# Summary analysis of submissions to the call for evidence

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Chapter 1 – Introduction

1.1 This paper collates all the summary evidence papers on the submissions to the call for evidence, that the secretariat produced and presented to the Expert Advisory Group to consider, for the Inquiry into capacity problems in NHS eye care services and avoidable sight loss in England, by the All-Party Parliamentary Group (APPG) on Eye Health and Visual Impairment.

1.2 The papers summarised the evidence in response to questions which were grouped together according to particular themes (e.g. ‘assessing the eye health needs of local populations’) which were asked to each of the different sectors, and they are now presented here as different chapters in this paper. They were used to capture the range of respondents’ information and perspectives and to identify key trends and themes. Where quotes have been included they have remained unedited.

1.3 The call for evidence was run for twelve weeks from the 28th July until 20th October 2017 and can be seen at [www.rnib.org.uk/appginquiry](http://www.rnib.org.uk/appginquiry). The following is a breakdown of the number of submissions we received by sector and a list of responses is shown in the Annex with an explanatory note.

|  |  |
| --- | --- |
| Respondent | Written submissions (number of organisations or people who have responded) |
| Commissioners, NHS Eye Departments, clinicians | 46 (65) |
| Charities/ umbrella bodies | 10 (11) |
| Patient or patient representative | 9 |
| STPs | 7 |
| Professional bodies | 5 (6) |
| Government/ national bodies/ initiatives | 4 |
| Healthcare/ pharmaceutical industry | 4 |
| Local Eye Health Networks | 4 |
| Local Optical Committees | 1 |
| Universities | 1 |
| **Totals** | **91 (112)** |

Chapter 2 – Government and national bodies on capacity in eye health services, sight loss, commissioning, STPs and other information

### 2.1 Introduction

2.1.1 The call for evidence asked the Department of Health (as it was called at the time), NHS England and Public Health England:

* Q1 What plans do the Government and NHS have to address the problems of a lack of capacity in eye health services and the high incidence of avoidable sight loss across England?
* **Q3** What measures will the Government and NHS take to improve commissioning to raise capacity levels to meet demand for eye health services in line with national best practice across England?
* **Q4** What measures will the Government and NHS take to ensure that Sustainability Transformation Partnerships (STPs) [**[[1]](#endnote-1)**]deliver eye health services that can meet current and future demand in line with national standards for best practice?
* **Q6** Please provide any other information that you feel the APPG should be made aware of in support of your response.

2.1.2 This paper analyses responses from the above bodies and a response from the General Optical Council (GOC), the regulator for the optical professions, is included in relation to Q6.

2.2 Q1 What plans do the Government and NHS have to address the problems of a lack of capacity in eye health services and the high incidence of avoidable sight loss across England?

Department of Health

2.2.1 This response acknowledges the concerns of clinicians and the sight loss sector about timeliness of patient access to services, and they are looking into concerns that capacity issues in some secondary care eye services are leading to delays or cancellations to follow up appointments which may be leading, in some cases, to avoidable sight loss.

2.2.2 The Department of Health refers to existing clinical guidance and clinicians determining clinical priorities, that “patients should not experience undue delay at any stage of their referral, diagnosis or treatment.” They also refer to active management of patients waiting for follow-up appointments being reinforced in NHS England guidance.

2.2.3 The department say they take seriously concerns and evidence that patients may be losing sight unnecessarily, and that department and NHS England officials have put work in place:

“to understand the implications of the research conducted through the British Ophthalmological Surveillance Unit [(BOSU)], published in February [2017], which suggested that up to 22 patients a month might be losing sight due to delays in follow up appointments and to carefully consider what action might be needed.”[**[[2]](#endnote-2)**]

NHS England

2.2.4 This response acknowledges that avoidable sight loss may be an issue due to capacity. They cite a 2009 “National Reporting and Learning Service” alert for glaucoma which found 44 patients developed avoidable loss of vision between 2005 - 2009 due to delays in follow up arrangements, as well as BOSU (2017) findings.

2.2.5 NHS England’s response states it directly commissions eye sight tests in primary care and Specialised Ophthalmology for adults and children; with Clinical Commissioning Groups (CCGs) being responsible for commissioning secondary care eye services, treatments and hospital ophthalmic services.

Public Health England

2.2.6 Public Health England’s response said its remit does not cover eye health treatment which it says falls under the NHS and that the Department of Health lead on policy. It said its role in eye health is confined to being responsible for the NHS Diabetic Eye Screening (DES), programme and that people with diabetes are at risk of damage from diabetic retinopathy[**[[3]](#endnote-3)**] which can lead to sight loss if untreated.

2.2.7 Public Health England says the DESprogramme introduced digital surveillance in 2014 to reduce the number of DES programme patients within hospital eye services. It does not otherwise address the call for evidence questions.

2.2.8 However, Public Health England’s stated public-role (on its website) includes six objectives, half of which (shown below) could be interpreted as being relevant to eye health treatment:

* making the public healthier and reducing differences between the health of different groups by promoting healthier lifestyles, advising government and supporting action by local government, the NHS and the public
* improving the health of the whole population by sharing our information and expertise, and identifying and preparing for future public health challenges, and
* supporting local authorities and the NHS to plan and provide health and social care services such as immunisation and screening programmes, and to develop the public health system and its specialist workforce.[**[[4]](#endnote-4)**]

2.3 Q3 What measures will the Government and NHS take to improve commissioning to raise capacity levels to meet demand for eye health services in line with national best practice across England?

Department of Health

2.3.1 The Department of Health’s response to Q3 and Q4 overlaps addressing both CCGs and STPs.

2.3.2 The department refer to the aim of STPs to redesign services to make it easier for patients to access health and social care at the right time and place, and that the local NHS is best placed to `make decisions about local services and people’s needs.

2.3.3 The department acknowledge concerns about varied commissioning of eye services by CCGs; but say: “The larger footprint and redesigned approach of STPs will maintain the benefits of localised commissioning while reducing the number of organisations stakeholders need to engage with.”

2.3.4 The department’s response says CCGs and STPs must have access to best practice information and refers to guidance published by the Clinical Council for Eye Health Commissioning[**[[5]](#endnote-5)**].

2.3.5 The department also says ophthalmology is part of the second-wave of NHS England’s Elective Care Transformation Programmewhich starts work in 2018. The programme supports health and care systems to reform and modernise elective care pathways so patients can access the right person, in the right place, first time. Frontline teams are supported and challenged to develop, test and spread innovation, which is captured in case studies and elective care specialty handbooks for use across the NHS.

NHS England

2.3.6 NHS England’s response to this question refers to its role directly commissioning Specialised Ophthalmology for adults and children. Its Ophthalmology Clinical Reference Group (CRG) has a scope of services and specifications for all aspects of specialised ophthalmology, and service specifications define the standards of care that NHS England expects the organisations it commissions services from to deliver for patients. It lists specific work for patients of specialised ophthalmic services:

* An interim policy for the use of adulimimab in severe refractory uveitis[**[[6]](#endnote-6)**]for children is in place
* An interim policy statement for adults whilst a full policy is developed to meet the recently published NICE[**[[7]](#endnote-7)**]Multiple Technology Appraisal, and
* A Commissioning Through Evaluation programme for the use of Argus II retinal implants [**[[8]](#endnote-8)**] for patients with severe visual loss due to the genetic condition retinitis pigmentosa [**[[9]](#endnote-9)**]. The Ophthalmology CRG continues to work on new policy proposals to submit for consideration for funding as well as contributing to cross CRG themes.

2.3.7 On services for the following conditions, NHS England states:

* glaucoma[**[[10]](#endnote-10)**] – it commissions regular eye tests; NICE is developing a clinical guideline due to be published January 2018 and NHS England will take account of it for specialised glaucoma services, and
* diabetic retinopathy – services are commissioned by CCGs; but NHS England’s diabetes prevention programme helps prevent sight loss by addressing some of the health risk factors.

2.3.8 NHS England cite the experience of Moorfields Eye Hospital NHS Foundation Trust which has used its learning from providing a single speciality service to produce an evidence-based learning ‘toolkit’ for other health providers to use when considering following such a model.

2.3.9 NHS England refer to working with the Getting it Right First Time ophthalmology work stream which is focussed on improving quality of patient care and driving out unwanted variation.

2.3.10 NHS England states it has met with the Royal College of Ophthalmologists (RCOphth) and the College of Optometrists regarding their concerns about timed follow-up appointments for patients with glaucoma and age-related macular degeneration (AMD)[**[[11]](#endnote-11)**]. It also references its Elective Care Transformation Programme which is starting a focussed piece of work on this issue with the Getting it Right First Time--lead for ophthalmology and other stakeholders. Ophthalmology is included in Wave 2 of NHS England’s Elective Care Development Collaborative, part of the Elective Care Transformation Programme. They will devise and develop interventions to rethink referrals, support self-management and shared decision making and transform outpatient’s services across the ophthalmology elective care pathway. They say current key issues in ophthalmology will be considered as part of this work and elective care and specialty handbooks will be published in 2018, following the conclusion of Wave 2.

2.4. Q4 What measures will the Government and NHS take to ensure that STPs deliver eye health services that can meet current and future demand in line with national standards for best practice?

2.4.1 See the Department of Health’s answer to Q3. NHS England did not address this question.

2.5 Q6 Please provide any other information that you feel the APPG should be made aware of in support of your response.

2.5.1 Although not responding to this question, the Department of Health’s submission includes charts using data from the Public Health Outcomes Framework (PHOF)[**[[12]](#endnote-12)**]indicator on the rate of sight loss, showing reductions in recent years for Certificates of Visual Impairment (CVI)[**[[13]](#endnote-13)**], diabetic eye disease and AMD; but an increase for glaucoma.

2.5.2 The GOC refer to their Education Strategic Review which they started in late 2016, to ensure the statutory system of optical education and training which it oversees prepares students for their future roles. They refer to the Inquiry possibly looking at the contribution that optometrists and dispensing opticians make to a wider eye health team and the future shape/ scope of service need in England, which their education review is also looking at.

2.5.3 GOC say they recognise that optometrists and dispensing opticians can play an important role in helping to meet the rising demand for eye care services, in the context of an ageing population and to relieve pressure on hospital eye services. GOC acknowledge the increasing opportunity for some practitioners to provide certain diagnostic and eye health management services outside of hospitals, to effectively respond to changing patient need, particularly for long-term eye conditions.

2.5.4. GOC also cite its own recent research including a call for evidence (December 2016 to March 2017), a 2016 “Registrant Survey”, and “Stakeholder Perceptions Survey” (2016), which variously suggest “some level of anticipation from many of our stakeholders that a greater range of eye health services may need to be delivered in the community in the future.”

Chapter 3 – Assessing the eye health needs of local populations

3.1 Introduction

3.1.1 The call for evidence asked Commissioners and NHS Eye Departments and STPs:

* Q7 / Q15 How do you assess the eye health need of your local population?

3.1.2 Health profession bodies, charities, research and health industry organisations were asked:

* Q25 How effective are the following at assessing the eye health needs of their local populations (a) CCGs? (b)STPs?

3.2 Q7 / Q15 How do you assess the eye health need of your local population?

Commissioners and NHS Eye Departments

3.2.1 The responses to this question included the tools/data used, the people that were engaged in assessing need and some of the factors that were taken into consideration. Tools/data used to aid commissioning of eye health care included:

* Joint Strategic Needs Assessments (JSNA) [**[[14]](#endnote-14)**]
* Eye Health Needs Assessment (EHNA)[**[[15]](#endnote-15)**](sometimes in conjunction with Local Eye Health Networks[**[[16]](#endnote-16)**])
* Referral To Treatment (RTT)[**[[17]](#endnote-17)**]monitoring
* Audit of clinics
* Outpatient attendances
* Waiting times
* Patient surveys
* RightCare Value Packs [**[[18]](#endnote-18)**].
* Royal National Institute of Blind People (RNIB) sight loss data tool[**[[19]](#endnote-19)**], and
* Referral numbers and types.

3.2.2 CCGs gave a number of examples of the people they worked with to arrive at their assessments of eye health needs, these included working with:

* Managers
* The voluntary sector
* General Practitioners (GPs)
* Clinicians from the hospital eye service
* GPs with a special interest
* Optometrists
* Community eye providers
* Commissioning Support Unit (for contracts and performance intelligence)
* Commissioning manager allocated to the ophthalmology pathway, and
* Local Optical Committee [**[[20]](#endnote-20)**]**.**

3.2.3 CCG-responses indicated that they might take the following other factors into account when assessing need:

* Previous demand
* Population growth
* Demography/ high risk groups within the population
* NICE guidance
* Evidence of treatment effectiveness and efficacy (from NICE, RCOphth and other colleges)
* Impact of awareness campaigns
* Demand can be a poor proxy for need
* People with multiple needs
* NHS sight testing services
* Health and wellbeing boards[**[[21]](#endnote-21)**]
* Children’s reception vision screening, and
* Diabetic retinopathy screening.

STPs

3.2.4 STP responses in respect of assessing eye health needs gave the types of data, how the data was used, and where there was a lack of data. Those who addressed this question in their responses generally used EHNAs sometimes prepared by the Local Eye Health Network.

3.2.5 Other sources of data include:

* Public Health England data
* Referral data including RTT data
* Hospital data including new patient referral, waiting lists, activity and utilisation data, and
* Consulting by constituent CCGs with the public.

3.2.6 Use of data:

* Data used to manage resources such as sub specialist clinics and recruitment needs
* Data used to adjust supply and demand not just at departmental level but regionally, and
* Trend analysis.

