WORKSHOP ORGANISER

medical management services
where medicine meets management

ACT NOW TO IMPROVE EYE CARE SERVICES

Recommended Actions for Commissioners & Providers with Case Examples from a Series of Four Workshops in England

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NOVARTIS

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A SELECTION OF QUOTES FROM THE SERIES OF FOUR WORKSHOPS

"One of the best events of this type I've been to in 10+ years"

NHS England Area Team

"I am already reviewing ophthalmology so will be using most of the day"

CCG

"Presentations and areas of discussion really useful and informative"

CCG

"Will feel more confident about prioritising eye care and how to approach redesign"

CCG

"More meetings like this please"

Optometrist

"Encouraged to pursue relationships with primary care"

Consultant

EXECUTIVE SUMMARY

"We are facing a tsunami of demand for eye care services (due to the ageing population, NICE guidance, obesity and rise of diabetes, etc) – Existing services are likely to be swamped in the next three years if we don't take action now to improve eye health services and absorb demand."

MICHAEL SOBANJA

POLICY DIRECTOR & FORMER CEO, NHS ALLIANCE & MEMBER OF THE UK VISION STRATEGY ADVISORY GROUP WORKSHOP CHAIR

WHY DOES EYE CARE MATTER?

Preventing avoidable sight loss

In 2003 the World Health Assembly's launched a resolution to tackle visual impairment globally. The UK responded by launching the UK Vision Strategy, a cross-sector initiative. In the UK, the scale of partial sight loss and blindness is:

- Currently around 2 million people with sight loss (*vision below 6/12)*
- By 2020, this number is predicted to have increased by 22%
- Patients with sight loss have an increased risk of falls, depression, diabetes and stroke, as well as suffering social isolation
- 4.5 million GP consultations per year include an eye problem *(direct cost £26billion/year and the cost to UK economy as a whole estimated at £22billion/year)*
- Ophthalmology is the second highest referred specialism from GPs; 6.4 million out-patient consultations in 2010/11

Importantly, **over 50% of sight loss is preventable**. Consequently, eye health, with a focus on ageing and sight loss, has been chosen as one of the four clinical priorities for the next three years by the Royal College of General Practitioners (RCGP).

Meeting the challenge by optimising eye care commissioning

Eye care services currently have a low profile, yet involve a high volume of work:

- 9% of all outpatient appointments
- 7%-8% of all operations performed by the NHS
- Demand in out-patients has risen by 25% over seven years.
- Currently there is unacceptable variation in the costs and outcomes of eye surgery, as well as wide variation in model of care delivery.

"Eye care's current situation is like a burning oil rig platform: STAYING PUT IS NOT AN OPTION"

JULIE WOOD

DIRECTOR, NHS CLINICAL COMMISSIONERS & INDEPENDENT HEALTHCARE CONSULTANT

The example of rationing for cataract surgery has shown that blunt measures have failed to sustainably reduce eye surgery but have had measureable adverse impact on quality of life of the patients affected. Moving forward, we need to optimise the commissioning of a broad range of eye care, to minimise avoidable sight loss through streamlining care pathways and maximising the appropriate use of all secondary and primary care providers.

CURRENT

- Unacceptable variation:
  - Costs, outcomes in 1° & 2° Care
  - Access to care
  - Between surgeons, hospitals
- Doctor delivered
- Manual & Face-to-face
- Hospital
- Paper
- Inadequate audit
- Slow communication
- Commissioning in the dark

Source: Robert Johnston, Gloucestershire

FUTURE

- Standardisation:
  - Process
  - Data collection
  - Outcomes
- Multi-professional
- Technology & Virtual
- Hospital + Community
- Electronic
- Automatic audit
- Immediate communication
- Commission to quality standards

Source: Mr Robert Johnston, Gloucestershire

This summary report is based on presentations, discussions and syndicate feedback from four Workshops held in November 2013 at Bristol, London, Warrington and York. The workshops were attended by the full range of stakeholders interested in eye care services, including NHS England, Clinical Commissioning Groups (CCGs), NHS Trust managers, ophthalmologists, optometrists, GPs, orthoptists and sight loss charities.

The primary aim of these workshops was to assemble an action plan to address the actions required by the various stakeholders in order to improve eye care and eye care commissioning.

