC press release • Mail out from the Chair	*See work plan (Annex B)*	This is to raise awareness of what the CCEHC is doing to advance eye health to both the stakeholders/ commissioners on what they might want to do, and the public on what they would expect. Our primary goal is to ensure as much as possible that our recommendations are effectively implemented, benefit patients, communities and the public and are evaluated. We acknowledge that the primary target audience will vary depending on the topic and objective. This table is listing our main audiences in general.