3.2.7 Lack of data:

* Lack of reliable standardised data in hospital eye departments
* The General Optical Services (GOS) contract[**[[22]](#endnote-22)**] provides little data in terms of visual outcomes and no data collected from non NHS patients, and
* Lack of data on children’s eye health.

3.3 Q25 How effective are the following at assessing the eye health needs of their local populations (a) CCGs? (b) STPs?

Health profession bodies, charities, research and health industry organisations

3.3.1 Responses on (a) CCGs

* One respondent pointed out that the assessment of eye health needs was the responsibility of Local Authority public health teams but that CCGs should work with these teams
* CCGs need to work with Local Eye Health Networks
* CCGs are not consistent in how need is assessed, nationally mandated data should be collected to establish a common framework of assessing need
* EHNAs completed by CCGs should be part ofJSNAs, and
* Where such assessments are done, they need to be used to inform the commissioning of services.

3.3.2 Responses on (b) STPs

* The responses thought that little planning of eye health was taking place at the STP level, that STP proposals did not take into account the size, state of health and locations of their population.
* Some responses suggested this was because STPs were relatively new organisations.
* It was also suggested that they use the expertise of Local Eye Health Networks (LEHN).

Chapter 4 – The priority given by Commissioners and NHS Eye Departments and STPs to eye health services

4.1 Introduction

4.1.1 The call for evidence asked Commissioners and NHS Eye Departments and STPs:

* Q8/Q16 Compared to other areas of health care what priority do you give to eye health services?

4.1.2 Health profession bodies, charities, research and health industry organisations were asked:

* Q26 Compared to other areas of health and social care what priority do you consider the following give to eye health services? (a) CCGs (b) STPs.

4.2 Q8/Q16 Compared to other areas of health care what priority do you give to eye health services?

Commissioners and NHS Eye Departments

4.2.1 Seventeen of these responses expressly state that they prioritise eye health or consider it to be important. As regards what this means in practice responses were along the following lines (with some including more than one element):

* some don‘t elaborate
* six refer to a review, redesign or transformation project (either completed, current, or planned), or mention moving services out of acute care into the community, and/or developing additional services in the community
* two say eye health is a stated priority in the CCG’s operational or strategic plan (one also says it is a prioritised at STPlevel)
* a small number refer to eye health as a dedicated priority area (e.g. referred to as one of three prioritised specialties)
* some responses simply state that eye health is a priority, without clarifying whether it has been formally prioritised compared to other areas of health
* one response refers to having a commissioning and clinical lead for eye health
* one mentions that eye care is their highest area of planned spending, and
* one says that whilst eye health is undoubtedly a priority and the commissioning manager is working hard to prioritise the service, there are competing priorities, and this makes allocating funding to commission eye care services difficult, particularly where key metrics like RTT are met, despite evidence of the benefit of these services. They give an example of currently trying to get funding for an Eye Clinic Liaison Officer (ECLO) [**[[23]](#endnote-23)**].

4.2.2 A further nine responses either refer to review or redesign or describe the services they commission in the community (like the six referred to in the above paragraph), but don’t expressly state that eye health is a priority, or directly respond to the question about priority.

4.2.3 Eight responses make general comments about commissioning/ prioritising, without commenting on current prioritisation of eye health. These include responses along the following lines with some including a combination of these elements:

* no area of health is prioritised over another
* services are commissioned on the basis of need/ clinical need and available local evidence such as JSNAs
* one response states that they prioritise based on condition or wider domains of health (such as cancer or frailty) rather than on parts of the anatomy, and that some eye conditions such as glaucoma, AMD and cataracts[**[[24]](#endnote-24)**] may fall within these wider domains, and
* some responses mention ongoing monitoring of contracts or RTT times, or discussions with contractors and partners, to assess and review service delivery and demand.

4.2.4 One response states that, while eye health is not a designated priority in the area, there are commitments in the CCG’s plan in the area of prevention which will impact on eye health, such as smoking cessation programmes, diabetes screening programmes, sun screening programmes and eye tests.

4.2.5 A number of responses make reference to factors such as the high proportion of outpatient appointments or operations which are for eye care, and the challenges of having capacity to meet demand which is already increasing and likely to continue to increase. Some cite this as a reason for prioritising eye care or reviewing services. One states that eye health is experiencing the biggest challenge in meeting RTT times.

4.2.6 Whilst there are common threads in a number of the responses – i.e. reviews and redesigns to assess need, improve care, make savings and/or streamline pathways these responses differ in terms of the extent of the reviews undertaken, the approach/ models used and what stage these reviews are at.

4.2.7 Some responses describe collaboration, such as working groups including representatives from some or all of the following - primary and secondary care, clinical and commissioning leads, commissioners and providers, and involvement of LEHNs and patients. Two responses state that they have undertaken a review as part of Quality, Innovation, Productivity and Preventionprogramme [**[[25]](#endnote-25)**]and one as a result of a Care Quality Commission [**[[26]](#endnote-26)**]inspection. Another response refers to national guidelines as a factor in its approach.

4.2.8 Two eye clinics/ trusts provide a combined response with the CCG and this is captured in the bullet point list above. The other eye clinics/ trusts don’t directly address this issue, with some focusing more generally on issues of capacity and managing demand, and some focusing on specific issues relating to treatments, the need for national research or priority, and general developments within their trusts, although one states:

“It is very difficult to get any engagement from the CCG in service delivery and development. Eye health seems to be a very low priority for them. We have had no contact from the STP.”

STPs

4.2.9 The majority of STPresponses refer to eye health as a priority area or “importance” or an area of “great health care need”, and/or refer to capacity issues and action taken to address these. Only two directly state that eye health has not been prioritised:

* one of these states “Eye health is not unequally prioritised above other areas of health”
* the other states that eye health has not been prioritised as a work area in the initial STP work plan but “aspects of eye health is covered within a prevention, early intervention and self-care work stream. Screening uptake including diabetic retinopathy service is a high priority.” The response states that diabetes is a prioritised area.

4.2.10 As regards what the prioritisation means in practice, responses include the following (with some including more than one element):

* there is mention of capacity issues including quotes from RCOphth’s “The Way Forward”, with two responses referring particularly to local capacity issues including increasing RTT times and trusts struggling to meet demand. Another response mentions the proportion of eye care patients, including statistics on the number of cataract operations, and cites this, combined with disability life years statistics[**[[27]](#endnote-27)**] on sensory organ disease and cost effectiveness of cataract operations as a reason for prioritising
* mention having undertaken some or all of the following (with some reference to this as “changing pathways”) – use of alternative providers e.g. for Hospital Eye Service activity, triaging in some areas, Minor Eye Conditions Service (MECS) or general mention of commissioning of additional community capacity
* one mentions investment in equipment - optical coherence tomography (OCT) machines[**[[28]](#endnote-28)**] and Fundus camera[**[[29]](#endnote-29)**]
* two mention use of locum consultants (one states long term and one states to undertake a review of the backlog)
* one mentions external review of services
* one mentions using shared metrics and data with aim of aligning ophthalmology services across the STP including discussions amongst collaborative teams of clinicians and commissioners about service improvements. This response comments that “short term responsive actions”…to “manage patient flow” are not sufficient pathways for activity to be diverted to alternative commissioned providers to reduce hospital referrals, and that commissioning across multiple CCGs is more cost effective.
* one mentions that eye health should be prioritised because of the effect of sight loss on co-morbidities such as dementia, diabetes, falls etc. and ability to lead an independent life and manage own healthcare.

4.3 Q26 Compared to other areas of health and social care what priority do you consider the following give to eye health services? (a) CCGs (b) STPs.

Professional bodies, research and health industry organisations and Local Eye Health Networks

4.3.1 Of these, two of the organisations and the researcher did not address this issue. Eight of the organisations said that eye health is generally treated as a low priority for commissioners locally.

4.3.2 A lot of responses focused particularly on how low priority eye health is amongst STPs,l with some stating expressly that the priority appears to be even lower there than CCG level. The majority, whilst emphasising that priority generally appears to be low, mentioned that the priority varies between and within STP and CCG areas, with the phrase “a postcode lottery” being used more than once.

4.3.3 Some responses give examples of what they consider to be “accessible and well commissioned eye health” in certain STP and CCG areas. They include reference to the impact of this on the issue of capacity in secondary care, and mentioning key performance indicators and audits which can measure the impact of some of this commissioning.

4.3.4 A number of responses express concern about how eye health is prioritised in the STP’s plan, including:

* lack of any mention of eye health in the STP plan
* lack of adequate detail about the provision of services e.g. “Of the 40+ STPs in England who have published draft plans, only around half (from what we have found) include plans around delivery of ophthalmology services, many of which are limited to one or two lines with no detail around local need, delivery etc.” (Evolutio); and “only 22 of the 44 STPs mention ophthalmology and the content is often limited to a few sentences, despite the fact that ophthalmology accounts for around 8 per cent of the 90 million hospital outpatient appointments in England, and that most acute trusts are facing significant capacity pressures” (College of Optometrists).
* not citing it as a key service – e.g. “With so few STPs citing ophthalmology as a key service, this suggests it is a lower priority compared to other areas which are widely cited, such as improving A&E waiting times and oncology services.” (Bayer).
* not citing it as a priority for redesign “Whilst several [STPs] are looking at ophthalmology as an issue, only three out of 44 have directly referred to ophthalmology as a priority service for redesign in their published plans.” (Bayer).
* One response also mentions “lack of discussion at STP level and a lack of orthoptic representation which could provide solutions for successful service review and delivery” (British and Irish Orthoptic Society); with a number of others expressing general views about the need for involvement of various parties such as professionals, patient representatives and voluntary organisations in planning services and pathways.
* Another response stated that the priority of eye health should feature in all mental and physical health care pathways being considered by CCGs and STPs.
* Whilst the need to find cost effective ways of providing services was often acknowledged one response made the point that this should not just be about cost savings, stating: “The CCG have given limited priority to eye health services and any priority given has been entirely underpinned by cost savings rather than also addressing capacity issues within Ophthalmology” (Response from a Local Optical Committee).

Local Eye Health Networks

4.3.5 Responses from Local Eye Health Networks included the following:

“I am aware that eye health care is perceived as low priority by CCGs and STPs locally as they strive to address their overarching priorities for emergency care, cancer & mental health.

The [network] is trying to be creative in linking eye health care to other STP projects i.e. frailty, early discharge from hospital, falls prevention, but it has proved difficult to find a way to directly influence strategic thinking as little is happening yet at service planning level with STPs.

“At trust level there is acknowledgement of increase in demand and high costs of providing ophthalmology services but little appreciation of impact on and risk to patients. Response often tends to be reactive rather than proactive i.e. learning from incidents, but I see little evidence of planning for the future.”

4.3.6 These responses did not always respond to the question about priority directly, e.g. we received a report proposing more integrated working at STP level.

Charities

4.3.7 Only five of the ten responses from charities directly respond to this question, with all of these stating that eye care is currently generally a low priority for CCGs and STPs. Comments from these include the following:

“The majority of CCGs and STPs do not prioritise the systematic planning of eye care services to effectively meet the needs of the populations served. There is a lack of recognition of how the effective systematic assessment of eye health population needs, followed by systematic planning and delivery of co-ordinated eye care services can benefit patients and have a positive effect on the wider demand for health services” (RNIB).

“Eye health is given a lower priority despite being on PHOF, the main conditions still dominate service procurement (chronic obstructive pulmonary disease] [**[[30]](#endnote-30)**], smoking cessation, obesity, child mortality, pregnancy) sight loss is prevalent as a consequence of those conditions” (Vista).

“We recognise the likelihood that STPs will play an influential role in the reconfiguration of services and the delivery of eye care, but in our – limited – experience, it is currently a very low priority” (International Glaucoma Association).

4.3.8 So, responses include emphasis on a lack of systematic planning of co-ordinated services to meet need, with some linking effective needs assessment with effective prioritisation:

“… there is significant variation in how CCGs prioritise eye health services. It isn’t really surprising that where CCGs aren’t adequately assessing the needs of their local populations in terms of eye health, then they won’t have a basis to effectively prioritise” (Thomas Pocklington Trust and VISION 2020 UK submissions).

“Sight loss / Sensory loss still fails to hit Joint Strategic Needs Assessment despite there being a dedicated one in the pipeline; this has yet to be published for [the local area]” (Vista).

“We also note with some alarm the findings of the London South Bank University critical review of STPs that “thirty-one of the 44 STPs offer no proper needs analysis above a few selected statistics and fail to show that their proposals take account of the size, state of health and locations of the population” (International Glaucoma Association).

4.3.9 Two responses state that where there are effective Local Eye Health Networks working with local CCGs on needs assessments then prioritisation is better.

4.3.10 Most who express concern about low prioritisation at local level are concerned that it is even lower at STP level than at CCG level, as with the following respondent who said there was much variation in prioritisation at CCG level, but said of STPs: “STPs do not appear to prioritise eye health either explicitly or implicitly” (Thomas Pocklington Trust and VISION 2020 UK submission).

4.3.11 A number of responses highlight the link between eye health and other conditions. For example, the quote at the top of this section highlights other conditions prioritised over eye care, including a lack of recognition of how these other conditions can actually impact on sight loss.

4.3.12 Responses which don’t directly respond to this question include those which are in a free format rather than following the inquiry questions and those which have answered some questions but not others. These generally also have concerns about the prioritisation of eye care with the themes of variation from area to area coming up (e.g. as regards diabetic screening programmes) and concerns expressed about access for particular groups such as those with learning disabilities, and evidence about the impact of delays and capacity issues.

