CLINICAL COUNCIL

FOR EYE HEALTH COMMISSIONING

Community Ophthalmology Framework

July 2015

Contents

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1 Introduction

This document outlines the broad components of a Community Ophthalmology Service. Such a service is distinct from primary and secondary care services and is defined by the functions it performs and its composition, such as the use of multidisciplinary teams with a targeted case load.

A Community Ophthalmology Service will have some or all of the following characteristics:

- the ability to make definitive diagnoses to manage and treat the majority of cases referred into it
- be effective as a monitoring service for patients at risk of their condition deteriorating asymptomatically
- provide an access point for patients with recurrent symptomatic disease.

What can be treated in a Community Ophthalmology Service depends on the skill set available within the service and the risk of deterioration of the patient's condition but will typically include:

- a wide range of anterior segment conditions such as conjunctival or corneal conditions, anterior uveitis and lid conditions
- glaucoma within the context of NICE [1] guidelines
- retinal disease such as surveillance of diabetic retinopathy and other retinal conditions that need monitoring outside any screening service
- children with amblyopia and squint

The use of the word 'community' does not imply that the service is at any particular site, but that it is local and convenient for patients while maintaining high quality care. This service is about managing need, not managing demand and must be integrated into the other pathways in primary and secondary care to avoid duplication.

The actual configuration and location may vary but there needs to be a consistent approach as outlined in this framework.

In developing the Community Ophthalmology Framework, the focus has been on maintaining quality, ensuring safe care, reducing service variation and improving equity of access. Given the current capacity issues in ophthalmology services and the pressures on general practice, the status quo is not sustainable and these innovative models of care need to be tested at greater scale to have maximum impact. However, any service redesign should not be done in isolation as it will impact on the whole pathway.

Patient centred pathways and care

The traditional separation between primary care, community services, and hospitals - largely unaltered since the birth of the NHS - is increasingly a barrier to the personalised and coordinated health services patients need. The patient must be at the heart of all service redesign.

Population size

The size of population served by a Community Ophthalmology Service will depend on a number of geographical and demographic factors and cannot be specified.   Depending on circumstances, a CCG can either commission a service for its local population or collaborate with neighbouring CCGs and commission a service covering a wider area to meet health needs, whilst also minimising procurement costs.

2   Context

Increasing eye health needs due to the ageing population and availability of new treatments is creating capacity issues within the Hospital Eye Service, especially in relation to age-related macular degeneration (AMD), diabetic eye disease and glaucoma.

Between 2010 and 2020, it is predicted that there will be a 26% increase in patients with AMD, a 20% increase in patients diagnosed with OHT or glaucoma and a 25% increase in people with diabetic eye disease[2] (see appendix A).

NHS Five Year Forward View

The drive for more healthcare in the community is in the NHS Business Plan 2015/16[3] and embedded throughout the NHS Five Year Forward View (5YFV)[4]. A key objective in reorganising services has to be to achieve better management of patient flows as well as freeing up capacity in the Hospital Eye Service.

Across CCGs, a number of Community Ophthalmology Services have already been commissioned in response to the increase in demand. New models need to be tested at scale but it is important that there is a common framework around each one and we do not continually reinvent the wheel. "*While the answer is not one-size-fits-all, nor is it simply to let a thousand flowers bloom" (FYFV page 17)*[4].

The main aims of a Community Ophthalmology Service should be the assessment and management of patients whose eye conditions are at low risk of deterioration who are either referred by primary care for assessment or discharged from secondary care for monitoring. Schemes that are supplementary to the NHS sight test in primary care, that are undertaken prior to the decision to refer e.g. glaucoma repeat readings, minor eye conditions, learning disabilities and cataract pre- assessment, should not be considered as community ophthalmology and should be commissioned separately based on national pathways.

A referral management function (based either in community or secondary care) which directs the patient to the most appropriate service based on a risk assessment of the referral information should be considered. However this should be commissioned separately from a community ophthalmology service.

3   Understand local population needs, current services / pathways and available workforce

Before embarking on the commissioning of a Community Ophthalmology Service, a comprehensive Eye Health Needs Assessment[5] should be completed. If there are specific local priorities that need to be addressed in the short term there are some key questions to consider:

- Have you consulted patients and public to hear their views?
- Have you consulted current primary and secondary care providers?
- How is care currently delivered, by whom and where?
- What is the level of activity/demand that needs to be delivered?
- Have you identified which low risk / stable eye conditions will be included in the service specification?
- Are there health professionals ready and willing to develop further skills and take on a wider role?

4   Aims of a Community Ophthalmology Service

Common aims of a Community Ophthalmology Service are listed below. It should be noted that not all aims listed may be relevant in all areas.