Recommended Actions for Commissioners:

[e.g. CCGs, NHS England, HWBs]

- **PRIORITY:** Eye care planning and commissioning community-based services needs to be a priority for all CCGs (see case examples in Appendices), due to the current high demand in the hospital eye service, which will only get greater with an aging population.
- **PREVENTABLE EYE LOSS:** Avoidance of sight loss is important in terms of A&E pressure, falls, social care, etc as well as for the patients concerned.
- **EYE CHAMPION:** Appoint champions for each CCG to lead on eye care, if not already in place.
- **SHARE** information, including quantitative data, (e.g. National Ophthalmology Data – R.C.Ophth) on successful eye care commissioning pathways with other CCGs, including reporting via LOCs, NHS England and other relevant bodies. *There is no need for each CCG to reinvent the wheel.*
- **EXPAND** successful commissioning pathways/ extended community programmes into neighbouring CCGs.
- **RISK STRATIFICATION OF PATIENTS:** It is important that the clinical need (and risk/benefit) is considered within any care pathway to set parameters for step up and step down referral.
- **IMPROVE COMMUNICATION** with and between all stakeholders in the treatment pathway is vital.
- **SERVICE SPECIFICATIONS** for enhanced community eye services would ensure the same standards and parameters were applied regardless of whether they were performed by an optometrist, GP or nurse.
- **NEW TECHNOLOGY:** IT initiatives, such as virtual clinics, can improve productivity.
- **METRICS:** Systems need to be in place for the straightforward collection of data at each stage of the pathway. *[Benchmarking can be problematic due to variations across the country]*
- **AUDIT:** This should include both quantitative outcomes data, and patient-centred qualitative outcomes, including functional capacity. Royal College of Ophthalmologists and College of Optometrists already have quality of service measures in place.
- **PATIENT INFORMATION:** Work with the voluntary sector to make sure patients are aware of local community services and different pathways for eye care. Manage patient expectations, and ensure patient choice is built into pathways. Failure to do so can result in a high rate of non-attendance for appointments.
- **CONSULTATION:** Local Authorities, including HWBs and Local Eye Health Networks (LEHNs), may assist with contacting appropriate patient and client groups. Always ask: *Are we meeting local community needs?*
- **WHO NOT TO TREAT:** There needs to be consistency with regard to which conditions are out of scope and avoid the problems of 'post-code lottery'.
- **CHILDREN'S SERVICES:** Paediatric eye care also needs to be included when commissioning eye care services.

Recommended Actions for NHS England:

- **Priority:** Contracts for Optometrists need to be reviewed to encourage them to develop new community based services via a GOS Plus Contract.
- **High Level Voice:** Eye health needs a high level voice separate from professional bodies and the different sectors. While there is no National Clinical Director; a new Clinical Commissioning Council for Eye Care has just be launched.
- **National Service Specifications:** Community eye services would ensure the same standards and parameters were applied regardless of whether they were performed by an optometrists, GP or nurse.
- **National Eye Care Pathways:** Relevant bodies need to work with NICE who are preparing commissioning guidance and care pathways for glaucoma, cataracts and later other conditions.
- **Competency Framework:** Relevant colleges/ professional bodies need to be encouraged to develop refresher training and/or additional qualifications.
- **Email:** Ensure optometrists, especially those providing enhanced services, have access to nhs.net with an email address, to allow improved communication and referral.
- **Patient Education:** Education on the importance of eye health should be started in schools.
- **Public health Campaigns:** Public Health England need to be encouraged to promote eye care health screening for early detection of preventable sight loss. Encourage other campaigns to include eye health; for example, the successful FAST stroke campaign did not mention eye symptoms associated with stroke.

Recommended Actions for Ophthalmologists/ Hospital Trusts:

- **Capacity:** Raise with all relevant bodies (Hospital Trusts, CCGs, NHS England, etc) the current and future demands facing the hospital eye service, and use as a key driver for change including GP training.
- **Agree Who Needs Hospital Care:** Need to prioritise which conditions/at risk patients receive hospital eye service care and ophthalmologist care; other patients can be moved to community eye service care. Learn from other specialties, e.g. in Portsmouth, clinicians identified the 'Super Six' diabetes scenarios that needed hospital referral, others were managed in community with support of a 24/7 helpline *(Kar, 2011).*
- **Commissioning:** Develop links with Eye Champion and other relevant commissioners on the CCG.
- **Consultant Led Service:** Engage with CCG to ensure that any new pathway is consultant led and has clear parameters for re-referral to hospital.
- **Networks:** Join Local Eye Health Networks, and other such groups or meetings, in order to increase interaction between the different healthcare professionals interested in eye health. This will improve understanding of the respective roles of the different professional groups, to build up mutual trust and promote collaborative working.
- **Locum Cover:** Due to pressure of work, many ophthalmologists do not find time to get involved in commissioning, cross-professional meetings, etc. Locum cover needs to be improved to allow more involvement.
- **Step Down Care:** There should be greater focus on step down care in eye health, so that stable patients are more routinely managed in the community by GPs or optometrists.
- **Outcomes** need to be clearly defined from the start and the appropriate data collected in order to assess the effectiveness of new pathways.
- **Referral Feedback:** Provide more informative feedback to primary care regarding appropriateness of referral, diagnosis and treatment, etc. Where referral was from optometrist, provide referral feedback to both GP and optometrist.
- **Eye Casualty Referrals:** A&E need to produce clearer reports, with unified coding and data to ensure a more accurate record is obtained. *Avoid hand written notes with abbreviations!*
- **New Technology:** IT initiatives, such as virtual clinics and sharing retinal imaging, can improve productivity, allowing a consultant to advise on the management of more patients than possible by face-to-face consultations.