Chapter 5 – Planning of eye health services to meet local patient demand

5.1 Introduction

5.1.1 The call for evidence asked Commissioners and NHS Eye Departments and STPs:

* Q9/ Q17 Are you currently able to commission eye health services to meet local patient demand? Yes or no, please explain why?

5.1.2 Health profession bodies, charities, research and health industry organisations were asked:

* Q27 How effective are (a) CCGs at commissioning and (b) STPs at planning eye health services to meet local patient demand? Please explain why.

5.2. Q9/ Q17 Are you currently able to commission eye health services to meet local patient demand? Yes or no, please explain why?

Commissioners and NHS Eye Departments

5.2.1 The majority of respondents said they were able to meet local demand. However most recognised the increase in demand that would occur, and one respondent said:

“The key point with these diseases is that the patient cohort is broadly cumulative; for the majority of patients, detection does not lead to a one-time treatment but to regular interventions, sometimes over many years. The pressure on capacity from these conditions has a knock on effect on other conditions such as cataract and corneal, making it difficult for eye departments to cope with demand.”

5.2.2 Steps taken to mitigate the increase in demand include:

* Introduction of Community Services for cataract surgery, wetAMD, glaucoma referral refinement and stable glaucoma
* Regular meetings to monitor outcomes and resources resulting in reallocation of resources
* Pathway analysis/ system review for commissioning and provision of services
* Training nurses to do injections – freeing up consultant resource
* Introduction of MECS, Glaucoma referral services
* Use of private eye cre companies made of local optometrists [Local Optical Committee Support Unit (LOCSU) provide guidance on this, see comment in STP evidence below]
* Pharmacy Minor Ailments Scheme (for some minor eye conditions)
* Telephone triage
* Outsourcing
* Virtual follow up reviews
* Using Getting It Right First Time
* Use of evidence based clinical referral and treatment thresholds
* Using GPs with a Special Interest in ophthalmology as part of the pathway with the aim that only those requiring hospital eye service management or treatment end up in hospital, and
* the hospital eye service operating a six day a week service.

5.2.3 Those Commissioners that were not meeting current demand cited a number of reasons for this including:

* Workforce capacity and recruitment
* Constraints due to existing buildings
* The RTT measure having priority over follow up treatment
* Financial pressures, and
* Local population characteristics increasing demand.

STPs

5.2.4 The majority of STPs said they were meeting demand and gave examples of the ways in which they were achieving this including:

* Mixed economy using hospitals and elective capacity at independent providers, and
* Multi-disciplinary teams working across clinical pathways to manage long term conditions.

5.2.5 Difficulties they identified include:

* An exponential growth in demand which will require STPs to redesign the service provision to mitigate this challenge
* A shortage of ophthalmologists specialising in paediatric eye services combined with the age profile of existing specialists will need to be planned for
* Commissioning of hospital eye services has become an exercise in cost savings with little clinical involvement
* The prioritisation of RTT times at the expense of follow up capacity
* Commissioning additional eye care pathways from community opticians is hampered by localised decision making, small schemes and limited contract duration
* Governance and secure IT have proved to be problems in commissioning from opticians [LOCSU advice on local eye care companies might address this], and
* STPs are establishing their structures and not all have addressed in detail the issue of eye health planning.

5.3 Q27 How effective are (a) CCGs at commissioning and (b) STPs at planning eye health services to meet local patient demand? Please explain why.

Health profession bodies, charities, research and health industry organisations

5.3.1 These respondents were more critical of the variations between commissioning in different areas, a ‘postcode lottery’, and they generally also thought that STPs did not regard eye health as a priority.

Responses on (a) the effectiveness of CCGs

5.3.2 Respondents gave the following messages and suggestions:

* To be effective strong local relationships between primary and secondary care, public health, wider local authorities, professionals and patients are key
* Large numbers of minor eye conditions do not need hospital treatment. It is when CCGs realise the number of unnecessary hospital visits that planning can be improved
* CCGs need to be proactive rather than reactive
* Funding needs to be measured against patients seen and outcomes
* Rationing of cataract surgery is ineffective, the use of non-clinical thresholds impacts on patients as well as requiring additional unnecessary resource being used to resolve the problem
* Local solutions are not taken up nationally, the RCOphth has produced The Way Forward which collates solutions, strategic input is required to deliver the required transformation, and
* Engage with Local Eye Health Networks.

Responses on (b) the effectiveness of STPs

5.3.3 Respondents gave the following messages and suggestions:

* Little evidence of STPs prioritising or planning eye health care and treatment to meet demand
* There is potential given the bigger footprint of STPs, for them to commission new models at scale (while not themselves contracting), and they can benefit from economies of scale
* There is potential for greater consistency where STPs are able to direct commissioning over a larger area
* Are STPs engaging with clinicians, professionals and patients, and

Eye health care should be considered in all mental and physical health care pathways.

Chapter 6 – If there are plans to raise the priority of eye health locally

6.1. Introduction

6.1.1 The call for evidence asked Commissioners and NHS Eye Departments and STPs:

* Q10/Q18 Do you have any plans to raise the priority of eye health in your local area to meet existing and/ or future patient demand. Yes, or no, please explain why?

6.1.2 Health profession bodies, charities, research and health industry organisations were asked:

* Q28 Do you think the priority of eye health should be raised at the local area to meet existing and/or future patient demand? Yes or no, please explain why?

6.2 Q10/Q18 Do you have any plans to raise the priority of eye health in your local area to meet existing and/ or future patient demand. Yes, or no, please explain why?

Commissioners and NHS Eye Departments

6.2.1 The majority of responses stated that they are already prioritising eye care. Some simply said that but more often this was described as part of ongoing activity to raise the priority. Some responses did not answer the question at all; whereas others did not answer it directly, but some of these still included information relevant to the question.

6.2.2 As with Chapter 4 (‘the priority given by Commissioners and NHS Eye Departments and STPs to eye health services’) there were a range of interpretations about what is meant by priority and different levels of detail given. Reference to a detailed action plan was rare.

6.2.3 Responses which addressed the question (directly or indirectly) included the following:

* References to ongoing high priority with no further detail
* Reference to redesign, review of services, pathways triaging etc.(sometimes described in detail but sometimes not)
* Reference to awareness-raising e.g. with GP practices and the general public to raise awareness of community eye provision
* Reference to regular monitoring of service provision including activity, onward referrals etc.
* Have a close relationship with primary eye care provider/ other providers
* Always looking to develop new services and take on board good practice examples
* Indicates a formal priority status e.g. eye health is in the highest priority of the shared demand management programmes across the local area
* Focus on prioritising and raising awareness of early detection and prevention (including the argument that this is cost effective)
* Reference to a multi-stakeholder group e.g. CCG, local authority, patients, voluntary organisations, eye health service providers, hospitals, opticians or some other form of collaborative working – (sometimes just mentioned in general terms but sometimes for a specific aim e.g. to develop services specification)
* One response refers to an action plan with a timescale and sets out some of the deliverables in it: raising awareness including amongst at risk groups; encouraging people to take personal responsibility for their sight issues; raising awareness amongst health and social care professionals of impact of eye health and sight loss, and encouraging early detection and prevention where possible, timescales for appointments, treatment, services for people with sight loss etc.
* Have increased choice of provider
* Identified and utilised the skills of accredited optometrists in line with the “Five Year Forward View”[**[[31]](#endnote-31)**], increased choice of provider and improving both GP consultation time for ophthalmic symptoms and hospital eye service waiting times
* Talks about projected demographic changes and increases in demand
* Mentions the need to redesign services/ develop new models
* Comment that closer links between NHS England and CCG would be beneficial to understand the level of unmet need for people e.g. who do not engage with GOS (other responses also refer to reaching groups not currently accessing services)
* Focus on promoting self-care/ personal responsibility
* Work underway across wider footprint so will take part in that
* No need to prioritise as eye health services in their area are high performing services, particularly within secondary care where all access standards are performing well and patient safety and quality is high
* No capacity issues in area but plan to address issue of fragmentation cause by there being a lot of providers, and
* Two trusts provided joint responses with CCGs. Three responses from trusts were general responses which did not address the question. The other stated that the question is not relevant to them as they are a single specialty provider of eye care.

STPs

6.2.4 Of the six responses from STPs, four state that they have plans to raise the priority of eye health to meet demand, and a further response which is not in the form of a response to the questions in the call for evidence does detail plans to address capacity issues.

6.2.5 Only one response does not give any detail of whether it intends to raise the priority or address capacity issues, just stating “The CCG commissions appropriate activity which are based on previous year’s outturn”.

6.2.6 From those who said they have plans to prioritise eye care, responses included the following:

* Reference to ophthalmology as a key service improvement area but no further details given
* Reference to eye health being proposed for the next round of prioritisation in the STP programme (it is not made clear how likely it is that this proposal would be adopted)
* Reference to a service redesign which is already happening, and reference to plans for “improving medical retina service” and “improving and co-ordinating training across secondary care”
* Participating in national audits (BOCSU study and Getting It Right First Time reviews) and surveys to help raise the priority of eye health and increase understanding of national supply and demand
* Working closely with the Local Eye Health Network
* Reference to the Ophthalmology clinical network made up of various parties and to a Local Plan for Ophthalmology which supports the emerging STP plan. States that this is in keeping with “The Way Forward” and commissioning frameworks as developed by the CCEHC. Talks about shift away from hospital settings, consultant led triage, enhanced service optometrists and says there is a further opportunity for provision of consultant led hospital clinics in community settings (refers to a number of factors regarding IT, training, venues and governance that it considers need to be in place to deliver this).

6.3 Q28 Do you think the priority of eye health should be raised at the local area to meet existing and/or future patient demand? Yes or no, please explain why?

Professional bodies, research and health industry organisations and a Local Optical Committee

6.3.1 Eight of these organisations said that the priority of eye health should be raised locally; although some of these also expressed the view that national action would be necessary to make this happen (as detailed further below). Two of the organisations, and the researcher, did not address this issue.

6.3.2 Views included the following quotes about the need to raise priority to address capacity issues and the potential for parties to work together to understand and address these issues:

“Yes. In England, ophthalmology accounts for the second highest number of outpatient appointments and as such is a considerable strain on NHS services across the entire country. This, in combination with the widely acknowledged capacity issues in ophthalmology departments, mean it is both surprising and disappointing that so few STPs have identified ophthalmology as a priority area for reform” (Industry Vision Group), and

“By raising the priority of eye care at a CCG and STP level, it will give the opportunity for providers and commissioners to work together to review the capacity of services to meet demand and understand the challenges that need to be addressed” (Bayer).

6.3.3 Some responses expressed the view that a higher priority at STP level could bring about more standard pathways across CCGs in a local area, as expressed here:

“working at STP level has significant potential to improve care and prevention, and enable commissioners to transform services at scale within likely available resources. With an average population of 1.2m, STPs provide the opportunity for groups of CCGs to work with eye care providers and Local Eye Health Networks …across whole pathways, and over acute trust footprints, to develop transformed and sustainable services – and deliver the ambitions of the Five Year Forward View – within a relatively short period” (College of Optometrists).

6.3.4 Other responses emphasised the need for national action to help raise priority locally including reference to national pathways and standards:

“By raising the priority of eye health and its associated mental and physical care pathways the future demand can be effectively assessed but this should be addressed at a national level” (British and Irish Orthoptic Society).

“While the priority of eye health clearly must be increased at a national level, local commissioners and providers must also act to relieve pressure on ophthalmology services.” (Bayer).

“Local area priority of health care should be acknowledged but national pathways which address the mental and physical health of patients should be developed – the Ophthalmology Alliance work may go some way to provide the quality standards required to address this” (British and Irish Orthoptic Society).

“In 2013, NHS England launched the ‘NHS belongs to the people’ call to action, with a specific strand for ‘improving eye health’, focusing on a more preventative approach and effective management in the community. Unfortunately, this Call to Action was never published by NHS England. Eye health and sight loss are not acknowledged as a key priority by the NHS Five Year Forward View published in 2014, and this position remains unchanged following the recent publication of Next Steps on the NHS Five Year Forward View” (College of Optometrists).

At this time, there does not seem to be a clear steer from NHS England or within STP plans that will make the required impact on delivering safe, high quality and sustainable eye care services” (Evolutio).

6.3.5 Responses also offered views about barriers to getting a higher local priority for eye health health, including reference to a lack of national metrics on eye health and a comment about lack of local data collection despite guidance from the RCOphth, stating that commissioners and providers should have in place systems for capturing this.

6.3.6 There was widespread mention of the high proportion of outpatient appointments and operations which relate to eye care and the capacity problems (including reference to reports and figures in support of this) as a reason why the priority of eye care needs to increase. Responses which argued that data collection needs to be improved, argued that in the absence of this it can be difficult to measure the extent of the capacity issues and their impact and so raise the priority of eye health.

Local Eye Health Networks

6.3.7 Responses from Local Eye Health Networks included the following:

“Yes [the priority of eye health should be raised at the local area to meet existing and/or future patient demand]. Ophthalmology demand locally echoes national trends with between 8% -12% increase over the last 24-36 months and currently represents the second highest outpatient activity in [the local] Trust.

The majority of this activity is delivering the assessment, treatment and management of long-term chronic eye conditions such as glaucoma, age related macular degeneration and diabetic retinopathy.

Recruitment and retention of safe staffing levels continues to be a huge challenge and resources are stretched to the limit, with staff regularly working evenings and weekends in an attempt to avoid delays.

I have witnessed many patients having delayed follow-up due to multiple cancelled appointments and in some cases this has led to irreversible sight loss.