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

5   Multi-disciplinary team in a Community Ophthalmology Service

In order to make the best use of available resources there are a number of different health professionals that can have a role to play in the multi-disciplinary team (MDT) that sits within a Community Ophthalmology Service.

The MDT may include:

- Ophthalmologists
- Optometrists
- Orthoptists
- Ophthalmic Nurses
- Dispensing Opticians
- General Practitioners (with an interest in ophthalmology)
- Technicians / Healthcare Assistants
- Eye Clinic Liaison Officers
- Pharmacists

Service management and administrative support are also required.

The composition of the multi-disciplinary team will depend to some extent on the availability of health professionals with particular competencies to work within the service during the period of the contract. The role of individual health professionals will depend on the competencies they can demonstrate. Support for health professionals to work under supervision while they develop further skills should also be considered.

6 Competencies required for service components

The commissioning process needs to ensure that a Community Ophthalmology Service is delivered safely, by an appropriately trained workforce, follows evidence based guidelines including NICE guidelines and is audited for outcomes and value for money.

Roles and responsibilities in the processes of commissioning and provision of care need to be clear to ensure safe, effective care based on clinical need.

The Service Specification should require a Lead Clinician(s) as the person who will take responsibility for the patient's care and has the competence to make the necessary clinical decisions.

Healthcare professionals who wish to perform extended clinical roles in Community Ophthalmology Services must undergo the necessary training to obtain nationally approved qualifications for assurance of competency as specified by, or equivalent to those specified by the relevant professional bodies and demonstrate maintenance of competence through continuing professional development thereafter. These qualifications and competency standards are either currently available or will be introduced soon.

7 Clinical leadership and Governance

Effective local clinical leadership is essential to deliver a Community Ophthalmology Service with appropriate clinical governance and clinical accountability arrangements. The Clinical Lead should be a consultant ophthalmologist or another clinician with a higher level qualification e.g. a certificate of completion of training.

Having a defined clinical lead will also bring the potential for healthcare professionals such as optometrists, orthoptists etc. to work within the service under direct clinical supervision while developing enhanced skills or training for higher qualifications. During the supervision period the supervised healthcare professional is clinically responsible to the supervisor and the supervisor must have appropriate involvement in the ongoing appraisal.

Governance arrangements should not only include having appropriate processes to demonstrate information and financial governance, but also processes for prospective evaluation of the design and delivery of new care pathways which can demonstrate:

- Good clinical outcomes
- Patient safety
- Competence of the workforce
- High patient satisfaction
- Appropriate infra-structure (equipment, premises etc.)

8   Define outcome measures and how to evaluate outcomes

A robust evaluation of the clinical service is essential.

It should be possible to monitor the effectiveness of the service. Well defined outcomes, key performance indicators (KPIs) and methods of measuring them are vital. Example outcomes and associated measures are listed below.

Example Performance/Outcome Measures

Performance Indicator	Desired Outcome	Threshold	Measure
NICE Quality Standard QS 7	People diagnosed with COAG, suspected COAG or OHT are monitored at intervals according to their risk of progressive loss in accordance with NICE guidelines[1]	95%	Proportion of people with COAG, suspected COAG or with OHT who are monitored at intervals according to their risk of progressive loss of vision in accordance with NICE guidelines
Access	Patients to be offered appointment within 2 working days of receipt of referral	90%	Proportion of patients offered an appointment within 2 working days of receipt of referral
Access	Patients to be seen within 20 working days of receipt of referral	90%	Proportion of patients seen within 20 working days of receipt of referral
Patient Satisfaction	Patients are satisfied with the care they receive under the community service	80%	Proportion of patients who are satisfied or highly satisfied with the care they received at their appointment with the community service
Referral feedback	Service must send originating referrers (GP and optometrist), a letter with the outcome of the 1st appointment consultation, within 7 working days after the appointment subject to patient consent.	90%	Monthly Audit

Any financial incentives for service providers should be based around outcomes.

When commissioning a Community Ophthalmology Service it is essential to avoid duplication of effort and costs that occur elsewhere in the system.

The provider must be required to audit and review the service regularly and should work collaboratively with other providers to implement a continuous quality improvement approach. For example, feedback should be provided to all referrers as long as patient consent is obtained.

9   Integrating the community service with primary and secondary care

The common vision for integrated care from the service user's perspective is described as *'my care is planned with people who work together to understand me and my carer(s), put me in control, co-ordinate and deliver services to achieve my best outcomes*'.

Referrals into a Community Ophthalmology Service from primary care (GP, optometrist, health visitor, other professionals) and referrals into the Community Ophthalmology Service from secondary care of low risk patients that need ongoing monitoring should be efficient and timely from the patient's perspective. Direct referral from the Community Ophthalmology Service to secondary care should be possible when necessary.