- **EMAIL:** Ensure optometrist email addresses are included in hospital software systems to aid referrals and feedback.
- **REHABILITATION:** See what can be learnt from stroke and cardiac rehabilitation where importance is well recognized within the system. In ophthalmology, low vision aids and sight loss rehabilitation are often cross-subsidised from the hospital eye service budget. Should these services be moved into the community? – *involve RNIB Eye Clinic Liaison Officers and HWBs.*

Recommended Actions for Optometrists:

- **NATIONAL ENGAGEMENT:** Some optometrists are already taking on additional roles such as independent prescribing and glaucoma refinement/management but there needs to be a call at a national level for a greater shift in resources to primary and community care in order to encourage more optometrists to be involved. The College is evidently producing Higher Qualifications to encourage optometrists to provide extended and enhanced services. This is required ASAP.
- **COMMUNITY SERVICES:** Most optometrists would like to be funded to use their skills more fully. Optometrists should promote optometry-led community services.
- **WORKING ARRANGEMENTS:** Some employers may not support extended roles, as it reduces the time spent on sight testing. May need to consider the use of other shared (or even mobile) premises for optometrists to deliver community services.
- **NETWORKS:** Join Local Eye Health Networks and other such groups or meetings, in order to increase interaction between the different healthcare professionals interested in eye health. This will improve understanding of the respective roles of the different professional groups, to build up mutual trust and promote collaborative working.
- **COMPETENCY FRAMEWORK:** Modules for refresher training and/or additional qualifications endorsed by relevant Colleges/professional bodies are needed. Cross-professional training for all providing follow-up/community eye care (optometrists/GPs/ nurses/orthoptics) may be an option?
- **FAST TRACK REFERRALS:** Ensure that in any new community based pathway, there is a fast track for emergency referrals.
- **OUTCOMES** need to be clearly defined from the start and the appropriate data collected in order to assess the effectiveness of new pathways.
- **TRAINING & SUPPORT:** Arrange co-operative working with hospital optometrists and ophthalmologists, etc.
- **EQUIPMENT:** Ensure equipment is of suitable quality; needs to be consistent across community care.
- **NEW TECHNOLOGY:** IT initiatives, such as virtual clinics, can allow an ophthalmologist to advise on the management of complex patients and helps boost confidence and experience.
- **CO-OPERATIVE WORKING** between eye professionals should be promoted at local and national levels (though colleges, etc).
- **MEDICAL HISTORY:** Patients may change optometrists, access to electronic medical or optometrist records would ensure fully history is available.
- **INCREASED AWARENESS:** Make sure patients are aware of local community services and what their local optometrists can do. *Not just sight tests but eye health.*
- **PUBLIC EDUCATION:** Optometrists should take a lead on eye education due to their prominent role in the High Street. Also to promote their health professional status and enhanced skills to enhance patient confidence in service.

Recommended Actions for General Practitioners:

- **IMPROVE REFERRAL QUALITY:** GPs need to assess whether patients need to be seen by the hospital eye service or can instead be referred to a local optometrist, thereby avoiding unnecessary referrals.
- **REFERRAL PROCESSES:** At the present, under many models, the GP is gatekeeper; e.g. optometrist refers patient to GP rather than direct to hospital eye service. Care must be taken that this does not cause delays and that referral forms are clearly worded. A particular issue was providing referral feedback to optometrists.
- **EDUCATION ON EYE HEALTH IS A PRIORITY:** GPs should be encouraged to attend local education programmes in eye health matters (e.g. the RCGP e-Learning module and workshops on sight loss), in particular the initial assessment of patients to ensure appropriate referrals. For example, a more confident assessment of flashes and floaters would reduce unnecessary referrals.