Attempts at trust, CCG/STP or regional level to address these shortages are again very reactive & short term without longer term future planning for increased demand in terms of staffing or resources.

Demographically in [the local area] we have some of the highest current (& projected) population statistics for over 65 and over 80 age groups in the UK as shown by the [EHNA] & therefore have evidence that this situation will get worse rather than better.”

6.3.8 These responses did not always respond to the question about priority directly, e.g. we received a report proposing more integrated working at STP level.

Charities

6.3.9 Only four of the ten responses from charities directly answer this question. All of these agree that the priority of eye health needs to be raised at local level, although three of the four state that action is also needed at national level for this to happen.

6.3.10 Comments on this include the following which emphasises the need for collaborative work locally to asses need, but considers CCGs lack the resources to take action to prioritise eye health locally:

“CCGs have a host of priorities and insufficient resource to regularly review and revise the commissioning of all specialities. Commissioners need to be encouraged and facilitated to look at the current and projected demand for eye care services to work with service providers to commission and plan services to adequately meet the needs of their population. We are calling for NHS England to prioritise eye care at a national level, to set the direction to improve capacity and thereby require local commissioners to prioritise eye care” (RNIB).

6.3.11 And this, which argues that some local initiatives already happening could benefit from national direction:

“Both local and national solutions are needed – capacity issues at Hospital Eye Services…are at breaking point and CCGs are looking at community ophthalmology as a viable means of alleviating this. The Local Optical Committees and the CCEHC all support and encourage this. Locally there are some effective [MECS] and direct referral schemes in place, which, with a national directive, could relatively quickly help to address these capacity issues, maximise the skills of optometrists and ensure there is not a postcode lottery in patient access to eye health services.” (Thomas Pocklington Trust and VISION 2020 UK submissions).

6.3.12 The following two quotes emphasise the need to ensure raising the profile includes provision of services and resources to meet demand:

“The higher the profile can be raised the more chance we all have of preventing avoidable sight loss, however the services have to be there to meet that demand”, and

“the [STP] is indicating a heavy reliance on voluntary sector picking up some of the fall out that result from decommissioned services at a point where the voluntary sector has financial challenges of its own” (Vista).

6.3.13 Many responses (including those which directly address this question and those which don’t) contain information (some referencing research and statistics) about the prevalence of sight loss. These sometimes include details of prevalence for particular groups and conditions and links between sight loss and other conditions such as diabetes, obesity, dementia etc. These include projections of increased demand in the future, and are often provided in support of the view that eye health needs to be prioritised.

6.3.14 Sometimes they are also provided in support of the view that recognising links between sight loss and other conditions is needed to prioritise sight loss:

“We feel that the [STP] was a golden opportunity to raise the profile of sight loss but unfortunately LTC, older people and mental health seemed to have stolen the limelight, without a second thought to related sight loss prevalence to those conditions” (Vista).

6.3.15 Those responses which don’t directly answer this question are often still arguing (expressly or implicitly) for more priority for eye health. These include the following:

* One states that it should be prioritised as “a key public health issue”
* Some emphasise the need for change at national level to improve access and ease capacity pressures, such as proposals for changes to the GOS contract (to improve access for people with learning disabilities) and to the policy on tariffs for first and second time visits
* Others focus on the need for action at local level, commenting on issues such as referral pathways (although there is also mention of national Vision 2020 UK pathways)
* One suggests robust research on the effectiveness of various models for community ophthalmology
* One response comments that hospital eye services are under-funded, and
* Some suggest local action needed to raise the profile of certain primary care services and engage people in prevention of sight loss.

Chapter 7 – Scrutiny of commissioning and planning

7.1 Introduction

7.1.1 The call for evidence asked what plans there were for the improvement of scrutiny of the commissioning and planning of eye health services and eye health outcomes.

7.1.2 This question was addressed as follows:

* Q5 - Department of Health, NHS England and Public Health England
* Q13 - Commissioners and NHS Eye Departments
* Q21 - STPs, and
* Q32 - Health profession bodies, charities, research and health industry organisations.

7.1.3 It was asked in the context of the PHOF data on preventable sight loss. This data shows variations in the rate of preventable health loss between local authorities.

7.1.4 The call for evidence describes how the PHOF produces data in respect of sight loss. The data recorded is the overall number of CVI issued. The PHOF also reports the number of CVIs issued for AMD, glaucoma and diabetic eye disease. This data can then be compared between regions and areas showing the rate of certification per 100,000 people. The data also shows the certifications over time, so also showing trends for each region/area. The data shows whether a region/ area have more or less certifications than the benchmark (England as a whole) [**[[32]](#endnote-32)**].

7.2 Responses

7.2.1 Responses were received from the Department of Health, CCGs, STPs, professional bodies, optometry organisations and a Local Optical Committee, charities, a healthcare company and an individual practitioner.

7.2.2 The responses mainly suggested that better and different data would help the scrutiny of commissioning and planning eye health services. There were suggestions about existing and additional data that could be considered with the PHOF data to deliver better outcomes. Some respondents also queried how the ‘best’ results could be replicated and how the ‘worst’ results could be held to account. Responses also said that the PHOF data was used by STPs and was incorporated in Joint Strategic Needs Assessments.

7.3 Suggestions for additional data

7.3.1 Respondents’ suggestions for additional data that could help improve scrutiny of the commissioning and planning of eye health services and outcomes, included the following:

* causes of sight loss to allow better targeting of resources
* demographics to understand whether the PHOF variations were reflected in local populations
* data was required to measure and understand unmet need
* to scrutinise planning and commissioning there need to be measures of outcome
* more local information is needed to plan at local levels
* a wider range of data is needed to address the needs of at risk groups e.g. people with a learning disability
* more information on how the services are provided e.g. workforce productivity, cost
* information on lifestyle factors that affect sight loss
* datasets should be consistent across all contracts
* analyse re-referral rates
* identify patients falling out of their clinically recommended review period
* measure the number of appointments that are delayed, and
* ophthalmology and outcome date to be included in the RightCare programme.

7.4 Suggestions of existing resources

7.4.1 Respondents’ suggested the following existing resources that could be used to help the scrutiny of planning and commissioning:

* Hospital Episode Statistics[**[[33]](#endnote-33)**]
* Patient Reported Outcome Measures[**[[34]](#endnote-34)**]
* Local Eye Health Networks
* NICE guidelines
* CCEHC
* Vision 2020
* Broad population indicators
* RNIB Sight Loss Data Tool
* GOS has information about NHS funded eye tests

Chapter 8 – The national / strategic priority given to eye health

8.1. Introduction

8.1.1 The call for evidence asked the Department of Health, NHS England and Public Health England:

* **Q2** How will the Government and NHS raise the priority of eye health to prevent avoidable sight loss at a national/ strategic level, for example by including eye health in the NHS Mandate?

8.1.2 Commissioners and NHS Eye Departments were asked:

* **Q12** What effect would raising the priority of eye health at a national/ strategic level (such as the NHS Mandate) have on how you commission these services in your area?

8.1.3 STPs were asked:

* **Q20** What effect would raising the priority of eye health at a national/ strategic level (such as the NHS Mandate), have on planning by your STP?

8.1.4 Health profession bodies, charities, research and health industry organisations were asked:

* **Q31** What effect would raising the priority of eye health at a national/ strategic level (such as the NHS Mandate) have on improving commissioning across England and at the local level, and planning and delivery by STPs, to help meet current and future demand for services?

8.2 Q2 How will the Government and NHS raise the priority of eye health to prevent avoidable sight loss at a national/ strategic level, for example by including eye health in the NHS Mandate?

Government / national bodies

8.2.1 The Department of Health response to this question refers to the PHOF which is already in place and refers to falls in the headline figure as reported under this and two of the underlying measures (AMD and diabetic retinopathy). The response generally also mentions measures to improve health (which impact on preventable sight loss) and the diabetic retinopathy screening programme. The response acknowledges concerns about delays in follow up appointments and says the department is doing work alongside NHS England to consider implications of research by BOSU published earlier this year and NHS England’s national Elective Care Transformation Programme. However, it emphasises that issues should be addressed locally (but with reference to national guidelines such as from the CCEHC and NHS England).

8.2.2 NHS England’s response is similar in that it talks about programmes already underway, but their response also mentions the Getting it Right First Time programme.

8.2.3 The GOC’s response doesn’t directly address this issue. It does mention differences of approach nationally in England to Scotland and Wales, mentioning the Scottish Government requiring some additional education for optometrists providing enhanced services in the community (additional to the training programme regulated by the GOC which it is currently reviewing under its Strategic Education Review). It doesn’t express a view on the different national approaches.

8.2.3 Public Health England’s response did not address this issue.

8.3 Q12 What effect would raising the priority at a national strategic level (such as the NHS mandate) have on how you commission services in your area)?

Commissioners and NHS Eye Departments

8.3.1 Eleven of the responses did not answer this question or issue at all. A couple of other responses provided an answer to the question but simply said what the CCGs are already doing to prioritise eye care, or emphasised that they want to see the right level of service, and made no comment on the impact of national or local mandates or targets or any changes to these.

8.3.2 Many emphasised that they were already prioritising eye health and did not identify any impact that raising the national priority would have on them. Of these, seven responded that raising the priority nationally would have no impact, whereas three others said that, whilst it would not impact on them, it would be useful for other areas which are not already prioritising eye health.

8.3.3 Four other responses mentioned adhering to the NHS mandate, adjusting their commissioning based on local need or changes in national strategic level of priority, or said that they are currently meeting demand and national targets (so suggesting that national priorities and targets impact on them although not addressing directly the issue of the impact of raising the national priority).

8.3.4 Another, but less common response was to provide more detailed comments about the possible impact raising the national priority would have, with some expressing a view that the impact would be positive. A few focused on the potential to improve consistency and clarity in commissioning, reinforce new models of care and broaden commissioning across regional footprints, utilise the broader workforce, and reduce pressure on secondary care. A few mentioned the potential for additional financial resources. In a couple of cases the focus was on additional financial resources or profile for initiatives already underway locally, but one mentioned a higher profile for hospital eye services possibly leading to help with additional theatre capacity where necessary, and another mentioned appropriate focus on eye care and finance for investment in research.

8.3.5 The potential for greater leverage for commissioners to make changes to meet demand was mentioned and possibly even a positive impact on workforce retention. Another response mentioned how raising the profile might help them to identify unmet (“hidden”) need in their area and the need to extend the scope of their services.

8.3.6 Another response focused not so much on raising the mandate or the priority, but on the need for work at national level by RCOphth and NHS England working with the College of Optometrists and the Association of Health Professionals in Ophthalmology, in developing evidence-based referral guidelines to be implemented locally – possibly involving hospital eye departments linking in and communicating with optometrists.

8.3.7 A slightly smaller number focused on the possible negative impact of raising the priority at national level, with mention of a higher national priority or changes to national guidelines such as NICE guidelines potentially creating additional financial pressure on the health economy, or presenting an additional reporting burden without addressing the key challenge of the need for additional workforce.

8.3.8 A couple of responses, whilst clear that raising the national priority would have an impact, were undecided about whether this would be negative or positive or expressed the view that this depended on the nature of the raised priority. One response, whilst acknowledging a potential additional cost burden, felt that this might be offset by the potential for a national approach to address the issue of system capacity, commenting that the upskilling of the primary care workforce would be more effectively done at scale either nationally or regionally. scrutiny and metrics which drive collaboration not competition.

8.4 Q20 What effect would raising the priority of eye health at a national level (such as the NHS mandate) have on planning by your STP?

STPs

8.4.1 Five responses from STPs did not address this question at all. Other responses said either that need was already being met; but that raising the national priority would be beneficial in raising the work those STPs were already doing locally, setting it in a national context and allowing allocation of further resources.

8.4.2 A couple of other responses were that raising the priority is unlikely to have any effect unless guidance for clinical pathways and standards are altered, and one response which advocates a proactive approach to redesign and local communications to mitigate the need for a national priority.

8.5 Q31 What effect would raising the priority of eye health at a national/ strategic level (such as the NHS mandate) have on improving commissioning across England and at the local level, and planning and delivery by STPs, to help meet current and future demand for services?

Charities

8.5.1 Four of the charities directly responded that raising the priority of eye health at a national/ strategic level would help to meet current and future demand for services, and three didn’t answer the question directly but advocated some form of national priority in their general response or in response to another question. Three did not respond on this issue at all. The following is a summary of the issues raised:

* Demand increasing due to demographics and other factors.
* Emphasise impact on health and wellbeing including links with falls, depression, dementia etc. as another reason for this should be a national priority (Fight for Sight).
* Raising priority at national strategic level (such as the NHS mandate) would help commissioning and planning and help prevent people unnecessarily losing their sight, but will only be effective with extra resources.
* Attention needs to be given to workforce development (RNIB).
* Eye health has a low priority compared to other conditions with similar rates of prevalence – all of these have national strategies co-ordinated from central government, are distinct clinical priorities within NHS mandate, CCG improvement and assessment framework and have indicators on long term condition packs for the NHS RightCare programme. There is currently no National Clinical Director for Eye Heath (Fight for Sight).
* There should be a national approach and messaging, with a Chief Optometric Officer (Seeability).
* There is a need for national accountable leadership (Macular Society).
* Action at national level on workforce planning, and national and strategic oversight to enable effective review and evaluation of investment in eye health services and for electronic records management system (International Glaucoma Association).
* Raising priority at national level would have a massive effect. Eye health services are often seen as an optional extra, and down to discretion of people at local level who may not be fully informed due to a lack of available reliable information
* It was mentioned that priority needs raising as there is a postcode lottery (Thomas Pocklington Trust and VISION 2020 UK submissions).