There is a need to develop and test protocols for sharing patient records between the teams involved in providing care for a patient across a Community Ophthalmology Service, and with primary and secondary care. Good communication and a two-way information system is essential to the successful delivery of an integrated service. It must be remembered that the GP has a pivotal role for holding patient information and should receive notification every time patient care is transferred from one setting to another.

10   Collaborative working to deliver a Community Ophthalmology Service

There is potential for existing local providers of primary and secondary care to collaborate to deliver a Community Ophthalmology Service or for an external provider to come in and deliver it. But collaboration between existing local providers may provide greater scope for developing fully integrated eye service pathways over time.

There are various contracting models and a number of options for locations from which services could be delivered depending on local circumstances – we are not advocating a 'one size fits all' approach. The model should be flexible in its use of available premises and providers and avoid becoming a carbon copy of the Hospital Eye Service in another setting.

Competition between potential service providers can be desirable, but competitive behaviour between providers within a single pathway can lead to clinical risk, delay, inconvenience and cost. Commissioners should be clear about this in the tendering process and ensure that there is appropriate multidisciplinary working within the pathway.

11   Equality Assessment of Community Ophthalmology Services

In order to ensure equitable access to and uptake of a Community Ophthalmology Service, the following must be accounted for:

- Assisted transport
- Interpreter service
- Disability access

Framework Development Group

A framework development group was established to review and advise on the content of the framework. This group met fortnightly via webinar and once face-to-face over a period of 3 months, with additional interaction taking place via email.

Name	Designation
Ms Rowena McNamara MSc, DBOT, SRO	Head Orthoptist, Imperial College Healthcare Trust, Chair, British and Irish Orthoptic Society
Miss Parul Desai	Consultant in Public Health and Ophthalmology, Moorfields Eye Hospital NHS Foundation Trust, London
Russell Young	Chief Executive Officer, International Glaucoma Association
Mr Wojciech Karwatowski	Consultant Ophthalmologist, Chair Local Eye Health Network (Leicestershire and Lincolnshire)
Katrina Venerus BSc (hons) MCOptom	Local Optical Committee Support Unit
Mr Glenn Tomison	Dispensing Optician representing the Optical Confederation
Mr Trevor Warburton BSc FCOptom	Optometrist representing the Optical Confederation
Dr Fergus Macbeth	Patient Representative
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Ms Yvonne Needham	Senior Lecturer, Dept of Nursing and Midwifery, University of Hull
Miss Lydia Chang FRCOphth MD	Consultant Ophthalmologist Hinchingbrooke Hospital Trust, Honorary Consultant Ophthalmologist Moorfields Eye Hospital (at Bedford Hospital NHS Trust)
Ash Soni	President, The Royal Pharmaceutical Society
David Parkins MSc FCOptom FEAOO	President, The College of Optometrists, Chair Local Eye Health Network (London)
Olivier Denève	The College of Optometrists
Ms Mercy Jeyasingham	Chief Executive Officer, Vision 2020(UK) Ltd

References

1) National Institute for Health & Care Excellence: Glaucoma diagnosis and management of chronic open angle glaucoma and ocular hypertension. Available online at: www.nice.org.uk/guidance/cg85

2) Future Sight Loss UK Report 2: An epidemiological and economic model for sight loss in the decade 2010-2020. Authors: Darwin Minassian and Angela Reidy, Publisher: EpiVision and RNIB (2009). Available online at: http://www.rnib.org.uk/knowledge-and-research-hub/research-reports/general-research/future-sight-loss-uk-2

3) NHS Business Plan 2015/16. Available online at: www.england.nhs.uk/about/business-plan

4) NHS Five Year Forward Plan (October 2014). Available online at: www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

5) UK Vision Strategy's Eye Health Needs Assessment. Available online at: www.ukvisionstrategy.co.uk/get-involved-england-commissioning-eye-care-and-sight-loss-services-commissioning/needs-assessment

Estimated number of affected adults in the UK

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

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

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

- **Community Ophthalmology Service** - a local service that is distinct from primary and secondary care services and is defined by the functions it performs and its composition, such as the use of multidisciplinary teams with a targeted case load.

- **Eye Health Needs Assessment** - a review of the provisions for eye health in relation to perceived (current and predicted) needs of a population in a specific locality.

- **Primary Care** - Healthcare delivered outside hospitals. It includes a range of services provided by GPs, nurses, health visitors, midwives and other healthcare professionals and allied health professionals such as dentists, pharmacists and optometrists/opticians. It includes community clinics, health centres and walk-in centres.

- **Referral Management Service** - a specific type of interface service that does not provide treatment, but accepts GP (or other) referrals and provides advice on the most appropriate next steps for the place or treatment of the patient. Depending on the nature of the service they may, or may not, physically see or assess the patient.