- **COMMUNICATIONS:** Overall there is a need for better communication between all stakeholders; GPs, ophthalmologists, optometrists, local optical committees and CCGs.
- **NETWORKS:** Involvement of GPs in Local Eye Health and other such groups or meetings, should be encouraged in order to increase interaction between the different healthcare professionals interested in eye health. This will improve understanding of the respective roles of the different professional groups, build up mutual trust and promote collaborative working.
- **COMPETENCY FRAMEWORK:** Modules for refresher training and/or additional qualifications endorsed by relevant Colleges/professional bodies are needed. Cross-professional training for all providing follow-up/community eye care (optometrists/GPs/nurses/orthoptics) may be an option?
- **PROMOTING EYE CARE AS A PRIORITY:** The RCGP has chosen eye care as a clinical priority. GPs can provide valuable additional local support to ensure eye care is kept on the agenda for future planning within general practice and within CCGs.
- **IT SUPPORT:** It should be easier for GP practices to email community optometrists, through their inclusion on NHS net. This would greatly facilitate referrals and feedback.
- **PATIENT SUPPORT:** GPs should supply patients with information sheets on common eye conditions. Ideally, the 'expert patient' scheme should extend to eye care in order to help patients manage long-term eye conditions.
- **PATIENT EDUCATION:** Routine referral of every eye problem to the eye hospital clinic or A&E reinforces the perception of the public regarding the seriousness of every eye condition. GPs can have a very effective role in reassuring patients that their eye condition is not urgent and can be just as effectively and more conveniently managed in the community.
- **VARIABLE ROLE:** Many community eye care pathways could be optometry led, with GPs having variable roles dependent in their interest, training and competencies in eye health issues. Perhaps link diabetic eye care with general diabetic care to engage GPs. There is also scope for locally commissioned services to be refined according to local stakeholders, for example involvement of GP or optometrists with special interest in ophthalmology to triage patients from other practices.
- **TEMPLATE FOR GP REFERRALS:** Currently a patient may be referred verbally to an optometrist, which means optometrist may not get full details. A template letter detailing symptoms reported at the time by the patient would be helpful.
- **COMMUNITY EYE CARE CLINICS:** There may be scope in some areas for community clinics, to avoid duplication of specialist equipment, which can be staffed by appropriate GPs and/or optometrists.
- **AUDIT:** Baseline data is fundamental to the commissioning of new pathways. GPs may be able to assist the hospital eye service in collation of existing patient referral data. As new services and pathways are rolled out, audit capabilities need to be incorporated.
- **ACCESSIBILITY FOR PATIENTS WITH SIGHT LOSS:** GPs should re-examine their practices from the viewpoint of those with visual impairment or sight loss, and make sure staff are trained in assisting such patients.
- **TRAINING:** GP training should include more eye care content; GPs with a special interest (GPwSI) in ophthalmology should facilitate more relevant training for colleagues.

London: *2.10pm Questions & Round Table Discussion with (from left to right) David Parkins, Katrina Venerus Professor Sir Muir Gray & Julie Wood*

Warrington: *2.10pm Questions & Round Table Discussion with (from left to right) Waqaar Shah, Julie Wood Robert Johnston, Dharmesh Patel & Susan Parker*

PHOTOS FROM THE SERIES OF FOUR WORKSHOPS IN ENGLAND

ROBERT JOHNSTON
CONSULTANT OPHTHALMOLOGIST, GLOUCESTERSHIRE

WAQAAR SHAH
EYE CARE CLINICAL CHAMPION, RCGP

BRISTOL WORKSHOP - 5TH NOV 2013

LONDON WORKSHOP - 6TH NOV 2013

YORK WORKSHOP - 13TH NOV 2013

WARRINGTON WORKSHOP - 14TH NOV 2013

APPENDICES

CASE STUDY – BRISTOL WORKSHOP

GLOUCESTERSHIRE: COMMUNITY FOLLOW UP OF STABLE WAMD PATIENTS

The key driver for a change in the care pathway in Gloucestershire for patients with wet age-related macular degeneration (wAMD) has been that **secondary care capacity is being stretched to the limit and beyond**. This has obvious cost implications but may also adversely affect clinical outcomes for patients. The primary aim of the service is to **minimise avoidable sight loss.**

Other considerations were the elderly patient population (many with ocular or medical co-morbidities, etc.), and meeting the needs of rural patients, who find it difficult and expensive to travel to hospital. The principles behind the new service were therefore:

"Right patient, right place, right time, right Clinician and right tariff"

The objectives of the new service were:

- To deliver community follow up of stable wAMD patients by using capacity at community optometrists. This would allow care to be delivered closer to home, whilst maintaining outcomes and reducing cost
- Novel use of IT systems to allow virtual review of data and enable decision making by hospital optometrists and consultants
- To take the test to the patient, not the patient to the test; thus, putting the patient at the centre of everything we do.