Professional bodies, research and health industry organisations and a Local Optical Committee

8.5.2 Seven of these organisations responded that raising the priority of eye health at a national level would help meet current and future demand for services (either as a direct response to the question or as part of their general response). Two organisations, and the researcher, did not provide a response on this issue. One organisation responded that it depended on the nature of the raised priority. The following is a summary of the issues raised in the responses:

* Strategic action at national level will help assess and meet future demand and reduce burden on other services and hospital admissions (Bayer).
* There should be a long term forward looking national strategy with hard recommendations like is already in place in Scotland and Wales, or for hearing loss and dementia, to address capacity issues currently experienced. NHS England should hold trusts accountable for improving services/ implementing recommendations in the strategy.
* Ophthalmology should have its own director as other major diseases do, to champion eye-care (Industry Vision Group).
* Raising eye care to a strategic level is essential as local and regional commissioning is currently ineffective despite attempts to improve. Local clinician-led solutions haven’t improved commissioning or STP planning, so need more strategic oversight.
* National approach needed to increase the number of ophthalmologists.
* Need a national approach for Association of Health Professionals in Ophthalmology training programme.
* Need a national approach for digital monitoring of follow up delays (RCOphth).
* Need a national strategy to deliver redesign of the system, better co-ordinated services and more consistency and effective use of scarce resources (College of Optometrists).
* By raising the priority of eye health and its associated mental and physical care pathways the future demand can be effectively assessed but this should be addressed at a national level (British and Irish Orthoptic Society).
* Increasing numbers of people with visual impairments, ageing population – current service approach unsustainable, need a change in strategy.
* Impact of sight loss on life – associated costs from links with e.g. depression and dementia (Evolutio).
* Would help give authority for redesign and structural reform – help to overcome resistance. Often CCGs and STPs don’t prioritise eye health services as they have limited resources and focus on addressing existing mandated priorities (Optical Confederation and Local Optical Committee Support Unit).
* Do not know whether raising priority would help – NHS tends to respond to targets, so a few carefully derived targets may be of value.
* Would depend on scope and execution of the “raised priority” – if strong national mandate given to all CCGs and STPs it “could” greatly increase awareness and focus additional resources to redevelop obsolete and inefficient pathways, but would likely need promise to CCGs and STPs of additional resources weighed against results (Devon Local Optical Committee).

Local Eye Health Networks

8.5.3 Two networks address this issue directly, the others don’t. The responses from those which do include the following:

* don’t know whether raising the priority would help - NHS tends to respond to targets, so a few carefully derived targets may be of value, and.
* raising the national priority would highlight the gap between primary and secondary eye services. Mentions current regional fragmentation and widespread inequalities.

Chapter 9 – Examples in local commissioning and STPs enabling demand to be met or to improve services

9.1 Introduction

9.1.1 The call for evidence asked Commissioners and NHS Eye Departments:

* Q11 Please tell us about examples in your local commissioning which currently enable you to meet demand for eye health services or which are enabling them to improve?

9.1.2 STPs were asked:

* Q19 Please tell us about examples in your STP which enables you to meet current and future demand for eye health services?

9.1.3 Health profession bodies, charities, research and health industry organisations were asked:

* Q29. Please tell us about examples which are currently meeting demand for eye health services and/or which are enabling them to improve as a result of: (a) commissioning by CCGs and/or (b) planning by STPs.

9.2 Commissioners and NHS Eye Departments

9.2.1 The responses from Commissioners generally gave examples where the aim was to ensure that the right treatment or diagnosis was done at an appropriate location by an appropriately qualified person. One CCG said:

“It is well known that many patients in acute ophthalmology services either do not need to be there at all or could be treated in a location closer to home.”

9.2.2 The examples to achieve this included triage giving work to optometrists, GPs with a Special Interest, nurses or other qualified professionals, the establishment of Minor Eye Clinic Services (MECS), virtual clinics and moving to locations within the community. One CCG reported that:

“The community provider operates from a range of community venues across the county and is able to see patients within two weeks from the point of referral.”

9.2.3 The types of treatment that can be done away from a hospital include certain glaucoma care, pre and post operation cataract care.

9.2.4 Other examples included integration of patient record keeping, commissioning of services using the Primary Eye Care Company model.

9.2.5 Additionally CCGs reported examples of working with others to improve eye health, using ECLOs to bridge the gap between health and social care, Local Eye Health Networks and Local Optical Committees.

9.2.6 Individual CCGs reported measures for children and those with learning disabilities and one CCG reported the use of sight loss examples in campaigns to improve health.

9.3 STPs

9.3.1 Examples provided by STPs included

* The use of local optometrists to undertake enhanced services
* The establishment of a 'cataract pathway' to reduce the need for cataract follow up in secondary care
* Introduction of a Clinical Assessment Service to triage routine referrals to secondary care – this is anticipated to allow better monitoring of demand and use of resources
* Giving GPs an advice and guidance service for an electronic referral system
* Use of evening clinics to give better use of the clinic space and more choice to patients resulting in improved attendance levels
* Signposting areas of support for children and young people and their families, when they are given a diagnosis of sight impairment
* Community MECs have been commissioned reducing the burdens on GPs and hospital eye casualty services, and
* CCGs aligning pathways and sharing best practice.

9.4 Health profession bodies, charities, research and health industry organisations

9.4.1 These stakeholders pointed to a range of initiatives across the country. Examples include working in partnership with industry to:

* increase capacity by improving pathways and patient flow
* introduce community high street services
* increase diagnosis and treatment of patients, and
* evaluating outcomes and sharing best practice.

9.4.2 Other examples included:

* introduction of an intermediate tier service to reduce the volume of patients referred to hospital
* MECs
* community services
* the RCOphth recommended their resources under the heading “The Way Forward” which share examples of best practice
* areas identified where demand is not being met

Chapter 10 – How commissioning, planning and delivery can be improved

10.1 Introduction

10.1.1 The call for evidence asked health profession bodies, charities, and research and health industry organisations:

* Q30 How do you think the commissioning, planning and delivery of eye care services can be improved at (a) local level, and (b) national level?

10.2 Professional bodies

10.2.1 Five submissions from professional bodies addressed this question.

Suggestions for local improvement

10.2.2 The following is a summary of suggestions variously made by The College of Optometrists, the Optical Confederation / Local Optical Committee Support Unit and the British and Irish Orthoptic Society:

* CCGs and STPs to make better use of planning resources e.g. EHNA and work with local public health teams
* CCGs – to regularly communicate and engage with local experts including Local Optical Committees, Local Eye Health Networks and patient representatives, at planning, tendering, mobilisation and delivery phases to avoid services which fail to deliver objectives. Use best practice across wider areas. All areas can base service design on successful pathways
* Avoid siloed and territorial working to achieve service integration and patient outcomes, and STPs to build on CCG-level successes and learn from inadequate service design
* Planning and commissioning to include eye health professionals and support staff as they have the expertise and evidence base to deliver quality standard pathways in addition to third sector eye charities
* Coordinate and commission eye health and sight loss services across STPs – which can improve care and prevention, and commissioners and providers can transform services at greater scale across a whole region. An NHS working at greater scale with clear responsibilities and objectives, giving opportunities for more efficiencies in commissioning, procurement, delivery of similar service specifications, reducing duplication of effort, resource and waste
* CCGs and local authorities – to implement CCEHCframeworks, the RCOphth’s “Three step plan”[**[[35]](#endnote-35)**]and “The Way forward” to manage demand/ capacity
* Optometrists providing capacity in hospital or community settings, to relieve pressure on hospital eye services, emergency departments and GP practices; with the latter concentrating on patients needing their services, and
* Improved communication and secure sharing of patient data between health and care professionals and patients, at each pathway stage, using electronic patient records and a community optometric connection to the NHS e-Referral system using Health and Social Care IT-network and NHS mail.

Suggestions for national improvement

10.2.3 The following is a summary of suggestions variously made by The College of Optometrists and the Optical Confederation / Local Optical Committee Support Unit:

* a national commissioning programme for MECS and other extended primary care programmes, for commissioners to meet national demand and improve eye health outcomes across England
* commissioning community services, using optometrists’ and dispensing opticians’ skills at national level, will reduce costs and admin (CCGs currently engage commissioning support units to develop service specifications, negotiate fees, and draw up contracts for each community service they commission)
* community services commissioned using standard national service specification, including pathways, existing accreditation and clinical governance requirements. Local Optical Committee (specialist contracting vehicles associated with them) have a key role driving local patient outcomes under national pathways
* CCGs / STPs - to use VisionUK 2020’s “Ophthalmic Public Health Committee: Portfolio of Indicators for Eye Health and Care”[**[[36]](#endnote-36)**], and
* to restore the balance in the ophthalmology tariff for new and follow up appointments to avoid a negative impact on patient care, lack of capacity and higher risk of avoidable sight loss.

Suggestions for local and national improvement

10.2.4 The following is a summary of suggestions variously made by the RCOphth and the Association of Health Professions in Ophthalmology:

* better engagement with stakeholders including patients and all ophthalmic professionals locally and nationally with professional bodies and patient groups
* a consistent and systematic approach to local health needs assessment and planning, to align with nationally agreed principles for effectively commissioning, planning and delivering eye care, e.g. CCEHC guidance. CCGs and STPs to use RCOphth, CCHEC commissioning guidance and NICE recommendations
* commissioning to support development of innovative service delivery models and pathways developed by professionals including local and regional networked solutions across primary, community and secondary care, with horizontal links in primary and secondary settings and supportive regulatory and financial systems supporting collaboration not competition. Stakeholders and those who need to change services, such as clinicians, need time and resource in order to
* commission networked / reconfigured regional care solutions must be commissioned to prevent some providers being adversely affected or adhering to different clinical standards and governance requirements; so that conflicts of interest are managed; clinical safety, adherence to key standards and cost effectiveness are managed and monitored across whole network; and joined-up pathways
* commissioning and planning to support national solutions to monitor follow-up delays – requires an IT system to monitor differences at national level between planned or clinically appropriate follow-up time scales and actual follow up date
* commissioning for chronic eye disease requires realistic new to follow-up appointment ratios and other appropriate contracting agreements - so that key safety areas (e.g. glaucoma and retinal conditions) deliver timely follow-up reviews and treatments without penalisation
* increase ophthalmologist posts
* adequate training and development of non-medical ophthalmic staff locally and improving national consistency - including a nationally recognised and resourced curriculum and training system, and buy-in from all ophthalmic professional groups
* training non-medical ophthalmic staff can improve commissioning, planning and delivery of eye care services at local and national level. Rising demand led to increased use of virtual clinics; but an absence of externally accredited education and training of non-medical staff and the variable quality of in-house programmes is a risk for the patient and ophthalmologist
* US model suggested to improve efficiencies, with (a) suitably-trained support staff, and (b) a restructure of the management and structure of services, e.g. with ophthalmologists seeing more patients with technicians’ support who examine patients in five or six fully equipped consulting lanes and an ophthalmologist who moves from lane to lane as the technician completes an assessment
* commission consultant led services in the community - use the skills of non-medical ophthalmic staff, reduce referral of patients back to the hospital eye service when community based non-medical healthcare professional seeks consultant opinion, and bring care of patients closer to their home - reducing staff and other costs, and
* the mandatory use of dedicated ophthalmic electronic patient records by hospital and community ophthalmic units for diagnostic tests and accessibility of data for quality assurance.

10.3 Local Optical Committee

10.3.1 The Devon committee suggested a fundamental redesign of local ophthalmic services to make better use of all ophthalmic (including community) providers, and formally involving Local Optical Committees and Local Professional Networks at all stages, including planning. They also suggested sharing and promoting, financially and clinically successful schemes at national level.

10.4 Charities / umbrella bodies

10.4.1 Four submissions from charities/ umbrella bodies addressed how the commissioning, planning and delivery of eye care services can be improved at local level and national level, and three submissions from charities indirectly addressed it.

Suggestions for local improvement

10.4.2 The following is a summary of suggestions variously made by the International Glaucoma Association, Thomas Pocklington Trust and VISION 2020 UK:

* Prioritise eye health as a public health issue
* Mandatory Local EHNA across England - commissioners need accurate data about eye care patient numbers, quality of life impacts in addition to financial costs and potential efficiency gains from improving service delivery and sight loss prevention
* More accessible community-based services for patients at increased risk of glaucoma such as people of Black African and Caribbean ethnicity or people experiencing socio-economic deprivation
* Commissioners to use VISION 2020 UK’s eye health and sight loss pathways for adults, children and young people, to commission and plan services, and CCEHC frameworks to address capacity
* Research on effectiveness of community-based delivery models
* STPs to include Local Eye Health Networks to ensure CCEHCframeworks are understood / implemented into integrated commissioning model to improve eye health and sight loss provision for local people
* Extra resource and funding for Local Eye Health Networks (Chairs do not have enough time to deliver NHS England work), and
* ECLOs/ Sight Loss Advisers in all eye clinics.

Suggestions for national improvement

10.4.3 The following is a summary of suggestions variously made by the International Glaucoma Association, Thomas Pocklington Trust and VISION 2020 UK:

* National and strategic oversight to review and evaluate investment in eye health services
* Increased use of NICE accredited CCEHC guidance, “The Way Forward” and NICE clinical guidance for glaucoma
* Higher priority and public messaging by the NHS, Government, the Prime Minister and all / political parties about the impact of eye health on people’s lives, and concerted efforts by health and social care to address them (for example as was done recently to address dementia). To increase promotion of public health interventions that prevent sight loss and early detection of sight threatening conditions, and ensure people at risk receive clear messages on their eye health and the importance of sight tests
* Increased parliamentary scrutiny of eye health and the Government’s approach.
* Increase public awareness about the role of community optometrists in glaucoma detection and monitoring
* Electronic patient record management systems for primary / secondary healthcare communication, and
* Workforce planning.

Suggestions for local and national improvement

10.4.4 The following is summary of suggestions made by the Royal National Institute of Blind People (RNIB):

* Patient experience needs to inform service design - streamline services to allow more people to receive appropriate tests, reviews and treatment in one visit; and deliver services to patients in alternative venues and ways (e.g. age-related macular degeneration treatment services in supermarket car parks)
* Patients need accessible information about diagnosis, condition, treatment options and risks, and support to adhere to treatment regimes, understand the importance of attending appointments, and following up hospital delays and cancellations
* People in poverty struggle to access eye care services and present with later stage eye disease, and the retail dimension of optometry can be a barrier to people accessing eye tests. There is a need to consider inequalities in access and outcomes throughout service planning to ensure people most in need of services receive them appropriately to prevent avoidable sight loss
* Anticipating demand via EHNA-based service planning
* More evaluation and audit including patient-reported measures of outcome and experience
* National leadership and strategy to support clinicians, service managers and commissioners to increase capacity
* National approach to IT systems to enable the efficient and secure transfer of patient data ensuring best use of the eyecare workforce
* The NHS and STPs to prioritise eye care in commissioning and planning more recognition of eye health and adequately resource it
* Mechanisms to facilitate consistent implementation of good practice
* Commissioners to specify efficient appointment systems to ensure patients have sufficient notification of appointments, reducing non-attendance and helping clinics manage demand
* More investment in training, build trust among professionals locally and nationally as optometrists, ophthalmic nurses and other professionals expand their roles for services to adapt to demand, and
* Change public perceptions of high street opticians and optometrists, and recognise their eye health expertise, and adequately fund and change perceptions of the eye test to a health check.

Indirect responses

10.4.5 Submissions from the following indirectly addressed the question as follows:

* Diabetes UK suggested commissioners should ensure there is a clear referral pathway for patients at high risk of diabetic retinopathy and that all services required to deliver this are commissioned, and
* Esme's Umbrella suggested co-ordinated commissioning for patients with Charles Bonnet Syndrome [**[[37]](#endnote-37)**]of NHS specialist assessment, counselling services and support networks.

10.4.6 A third response from SeeAbility and Mencap called on the APPG to endorse its recommendations to NHS England / government to address the health inequalities of people with learning disabilities in accessing eye care services, which in summary referred to

* a national learning disabilities eye care pathway funded by GOScontract enhancements
* a programme of properly funded sight tests and spectacle dispensing in special schools, a ‘one stop shop’ of eye care
* include those with learning disability in the list of ‘high risk’ groups eligible for NHS funded sight tests
* for commissioners to consider the cost effectiveness of eye care compared to long-term costs of ‘additional disability’
* a GP annual health check of materials for those with learning disabilities including better information on eye care preventing unnecessary referrals
* improved data collection of patients with learning disabilities, e.g. on the GOSform in hospital eye clinics, via Certificate of Vision Impairment (CVI) data[[38]](#endnote-38), flagging patients with learning disabilities on patient records in hospital eye clinics to support reasonable adjustments, and
* implementation of the NHS Accessible Information Standard[**[[39]](#endnote-39)**]

10.5 Local Eye Health Networks

10.5.1 Hertfordshire, Bedfordshire and Northamptonshire Local Professional Network (Eye Health) suggested locally, to give more influence and credence to Local Professional Networks; also CCGs being held accountable for eye care quality metrics; and nationally to establish a position equivalent to the Cancer Czar for eye health.

10.5.2 The Surrey and Sussex Network suggested:

* Greater clinical involvement ensures commissioning contracts are fit for purpose
* Innovative service design to maximise opportunities across settings
* Consider a range of service models to fit demographics of population needs across larger footprints and commission at scale with a range of options to reduce variation
* Investment in hospital eye service staffing and resources to provide adequate and safe ophthalmology capacity
* Training of a multi-professional workforce and delivery of services according to risk of sight loss
* Accurate data collection in primary and secondary eye care services to inform planning
* Investment and delivery of a secure and integrated shared ITsystem between primary care providers and hospital services, and
* Improved public awareness to promote greater understanding of prevention e.g. sight loss risk factors of smoking, obesity.

10.6 Healthcare/ pharmaceutical industry

10.6.1 Three submissions from this sector addressed the question.

10.6.2 Evolutio Care Innovations Ltd suggested expanding community optometrists’ resources to meet demand, via:

* Community-based services with oversight from consultants working within defined pathways and clear clinical governance frameworks (with secondary care treating high-risk patients and effective use of consultants), and
* An integrated single point of access NHS e-Referral support service to manage pathways from referral to treatment across primary, community and secondary care, to reduce fragmentation, variation, promote best practice, standardise referral content, quality, data capture and pathways. Also give all optometrists access to NHS Health and Social Care IT-network (N3) with extra funding and resource, and e-referrals via NHS IT-system without N3connection and ‘unconnected’ clinician referrals via fax, nhs.net integration and admin support.

10.6.3 Local improvement suggestions variously made by Bayer and the Industry Vision Group are summarised as follows:

* Mandatory local data collection on patient access to clinical support and interventions to identify variation in experience and assess how to streamline the eye care pathway to meet patient need, and use local evidence to ensure commissioning decisions are properly informed
* Commissioners and providers to implement RCOphth data collection guidance on follow-up appointments and patient outcomes impacts
* Providers to set compliance standards and establish mandatory reporting to check performance for follow-up appointments, and empower clinic managers and consultants with tools to analyse capacity bottle-necks and identify solutions
* Commissioners to prioritise ophthalmology in STPs and work with providers to agree consistent ophthalmology pathways and explore opportunities for more care in community settings
* Commissioners and providers to future-proof ophthalmology services against rising demand and prioritise investment in service redesign / development
* Address capacity issues at STP level in a joined up and holistic way to improve management of limited NHS resources. STPfootprints can enable groups of CCGs to work with providers to agree consistent pathways, implement innovative care, and develop transformed and sustainable services for NHS England’s “Five Year Forward View”.
* Providers – to train eye clinic admin staff to understand the importance of regular follow-up appointments for patients and manage the booking of follow-up appointments within clinical timelines, and
* Patients – to be empowered to understand and take an active role in their treatment (e.g. RNIB’s ‘Ask and Tell’ campaign [**[[40]](#endnote-40)**]).

10.6.4 National improvement suggestions variously made by Bayer and the Industry Vision Group are summarised as follows:

* NHS England – to prioritise developing a national strategy with stakeholders for commissioning, planning and delivery of eye care, focussed on improving capacity in local eye care services, providing a clear quality framework to secure improvements, guidance and support to commissioners and health authorities
* Getting It Right First Time review may assist development of national strategy
* Proactive NHS workforce planning to ensure ophthalmologists numbers match future demand, national assessment of need for training places, and combine recruitment with training for existing staff to improve capacity and efficiency
* NHS England to work with stakeholders to evaluate new models of care, collect and share good practice
* Develop guidelines to improve referral quality, increase patient discharge and assist patient flow
* NHS England to support a National Eye Health Survey to improve understanding of future prevalence and national assessment of patients who experienced moderate sight loss due to delays; and future collected-data to be made available at national level
* Review the national tariff system to examine how it affects planning and commissioning to ensure effectively prioritises eye health patients (i.e. vulnerable groups or follow-up appointments), and
* NHS England guidance to commissioners on moving to block contracts / incentives to increase capacity and meet demand.

Chapter 11 – Any other information

11.1 Introduction

11.1.1 The call for evidence asked Government and national bodies, CCGs, STPs and health profession bodies, charities, research and health industry organisations, to provide any other information that they felt the APPG should be made aware of in support of their responses, under Q6, Q14, Q22 and Q33. This chapter highlights themes which emerged from responses to these questions rather than by sector, as well as information provided as part of free form responses, and any other information on these themes which was not captured in other papers. A small amount of additional information received from STPs and CCGs is not captured here as this generally related to local needs assessments and other local details covered in other papers. The themes are:

* Evidence about capacity issues including the impact on sight loss
* Capacity, workforce and training issues
* Research on treatment
* Information from roundtable events, and
* Miscellaneous – including comments about resources, efficiency and access.

11.2 Evidence about capacity issues including the impact on sight loss

11.2.1 The RCOphth makes the following comments about capacity issues:

“Patient harm

The [BOSU] study published in January 2017 concluded there are up to an estimated 22 patients per month permanently losing sight due to hospital-initiated delays in care. Delayed follow-up or review appointments were the cause in most cases. This indicates insufficient capacity in the service.

National Reporting and Learning System (NRLS)[**[[41]](#endnote-41)**]data showed that between April 2011-March 2014 there were 577 delayed glaucoma appointments, 58 resulting in severe harm and 118 in moderate harm. NRLS data also showed that between August 2011 – September 2013, around 500 incidents of severe (130) and moderate (350) vision loss occurred due to delayed review appointments in ophthalmology outpatients. This was mostly in glaucoma, macular degeneration and retinal conditions including diabetic retinopathy.

The National Patient Safety Agency (NPSA)[**[[42]](#endnote-42)**] issued a rapid response safety alert in 2009 on managing glaucoma follow up delays. This followed NRLS data that showed 44 glaucoma patients experienced deterioration of vision between June 2005 and May 2009, including 13 reports of total loss of vision, attributed to delayed follow up appointments”.

“Cataract Rationing:

We are receiving increasing reports from patients and our members of cataract surgery being rationed, eligibility being based on arbitrary thresholds rather than clinical need. In some cases, patients have only qualified for surgery after sight loss has occurred in their second eye.

Our members are regularly having to complete Independent Funding Requests for cataract surgery, which causes delays to treatment and uses up significant clinician time. This is a highly inefficient method of funding patient care. We are currently carrying out a survey with members to quantify the extent of this issue.”

11.2.2 The Industry Vision Group response also cites the reports by BOSU, NRLS and NPSA.

11.2.3 The Macular Society response included the following:

“We have not had an opportunity to collect recent data on these issues in a systematic way so only offer anecdotal evidence to illustrate what we mean. Many areas of concern have come to our attention via our helpline and advocacy services:

Failure to meet national guidelines for appointments times

Many clinics cannot treat new wet AMD patients within the RCOphth guidelines i.e., within two weeks of referral, or meet recommended follow up intervals. Recent examples to our helpline are:

Patient A was told in July 2017 that she would have to wait 12-16 weeks for her first injection. She has paid for two loading doses privately to give herself the best chance of maintaining her vision. Patients at this clinic are apparently triaged for care with even those classed as ‘urgent’ waiting six weeks for a first injection.

Patient C was diagnosed on 7th August and was told his first appointment for treatment would be the end of October.”

11.2.4 The Macular Society goes on to list similar examples including people paying for private appointments due to lack of NHS appointments. It also includes the following background about the impact of delays on patients suffering from macular degeneration:

“AMD and similar conditions are progressive and the sight loss they cause is irreversible. Anti-VEGF drugs[**[[43]](#endnote-43)**] are designed to stop the growth of abnormal blood vessels in the eye and to reduce leakage from blood vessels in the retina. They do not work on mature blood vessels so must be given in a timely manner if they are to be effective. In our experience the biggest cause of unnecessary sight loss in macular disease is the failure to give the drugs at the right time. Many thousands of people are losing more vision than necessary because the drugs are given inefficiently in many clinics.”

11.2.5 The International Glaucoma Association (IGA) surveyed its members’ views about the diagnosis, management and treatment of glaucoma. They received 875 responses. Findings as reported to the APPG included the following:

“Encouragingly, more than two thirds of respondents (71%) felt that they received sufficient information at the point of diagnosis; 79% were given sufficient information about their initial treatment, and 84% were given sufficient information about any subsequent changes to treatment.

Overall communication between the patient and the hospital was rated as good, with many praising the professionals who care for them. The comments tend to show that the quality of patient care is often attributed to the Consultant who has a particular interest in glaucoma.

However, of those who did not feel they were given sufficient information at diagnosis, or sufficient information about treatment or subsequent changes of treatment, the main reasons given were busy departments, a lack of staff time, poor communication, information about treatment not being clear and appointment delays…short appointments…poor administration”.

11.2.6 The IGA go on to give further details about the survey findings about delays and cancellations:

“Over 40% (n: 329) had a delay or cancellation in the last 18 months, with nearly half being delayed once (47%: n: 149), 34% (n:108) twice and 19% (n: 61) more than three times (n:61). Six out of 10 (n: 218) were delayed by up to three months, 20% (n: 71) by three to six months and 19% (n: 68) for longer than six months [the percentages represent the percentage of those answering the question referred, with the n figure showing the actual number of people the percentage represents]”

11.2.7 And the following qualitative comment:

“Over many years I have noticed a steady decline in regular appointments, supposed to be 6-monthly but sometimes 14 months.”

11.2.8 The IGA also report that 22% were advised of visual field loss at their delayed appointment (although they say that they are not in a position to know whether the delay was the cause). They go on to say:

“Members also tell us that delays have a negative impact on their overall physical and emotional health. An increasing number of callers to our helpline report being extremely scared and anxious about losing sight whilst waiting for new appointments, and the stress this causes effects their daily lives and overall physical and mental wellbeing.”