BUSINESS PLAN

- Evaluate and describe current and future needs
- Clearly define current pathway and proposed new pathway
- Outline evidence base
- Evaluate risks and benefits of the new pathway
- Produce a clear breakdown of costings and timelines
- Plan to engage stakeholders

Major challenges for this novel programme have included capture of the right image by the community optometrist, using an OCT image and ensuring a consistent quality of image. Related IT issues have included the size of the image file and transmission through the Acute Trust firewall. Other challenges have been the large volume of "stable" patients to be seen by appropriate community optometrists and making sure that rural patients have easy access and not just urban patients.

It was important that any new community-focussed care pathway meet the QIPP programme agenda. In this case, Quality would be maintained; Innovation met through the use of new IT initiatives; Productivity improved together with financial savings and Prevention of falls, depression etc. through the effective treatment of wAMD.

An audit of wAMD patients, whose first injection was at least 12 months previously, identified 238 patients who were being reviewed by the hospital eye service who had not required an injection for 6 months, as well as 308 patients being reviewed who had not had an injection for 3 months. These 'stable' patients would be suitable for community follow-up. The indicative costs for such patients was estimated as follows:

- Fee to optometrists: £45
- Tariff for virtual review by Consultant Ophthalmologist: £35
- Data transfer cost: £4.30
- Total: £84.30

This compared with the £148 (BZ23Z) fee for an outpatient vitreous retinal procedure.

LESSONS LEARNED

Keep it simple

Must fit with the QIPP agenda

Make it deliverable

Remember it always takes longer than you think….

"Only rapid and radical service redesign will allow us to meet the challenges that we currently face"

Based on a presentation by Graham Mennie, GP & Ophthalmology Clinical Lead, Gloucestershire given at the Bristol workshop

CASE STUDY – LONDON WORKSHOP

BEXLEY: HOW TO MAXIMISE OUTCOMES WITH COMMUNITY BASED SERVICES

In the London Borough of Bexley, as elsewhere in the UK, the ageing population has increased the demand for eye care related to cataract, glaucoma, AMD, diabetic retinopathy, etc. This brings pressure on the secondary care capacity, together with increased costs associated with more advanced and expensive treatments.

"There is increased pressure on the existing provision to do more"

Eye care schemes should seek to use the skills of community optometrists more effectively. Optometric practices have already made the capital investment in equipment and have accessible premises. New initiatives should follow the Right Care principles to reduce variation and duplication of effort and ideally be set up on a multi-CCG basis.

When commissioning a new service the essential elements are:

- Agree key outcomes at outset – leads to better outcomes and patient experience
- Back recommendations with clinical and financial evidence
- Commission a model to manage the whole service (all major pathways)
- Redesign needs to link to an element of decommissioning
- Programme budgeting along pathways of care – for best use of resources
- Encourage collaborative working and build on existing pathways
- Clinical leadership, educational and referral feedback
- Ensure IT is in place to support the programme needs
- Ensure there is timely auditing and evidence of quality

Current community eye care schemes

1. CATARACT REFERRAL SCHEME

Patients offered optometrist referral under choose & book scheme. Protocol included discussion of risks and benefits of surgery; 20% of patients decided not to have surgery after their optometrist assessment. Overall, 77% of those referred go on to have surgery after the first appointment, and 88% after one further visit; by comparison, this was previously under 60%. Importantly, 'did not attend' (DNA) rates reduced from 16% to 4%.

2. GLAUCOMA REPEAT MEASUREMENT SCHEME

This scheme was launched June 2005, and has resulted in 76% of glaucoma patients not requiring onward referral to the hospital eye service. In nearly 45% of cases, where raised intraocular pressure >21mmHg was found by non-contact tonometry, repeat measurement by applanation tonometry resulted in lower readings whereby referral was avoided. A financial review has proposed savings of up to 62%. *(NICE Proven QIPP case study 11 0018 – NHS Evidence)*

3. PRIMARY EYECARE ASSESSMENT & REFERRAL SCHEME (PEARS)

An audit shows the main reasons for referral are dry eye (21%), flashes/floaters (17%), red eye (16%), corneal trauma (9%), watery eyes (5%), foreign bodies (3%) and in-growing eyelashes (3%). Within the same audit, 68% of patients were discharged by the optometrist following the first appointment, 13% received a routine referral, 10% an urgent referral and 9% had a follow-up appointment. Since 2011 when the scheme was started, there have been no complaints or serious incidents. Patients were 100% confident in the service.