11.2.9 The IGA recommend:

* Delays and cancellations must be addressed and capacity expanded in accessible locations, and
* Newly diagnosed people with glaucoma must be given support and information about how to take eye drops, and about the techniques and aids that are available to help.

11.2.10 The IGA report that:

“An earlier IGA membership survey in 2014 showed that 45% of people [responding to the survey question] were not told how to use their eye drops, 50% were not aware they should press the corner of the eye for one to two minutes after putting the eye drop in, and only 9% had been given any information on the aids available to help people administer the drops.”

11.2.11 They advocate having groups to assist people with this, reporting that it has set these up in many parts of the country but the support of hospital specialist glaucoma staff is required, and information needs to be given to patients where the groups don’t exist and advise that they can provide free support to hospitals with this at scale. They quote that 20% of calls to their helpline are about this issue and it poses a risk to sight. They advocate the involvement of community pharmacists and optometrists to support hospitals with this.

11.2.12 The IGA’s response also highlights the need for better co-ordination and scheduling of clinical activity, citing concerns raised by patients about attending appointments where tests results aren’t available and waiting and being transferred between hospitals due to lack of available facilities.

11.3 Capacity, workforce and training issues

11.3.1 The Industry Vision Group response makes the following comment:

“It can be difficult to persuade budget holders of the benefits of expanding eye health services to keep up with growing demand. This can result in an inefficient, short-term approach to service delivery, where expensive locum staff are recruited to alleviate immediate staff shortages. NHS workforce planning should look seriously at the number of ophthalmologists that will be needed to cope with demand in the future. The NHS can counteract this through proactive workforce planning and by adopting a longer-term perspective on ophthalmology staffing. By combining recruitment with training for existing staff, departments can improve both their capacity and efficiency.“

11.3.2 The Industry Vision Group also said:

“A number of individuals can be included in the ophthalmology workforce beyond ophthalmologists. The [RCOphth] is exploring issues around workforce training, including conversations with Health Education England[**[[44]](#endnote-44)**] to ensure there is a highly-trained workforce in operation. A recent Westminster Hall debate [in Parliament] into preventing avoidable sight loss prompted a concerning response from the Government. The Minister stated that recent workforce increases do not imply that there should be current capacity issues within the ophthalmology sector.”

11.3.3 The RCOphth response includes the following statement:

“We have evidence of significant deficiencies in the workforce. Our 2016 workforce census show that Trusts are struggling to fill consultant posts. The figures show:

• 51% of units in the UK have unfilled consultant posts (73% in Scotland)

• There are at least 73 unfilled consultant posts in the UK

• 47% of units in the UK have unfilled [Specialty and associate specialist] doctor posts[**[[45]](#endnote-45)**]

• 42% of units are using locums to cover unfilled consultant posts

• 66 locums are being used in responding units to cover unfilled consultant posts

• 91% of units are undertaking waiting list initiatives

• 71% of waiting list initiatives are undertaken by responding units rather than by other independent providers”.

11.3.4 RCOphth make the following comments about staff training:

“We also have concerns about the absence of standardised training for non-medical ophthalmic practitioners in expanded roles. If this part of the workforce is to be developed further, there must be assurances that their skills and knowledge are sufficient to deliver safe and effective care. We provided a framework for developing non-medical ophthalmic staff in the hospital eye service within our Common Competency Framework.”[**[[46]](#endnote-46)**]

“There also needs to be greater consideration of how the system enables adequate training and development of non-medical ophthalmic staff, both locally and improving consistency nationally. A nationally recognised and resourced curriculum and training system, with potential for [continuing professional development] and updates, with buy in from all ophthalmic professional groups, is key to fulfilling demand and local teams and staff need to be resourced to access or deliver the training.”

11.3.5 The GOC response refers to the trend towards multi-disciplinary working and outlines the various regulatory bodies. They also summarise findings from its Education Strategic Review about training needs and the changing workforce, including quotes from stakeholders, and mention proposed follow-on work including a roundtable event it had planned for autumn 2017.

11.3.6 The GOC response mentions the Quality Assurance Agency for Higher Education which sets out its own requirements for undergraduates and post graduates.

11.3.7 The response also provides background about guidance, including guidance about training and qualification and the different frameworks in the different UK countries, noting:

“• The [RCOphth] has produced tailored guidance associated with the commissioning and practice of certain services which also refer to optometry practice.

• The College of Optometrists has published a series of condition-specific Clinical Management Guidelines.

• In Scotland the Scottish Intercollegiate Guidelines Network (SIGN) has produced evidence based recommendations and best-practice guidance, including on primary-care assessment and referral of patients with suspected glaucoma and safe discharge.

• In England, NICE has developed a range of eye conditions guidance, including relating to refractive errors, cataracts, glaucoma and Age-related macular degeneration.

• In November 2016, the [RCOphth] together with the College of Optometrists and others developed the ‘Ophthalmology Common Clinical Competency Framework’. This sets out standards and guidance for the knowledge and skills required for, what are described as, non-medical eye healthcare professionals to deliver patient care. It applies in a hospital setting where there is an ophthalmologist overseeing the care of the patient and recognises an increasing professional interface between ophthalmologists, optometrists, nurses and other eye health professionals.

• The Framework covers acute and emergency eye care, cataract assessment, glaucoma and medical retina. Education and training providers are encouraged to voluntarily take account of the Framework within their programmes in order to equip professionals to safely and competently deliver care in such a multi-disciplinary context.

• The [CCEHC] provides evidence-based clinical advice and guidance to those commissioning and delivering eye health services in England on issues where national leadership is needed.

• The [RCOphth] has published commissioning guides into glaucoma (published in 2016) and cataract surgery (published in 2015) (NICE accredited). For Glaucoma patients, the guidelines indicate that optometrists may participate in repeat measures based on their existing initial training, and in enhanced case finding if they hold the College of Optometrists’ Professional Certificate in Glaucoma (or equivalent). Optometrists may participate in referral refinement with diagnosis of suspected Ocular Hypertension/Glaucoma in the community if they hold the College Professional Higher Certificate in Glaucoma, (or equivalent) and in a hospital setting if they hold the Royal College Professional Diploma in Glaucoma (or equivalent).”

3.8 The GOC response describes the different position on commissioning and training in Scotland, making the following comment about training:

“NHS in Scotland has instituted a national programme of upskilling for all optometrists, funded by NHS Education for Scotland (NES)[**[[47]](#endnote-47)**], before they can deliver GOS services, which may be supplemented by other training based on the needs of Health Boards. NES has also funded a network of Teach and Treat Clinics to enable community optometrists to manage and treat patients under the close personal supervision of an ophthalmologist. The Scottish Government describes this as being necessary “to more appropriately manage acute ocular conditions”.

3.9 GOC is explicit in stating that “…if an optometrist wishes to move to practice in Scotland, they need to attend training”

3.10 The GOC response observes “This could suggest an actual or perceived lack of sufficiency of our education competencies, in terms of the practice of optometry in Scotland, and/or the need for refresher training in some areas of practice”. It said it is looking to gain greater understanding of this via the Education Strategic Review.

3.11 The response also describes the different framework in Northern Ireland, in Wales, and in England. Comments about England include the following: “Due to the emphasis in England on local commissioning, there is no single model of enhanced service provision in England.” GOC state that:

“optometrists practising in the community in England may currently have different experiences and levels of exposure to enhanced services delivery, and consequentially the volume and range of conditions related to this service delivery. This could arguably have an impact over time on the ability of practitioners to maintain their skills in these areas day to day without the need for refresher training as part of their CET. Some Local Optical Committees indicate that certain CCGs require additional training by optometrists before any contract to provide enhanced eye services can be entered into.”

3.12 GOC also comment that: “the definition of what these enhanced services are appears to be loosely defined and subject to variation across the UK.” Their response also comments on some research into the effectiveness of optometric enhanced eye care services published in the ‘Ophthalmic and Physiological Optics’ journal of the College of Optometrists in 2016.

3.13 The Association of Health Professionals in Ophthalmology submitted a report about their survey on the training needs of ophthalmic support staff. They asked hospitals which types of staff in their hospitals have qualifications in eye health, what demand there would be for an Open University Foundation Degree, and whether hospitals or the staff themselves might be willing to fund this. They established that a lot of the hospitals surveyed have staff in various support roles who don’t have qualifications in eye health, that there was demand for this qualification at most support levels except senior orthoptists, but that hospitals didn’t know to what extent people would self fund and trusts generally only willing to support two or three staff for the course per year. The Association also submitted a PowerPoint presentation entitled “Putting the Ophthalmic Team together: prospects and challenges”.

11.4 Research on treatment

11.4.1 The Industry Vision Group response mentions working in partnership on access to innovative treatments for preventable sight loss and say ophthalmology is a very active area in terms of research and development of clinical trials.

11.4.2 Fight for Sight’s response includes the following comments about investment in research:

“In the year 2014 through bodies such as National Institute for Health Research [**[[48]](#endnote-48)**] and the Medical Research Council][**[[49]](#endnote-49)**] the government spent £27.2m on eye related research. Considering the rate of prevalence, the economic burden of sight loss on the NHS and wider society and compared to other condition groups, eye health represents a neglected area of research funding. We would call on the Government to double the amount of funding for eye research over the next 5 years to meet the growing demand that sight loss will have on society in the future.

For the top 20 sight loss charities, of an overall expenditure of £732.9m in 2015/16 only £6 million was spent on vital medical research. This represents only 0.8% of the total spend of these charities. In line with more public funding being available for research to help prevent and treat eye conditions, more money needs to become available within the sight loss charitable sector earmarked for research so that instead of helping people live with sight loss we can help to beat sight loss.

By achieving breakthroughs in treatments and cures to sight loss this will reduce the increasing pressures on capacities in the NHS and social care.”

11.5 Information from roundtable events

11.5.1 RNIB’s submission to the APPG inquiry was informed by a series of policy roundtables held during 2017 by RNIB, supported by Specsavers. Background to the submission says:

“The five policy roundtables considered optimal models of eye care exploring how improving delivery in eye care services can help to increase capacity. Three roundtables focused on a major eye condition, one on treatment for minor conditions and a fifth on improving commissioning. In particular, they considered the evidence for moving eye care services into community settings, and patient experience of those services.”

11.5.2 The submission also includes links to the RNIB and Specsavers report “State of the Nation Eye Health 2017: A Year in Review”[**[[50]](#endnote-50)**], and to an evidence briefing section which includes notes from the roundtable events and their literature reviews. The latter considered literature on the effectiveness of various models including issues such as the impact on capacity in hospital eye services, cost effectiveness, patient experience, clinical safety and equity of access.

11.5.3 The Industry Vision Group also held a roundtable event with stakeholders across the eye health sector in 2017, and their submission summarises key points from it:

* The need to better utilise innovation to alleviate pressures elsewhere within the system (in the short and long-term), in turn creating further headroom for innovation and advances
* A forward-looking strategy is required rather than the short-termism nature of NHS policy
* An eye care champion is required to provide a single external voice for the ophthalmology sector
* Ophthalmology is not prioritised as a therapy area despite being responsible for the second largest number of outpatient appointments and the wider economic and societal benefits of early intervention are not being communicated clearly enough.
* Risk identification and management should be a priority for quality improvement and efficiencies in ophthalmology, and
* Attendees agreed that the sector is good at coming together to debate the issues but “crying out for a champion” to speak with a single voice externally.

11.5.4 The Industry Vision Group submission states that attendees also noted:

“Recent NICE and NHS England affordability reforms may slow patient access to innovation, whereby treatments with an annual bill of +£20m in any of their first three years could undergo further negotiation with industry or be subject to managed access schemes. Alternatively, NHS England will be able to make a request to NICE that access can be phased in more slowly than the current 90-day limit. The scale and scope of those with eye conditions means it is likely many new treatments will hit this cap, and therefore patient access to treatment may be restricted. This arbitrary means of budgeting treatments must be challenged…Treatment being perceived as a cost, rather than an investment, is hugely detrimental. However, the data to make this argument is difficult to accrue and would need to be solid to sway policy decisions. This is compounded by NICE’s failure to consider non-NHS budget impacts of not preventing sight loss.

The integration of health and social care – and the impact this will have on ophthalmology – was raised. Vision 2020 UK is doing some work with the King’s Fund on this; early findings indicate delays in intervention result in cost burden in social care.”

11.5.5 The Industry Vision Group also raised concerns about lack of resources for effective risk stratification.

11.5.6 Following the roundtable event referred to above, a consensus statement was drafted outlining clear calls to action for improving ophthalmology services in the English NHS, which the Industry Vision Group included in its response as follows:

* the Department of Health to identify ophthalmology as a national health priority
* the Department of Health to include improving eye health in NHS Outcomes Framework, and
* NHS England to expand RightCare to feature an ophthalmology conditions pack.

11.6 Miscellaneous – including comments about resources, efficiency and access

11.6.1 A submission from a healthcare company states it is: “currently giving referral support and consultant-led community ophthalmology services across 19 CCG’s in England,” and:

“We’re commissioned by NHS England to process the huge volume of GOS forms across Essex between Oct 2013 – July 2015 and provide the data for analysis by the Universities of Leeds and Bradford in conjunction with the [RCOphth] to look at the inequalities in uptake of NHS funded eye examinations” (this research is also referenced in its submission).