4. COMMUNITY EYE CARE SCHEME

Use of paperless triage on choose and book has seen 25-35% routine referrals diverted into community eye care clinics. The vast majority have been discharged after the initial or follow-up appointment, with just 4%-8% of patients being referred on.

5. Learning Disability Care Pathway

People with learning disabilities are 10 times more likely to have serious sight problems; 60% require spectacles and 9% meet the criteria for sight impairment or serious sight impairment. Extended examinations are provided for people with more profound disabilities, possibly with the attendance of a specialist worker. Improvement in sight has the potential to empower patients and may reduce the need for regular support workers. However, the savings may not come from the same budget – CCG/Health Vs Local Authority/Public Health.

The combined impact of repeat measure services and optometrist triage has been seen in a reduction in hospital eye service (HES) discharge rates after first appointment from 67% (2006) to 41% (to Oct 2010). Thus, the HES are seeing more appropriate patients that really need to be there.

"Supporting local professionals will develop and retain expertise in your local health economy"

Based on presentations given at the London workshop by:

David Parkins – Assistant Director of Quality & Clinical Advisor for Ophthalmology, Bexley CCG and Gordon Ilett – Chairman, Bexley, Bromley & Greenwich LOC

Case Study – York Workshop

Sheffield: Eye Care Services in the New World of Clinical Commissioning

The challenge within clinical commissioning is to understand the needs of the patients and ensure delivery of quality services within the resources available. A major focus is the re-design of pathways to increase the role of primary and community services.

Sheffield has a single Clinical Commissioning Group (CCG), which has close working relationships with foundation trusts and the local authority; it also has links with professional bodies: medical, dental, pharmacy, optometry, and other partners, such as NHS England. The overall aim is working to Make Sheffield Healthier and to bring care closer to home.

"Emphasis on service change, not service cuts; efficiency, not deficiency"

Eye Care Services

Eye conditions have an impact on all areas of the CCG portfolio - acute and elective care, long term conditions and the difficulties associated with old age are all affected in some way by eye health. The Sheffield CCG has worked to raise the profile of eye health and increase co-operation, communication and understanding between GPs and optometrists. They have supported training to enhance the skills required for empowered community delivery of eye care through making the best use of existing skills. This has enabled the diversion of funds to support primary care delivery of eye care. To date, Sheffield CCG has implemented the following new services:

1. Primary Eyecare Assessment and Referral Scheme (PEARS)

This service deals with patients reporting with flashes and floaters, visual blurring, dry irritable eye, non-emergency red eye, and other acute eye conditions of uncertain diagnosis. Enhanced training has been provided to the 25 optometrists offering this service. To date, 3,000 patients have been seen, with just 800 needing or requesting hospital referral. Patients have been highly satisfied with the service and there have been no reported serious events, such as false negatives.

2. Optometry Triage

All GOS18 referrals are sent via a single point of access and are screened by experienced optometrists. Patients with appropriate problems are diverted to specialist PEARS optometrists for community management and screening. So far, 7,500 patients per year have been triaged, with 50% diverted to optometry services via PEARS. Sheffield is currently piloting triage of all GP-generated ophthalmic referrals from part of the city.

3. Contact Applanation Tonometry Scheme (CATS)

This service re-screens non-contact tonometry failures with no other features at 28 approved optometrists across the city. To date, 900 patients have been seen, with 600 being discharged back to usual optometry monitoring.

4. **GLAUCOMA REFERRAL REFINEMENT (GRR)**
   The GRR service checks for pressure, discs and fields are available from 23 sites in the city.

5. **PAEDIATRIC REFERRAL REFINEMENT SCHEME (PRR)**
   Under this scheme, all school entry children are offered an in-school screen by an orthoptist. Screen failures are directed to optometry, if there is a refractive problem, or to hospital, for non-refractive issues. The optometry scheme offers correction and follow up, with an option to refer to hospital, if concerned. To date, 6,000 children have been screened, with 600 referred to optometry and 100 to hospital.

The above services have achieved high patient satisfaction, arising from the benefits of low waiting times (days) and local services, with convenient appointment times. Through the enhanced skills and wider range of optometry services, a higher quality of community eye care has been achieved, with resultant financial benefit to patients, optometrists, and the CCG. **These new services have had an assumed financial benefit of £400,000 per year.**

Future Plans

Community monitoring of stable ocular hypertension and stable glaucoma patients is being investigated, along with low vision and contact lens service provision in the community. Increased investment in training and education for optometrists are planned to further develop and expand enhanced eye care services; one aspect is to encourage optometrists to become additional prescribers by obtaining the appropriate college of optometrists' diploma.

Through enhanced eye care services, improved communication lines will be developed between hospitals and optometrists, and joint community based Optometry/Ophthalmology will be investigated. Commissioning of community-based eye care services should also help bring optometry into the public health framework.

Based on presentation given at the York workshop by:

Richard Oliver – Clinical Director Sheffield CCG and Michael Daybell – Optometrist & Sheffield Local Optometry Committee Chair & Treasurer

CASE STUDY – WARRINGTON WORKSHOP

STOCKPORT: COMMISSIONING A MINOR EYE CONDITIONS (MECS) SERVICE

" There is an Increasing capacity gap in secondary eye care"

In Stockport, there were 9,500 new eye referrals to secondary care and 25,000 follow ups, costing in excess of £5 million. However, the public are happy to see a clinician in primary care, provided they are properly qualified and experienced, and believe ophthalmologist care should be reserved for complex conditions. In a survey, 90% felt it was important to be able to self-refer for eye care services, rather than go via their GP.

Audit Results

a. An audit of 220 GP referrals (from 8 practices) found that 51% of urgent eye casualty referrals and 12% of routine referrals were suitable for MECS, overall 20% of referrals. Furthermore, a number of urgent referrals had been sent routinely.

b. An audit of Eye Casualty found 47% of patients meet MECS criteria, most commonly flashes and floaters, reduced vision, or red eye.

The Stockport CCG business case was that around 1,000 patients attend the eye casualty clinic who could be seen in MECS. This would result in:

- More appropriate use of secondary care appointments
- Assist with the increasing gap in capacity for ophthalmology

Conservative average payment by results (PbR) cost of patient attending eye casualty clinic is £152 (this assumes one follow up for 61% of patients); PbR cost of hospital follow up is £70.

By contrast, the proposed cost of Minor Eye Conditions Service is £60 (to include follow-ups).

MECS – Creation and Delivery

As well as achieving a safe and effective service, important factors for the development of MECS were to release capacity in secondary care and reduce use of GP appointments/A&E for minor eye conditions. Other major considerations were to reduce prescribing of antibiotic drops, achieve a faster and cheaper service for minor eye conditions than routine secondary care and ensure fast referral of urgent conditions into correct pathway.

An 'any qualified person' procurement process was chosen, with very detailed and specific specification. Community optometrists are well placed and skilled providers **BUT practices would need to work together**. This was achieved using the Local Optical Committee Support Unit-developed company (consortia) model:

- Management team oversee and responsible for service, with an appointed Clinical Lead
- Comprehensive IT platform to provide admin support, data collection and analysis

Stockport MECS is currently provided by 21 optometric practices (38 optometrists), meeting Quality in Optometry accreditation or having the Cardiff University (WOPEC/LOCSU) PEARS qualification. The service has the following criteria:

- **Entry**: Self-referral, or referral from a GP, pharmacist or the hospital eye service (HES).
- **Triage:** Eligibility and Urgency
- **Assessment:** within 24 or 48hrs
- **Management:** within service, where possible; referral to HES or GP, where appropriate

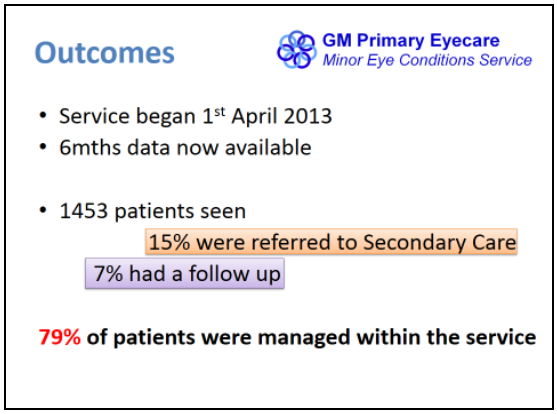
INCLUDED IN MECS

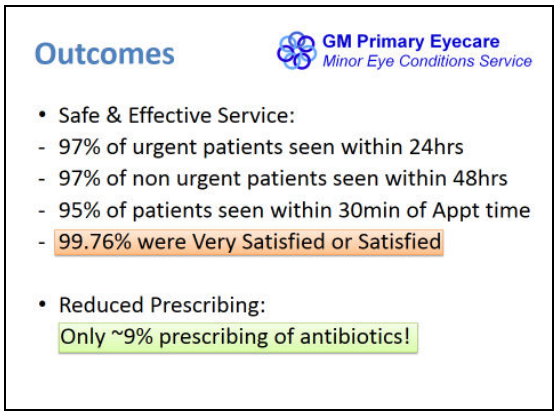
- Loss of vision
- Ocular pain
- Foreign body removal
- Dry eye/blepharitis
- Differential diagnosis of lumps and bumps
- Flashes and/or floaters
- Patient reported sudden onset field defect

EXCLUDED FROM MECS

- Orbital Cellulitis*
- Temporal arteritis*
- *Other severe eye conditions which need urgent hospital attention*
- Adult squints/longstanding diplopia
- Suspected cancers of the eye
- Dry AMD
- Conditions where other existing services are more suitable

Outcomes





"79% of referred patients were managed within the Minor Eye Conditions Service"

Based on presentation given at the Warrington workshop by:

Susan Parker, Clinical Lead for Eyecare, NHS Stockport CCG and Dharmesh Patel, Clinical Lead, Stockport Minor Eye Conditions, Greater Manchester LEHN Chair / LOCSU Optical Lead

Further Reading & Useful Links

Achieving Commissioning Excellence (ACE)
Available at: http://www.nhsace.com.server104.ukservers.net/ including ACE Focus, Issue 5: Commissioning Effective and Efficient Services to Reduce Avoidable Sight Loss. November 2013. Available at: http://www.nhsace.com.server104.ukservers.net/wp-content/uploads/2013/11/FINAL-Nov-2013-edition.pdf

Commissioning for Effectiveness and Efficiency project
This project, led by the UK Vision Strategy team, is working to develop effective and efficient approaches to the commissioning of eye care and sight loss services. More information about the UK Vision Strategy approach to commissioning can be found at: www.commissioningforeyecare.org.uk Further information about the project can be found at: www.vision2020uk.org.uk/ukvisionstrategy/commissioningproject.

College of Optometrists
Available at: http://www.college-optometrists.org/en/home.cfm

Partha Kar
The 'Super Six' for the acute trust; all else under primary care? Practical Diabetes 2011; 28(7):308-309.

Local Optical Committee Support Unit
Available at http://www.locsu.co.uk/ including Primary Eyecare Assessment and Referral Service (PEARS) Pathway December 2008 [Revised November 2013] Available at: http://www.locsu.co.uk/uploads/enhanced_pathways_2013/locsu_pears_pathway_rev_nov_2013.pdf

UK Vision Strategy
Available at: http://www.vision2020uk.org.uk/UKVisionstrategy/ including Commissioning guide for eye care and sight loss services. Available at: www.commissioningforeyecare.org.uk

Right Care 2013/14
Available at: http://www.rightcare.nhs.uk/ including Commissioning for Value insight pack. October 2013. Available at: http://www.rightcare.nhs.uk/index.php/commissioning-for-value/

Royal College of General Practitioners Eye Health
Available at: http://www.rcgp.org.uk/clinical-and-research/clinical-resources/eye-health.aspx; and GP Eye Health Network: email circ@rcgp.org.uk

Royal College of Ophthalmologists
Available at: http://www.rcophth.ac.uk/

Royal National Institute for the Blind
Saving money, losing sight. Campaign report. November 2013. Available at: http://www.rnib.org.uk/getinvolved/campaign/yoursight/Documents/saving-money-losing-sight-executive-summary-pdf.pdf http://www.rnib.org.uk/getinvolved/campaign/yoursight/Documents/saving-money-losing-sight-full-report-word.doc

Quality in Optometry
A toolkit for clinical governance in optometric practice. Available at: http://www.qualityinoptometry.co.uk/

World Health Organization
Vision 2020 Available at: http://www.who.int/blindness/partnerships/vision2020/en/

The National Ophthalmology Database
http://www.rcophth.ac.uk/page.asp?section=668&sectionTitle=National+Ophthalmology+Databse (last accessed October 2013)

Public Health Indicator briefing
http://www.vision2020uk.org.uk/ukvisionstrategy/commhome.asp?section=221&sectionTitle=Briefing+on+Public+Health+Indicator&preview=1

LOCSU LEHN Getting Started Guide www.locsu.co.uk/LEHNguide

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- **Mr Tim Manners** *(Consultant Ophthalmologist, York)*
- **Dr Andrew Partner** *(GP, Primary Care for Ophthalmology),*
- **Dr Waqaar Shah** *(GP & RCGP Champion for Eye Care with a Focus on Ageing & Sight Loss)*
- **Julie Wood** *(Director, NHS Clinical Commissioners & Independent Healthcare Consultant)*
- **Katarina Venerus** *(Managing Director, LOCSU)*

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