11.6.2 The company’s response describes its e-Care Community Ophthalmology Service Model and its telemedicine software, setting out the benefits that the company considers these provide:

* More effective use of clinical resource
* Improvements in service quality
* Value for money
* Reduced waiting times
* Reduction in false positive referrals
* Improved appropriateness of care (right care, right place, right time)
* Provision of high quality, patient centric care
* Enhanced patient safety
* Implementation of an electronic shared care record
* Convenient and accessible care closer to home
* Introduction and utilisation of innovative technologies, and
* Virtual OCT clinics and home monitoring apps for smartphones and tablets.

11.6.3 The joint response from Optical Confederation and the Local Optical Committee Support Unit use the section on additional information to express support for the NHS “Five Year Forward View” and more integrations between primary and secondary care.

11.6.4 The Macular Society response includes the following comment:

“It is abundantly clear that hospital eye services are short of funding. However, we believe the APPG’s inquiry risks missing some crucial issues if it focusses on capacity only in terms of financial resources.”

11.6.5 They express the view that leadership, working practices and the way providers work with commissioners, rather than just differences in available resources, are responsible for geographical variations. They say that some trusts have been slow to use nurses to administer injections despite a shortage of ophthalmologists and audited data on safety and effectiveness of using nurses. They also refer to good and bad practice for procedures for giving appointments and the availability of one stop shops, and describe anecdotal evidence of misinterpretation of NICE guidance causing delays and extra costs.

11.6.6 The Macular Society also said that: “Auditing of hospital eye services is weak” and attach with their submission information about the work of the National Ophthalmology Database Audit group[**[[51]](#endnote-51)**] and its recommendations for improvement. They comment specifically that audit of cataract operations has been conducted but funding is required to extend this work into glaucoma and macular degeneration.

11.6.7 On tariffs, the Macular Society said

“The [Department of Health] has been asked to address the issue of tariffs and the inappropriate way they are applied in ophthalmology. The significant difference between the tariff for a first appointment and follow ups is not appropriate in wet AMD treatment where the costs are similar for each appointment, assuming injections are given at each appointment. The response from the [CCEHC] (attached) provides the detail of the concerns.”

11.6.8 The Macular Society enclosed correspondence with the CEOs of NICE and NHS England and to the Secretary of State for Health on these issues. They say there needs to be less professional rivalry in the sector, commenting that:

“Too many meetings and forums are nothing more than repetitive talking shops. Umbrella organisations in the sector are unfunded and have no power. Enormous numbers of pathways, frameworks, guidelines and good practice models are created but little seems to come of them in terms of practical application.”

11.6.9 The Inquiry received a submission from an ophthalmologist who is now the director of a healthcare company, which included the following comments:

* the NHS could be more efficient e.g. comments that has supervised cataract operations in NHS and elsewhere and found fewer carried out in the NHS. It is not incentivised to be efficient
* should include more ophthalmic assistants and technicians in doing tests. 90 per cent can be carried out by these staff (although doesn’t quote a sources for this figure)
* there is duplication of work between different types of staff, communication problems, limitations of electronic systems
* should give optometrists access to hospital systems and vice versa
* consultants should use electronic medical records/ virtual eye clinics. There is evidence that this can reduce pressure and consultants need more training and awareness about this to reduce their fear
* talks about a lack of trust between consultants and managers. The solution is more clinicians in management and more communication between the two, and
* there are conflicts of interest where consultants are on the payroll of drug companies and alleges this can mean they recommend more expensive drugs when cheaper alternatives are available.

11.6.10 The Industry Vision Group response includes the following comment:

“A combination of new working practices, new technology and innovative thinking is providing solutions to the demand problem, though it should equally be recognised that if services remain consistently underfunded in relation to demand, then the pursuit of efficiency, no matter how rigorous, will only ever be able partially to close the gap.”

11.6.11 The Macular Society attach an article from the “Ophthalmological Times – Europe” (March 2016) by Karen Goodall of Care-UK and Adam Levy, Managing Partner, Manchester Consultants Eye Partnership. The article describes the provider’s experience of running a 48-hour wet-AMD treatment service in a real world setting. The article states that the service “was developed with limited impact on existing pathways” and the authors claim that although not every patient was seen within 48 hours, the results suggest that “performance achieved in clinical trials is achievable in real world practice”, and that their experience demonstrates that reference standard outcomes are achievable at typical commissioning scale at no extra cost over existing pathways.

11.6.12 Darren Shickle, Professor of Public Health of the Institute of Health Sciences at the University of Leeds, submitted the following academic papers about the uptake of sight tests:

* “Cost of sight test sensitivity analysis”
* “Why don’t older adults in England go to have their eyes examined?”
* “GOS and the public health interest”
* “Inequalities in GOS uptake in Leeds”
* “Why don’t younger adults in England go to have their eyes examined”, and
* “Essex GOS uptake inequalities – small area analysis”.

11.6.13 He says that, collectively, the papers argue for a significant change in the provision of primary eye care in England.

11.6.14 He says that in the paper about the “GOS and the public health interest”, he and his colleagues argue for a separation of clinical optometry from dispensing opticians saying that the current model relies on cross subsidisation of sight tests by the sale of optical appliances with the tests conducted in commercial settings. He comments that the research found that optometrists were seen differently to other healthcare professionals, with the retail aspect seen as too dominant.

11.6.15 His final paper is a letter to a journal arguing for a confidential enquiry into preventable sight loss. He says:

“In the letter I note that an often quoted figure is that half of sight loss is preventable. This figure is often quoted by organisations such as RNIB and now appears in a Specsavers advertisement. It has also appeared in the [PHOF]. The figure is almost certainly incorrect and is a misinterpretation of an old literature review of papers that are now out of date. While I don’t know the correct figure, as the data is not available, I would urge the Inquiry not to repeat this figure, or at least to use the more nuanced interpretation of the literature that I address in the letter.”

11.6.16 The submission from St Paul's Eye Unit at the Royal Liverpool University Hospital, included an article titled “NHS sight tests include unevaluated screening examinations that lead to waste”, by Michael Clarke Consultant Ophthalmologist, Newcastle Eye Centre, Newcastle upon Tyne Hospitals NHS Foundation Trust, Newcastle upon Tyne, and Reader, Institute of Neuroscience, Newcastle University (British Medical Journal, March 2014):

“The NHS must find a solution to the waste generated by unnecessary referrals from unregulated, scattergun screening of patients attending for NHS sight tests. Those solutions are not going to come from opticians or the “eye health” community. It is time for ophthalmologists to get up from their slit lamps, step into the light, engage with [GPs] and commissioners, and demand that ophthalmology is subject to the same evidential requirements as other medical specialties.”

11.6.17 Thames Valley Area Local Eye Health Network submitted a report called “AMD in Oxfordshire” (2017) – by NHS North of England Commissioning Support and NHS Thames Valley Eye Health Network. The project used a value-for-money methodology to identify inefficiencies and improvements in care for patients with wet-AMD in Oxfordshire.

11.6.18 The report identified the following challenges:

* Resources at the Oxford Eye Hospital are stretched
* Importance of emotional support and consistent information is underestimated
* Communication among providers of local eyecare, and with local management and commissioners could be improved

11.6.19 The report identified the following solutions:

* Move certain services into the community
* Make better use of current services, specifically eye health and sight loss advisers and the voluntary sector, and
* Further improvements of lower but significant impact were also identified.

11.6.20 The London Eye Health Network included the following reports on their strategy: “Achieving better outcomes” (2015) and an update for STPs (2017), and a checklist to help commissioners and providers undertake a gap analysis on their state of development versus the strategy and commissioning guidance. Their strategy aims to:

* minimise sight loss and reduce health inequalities for London’s population
* focus on delivering efficiencies and better value care across all the eyecare pathways, and
* look after individuals better and look after more people by cutting out waste, reducing variation and making resources go further.

11.6.21 Charities submitted information about self-care and screening exercises and about the links between sight loss and other conditions, including arguments about the cost effectiveness of prevention in reducing social care costs. Examples include:

* Fight for Sight, Thomas Pocklington and VISION 2020 UK, which advocate increasing awareness of e.g. the link between smoking and AMD and the importance of sight tests to prevent avoidable sight loss
* Diabetes UK suggest offering weekend and evening appointments and getting GPs to raise awareness of the need to attend screening appointments in addition to sight tests
* Guidance documents and Key Performance Indicator reports on screening programmes from Public Health England are cited as well as reports containing prevalence figures for diabetic eye disease and other causes of blindness, and
* Attendees at one of the RNIB roundtable events commented that diabetic retinal screening has been an enormous success story in medicine – as thousands of people can see today as a result of it which otherwise would not.

Chapter 12 – Patient submissions to the call for evidence

12.1 Introduction

12.1.1 In addition to patients completing the survey and giving oral evidence, nine patients submitted responses to the call for evidence.

12.1.2 The following questions were included in the call for evidence ahead of publication of the planned patient survey.

* Q23. What has been the personal impact of the care you have received from the NHS for your eye condition?
* Q24. From your experience, please tell us how you think eye care services could be improved to make sure people receive the care they need to keep their sight?

12.1.3 The following is a summary of the issues these patients raised.

12.2 Impact

12.2.1 Delays in appointments meant that treatment was not given at the appropriate time leading to eye damage and permanent loss of vision.

12.3 Improvements

12.3.1 A number of patients responded that there was treatment available for their condition outside of the NHS. However, they found this treatment through their own efforts and felt that the treatment should be available within the NHS; and until then the existence of the treatment should be signposted by the NHS.

12.3.2 Schedule the next appointment when leaving the current appointment.

12.3.3 More publicity for National Eye Health Week.

Annex: List of responses to the call for evidence

Please see explanatory note below for how submissions have been recorded.

Government/ national bodies

* Department of Health
* General Optical Council (GOC)
* NHS England
* Public Health England

Clinical Commissioning Groups (CCG), NHS Eye Departments, clinicians

* Ashford CCG
* Ashford CCG, Canterbury and Coastal CCG, South Kent Coast CCG and Thanet CCG
* Barnet CCG
* Bassetlaw CCG
* Bolton CCG
* Brent CCG
* Bromley CCG
* Cambridgeshire and Peterborough CCG and North West Anglia Foundation Trust
* Cannock Chase CCG, South East Staffordshire and Seisdon Peninsula CCG and Stafford and Surrounds CCG
* Canterbury and Coastal CCG
* Chiltern CCG and Aylesbury Vale CCG
* Coastal West Sussex CCG
* Croydon CCG
* Doncaster CCG
* Dorset CCG
* Durham Dales Easington and Sedgefield CCG, North Durham CCG, Darlington CCG and County Durham and Darlington Foundation Trust
* East Lancashire CCG and Blackburn with Darwen CCG
* Gloucestershire CCG
* Guildford and Waverley CCG
* Scott Robbie, Consultant Ophthalmic Surgeon, Department of Ophthalmology, Guy’s and St. Thomas’ Hospitals NHS Foundation Trust
* Hounslow CCG
* Isle of Wight CCG
* Kernow CCG
* Leeds Clinical Commissioning Groups Partnership made up of Leeds North CCG, Leeds South and East CCG and Leeds West CCG
* Lincolnshire East CCG
* Moorfields Eye Hospital
* Morecambe Bay CCG
* North East Essex CCG
* North East Hampshire and Farnham CCG
* North Norfolk CCG, South Norfolk CCG and Norwich CCG
* North West Surrey CCG
* Oldham CCG
* Portsmouth CCG
* Shropshire CCG
* Somerset CCG
* South East Hampshire CCG, Fareham and Gosport CCG and North Hampshire CCG
* Southampton City CCG and University Hospital Southampton NHS Foundation Trust
* St Helens CCG
* St Paul’s Eye Unit, Royal Liverpool University Hospital
* Sunderland CCG
* Surrey Downs CCG
* Tameside and Glossop CCG
* Torbay and South Devon NHS Foundation Trust
* Wakefield CCG and Kirklees CCG
* West Essex CCG
* Wigan Borough CCG

STPs

* Bristol, North Somerset and South Gloucestershire STP (response provided by CCGs for these areas)
* Cambridgeshire and Peterborough STP (response provided by North West Anglia Foundation Trust as the lead trust for ophthalmology for the STP)
* Cheshire and Merseyside STP
* Mid and South Essex STP
* South Yorkshire and Bassetlaw Accountable Care System
* Staffordshire STP (response provided by Cannock Chase CCG, South East Staffordshire and Seisdon Peninsula CCG and Stafford and Surrounds CCG)
* Surrey Heartlands STP

Professional bodies

* Association of Health Professions in Ophthalmology
* British and Irish Orthoptic Society
* The College of Optometrists
* Royal College of Ophthalmologists
* Optical Confederation and Local Optical Committee Support Unit

Charities / umbrella bodies

* Diabetes UK
* Esme's Umbrella
* Fight for Sight
* International Glaucoma Association (IGA)
* The Macular Society
* Royal National Institute of Blind People (RNIB)
* SeeAbility and Mencap
* Thomas Pocklington Trust
* VISION 2020 UK
* Vista

Local Eye Health Networks

* London Eye Health Network
* Thames Valley Area Local Eye Health Network
* Hertfordshire, Bedfordshire and Northamptonshire Local Professional Network (Eye Health)
* Surrey and Sussex Eye Health Network

Healthcare / pharmaceutical industry

* Bayer plc
* Evolutio Care Innovations Ltd
* Industry Vision Group (on behalf of Allergan, Bayer plc and Novartis)
* Dr Dinesh Verma, Dumfries Visionostics

Local Optical Committees

* Devon

Universities

* Professor Darren Shickle, Professor of Public Health, Institute of Health Sciences, University of Leeds

Patients

* Nine patients responded to the call for evidence rather than the survey.

Explanatory note:

* Submissions have been recorded and grouped according to how respondents addressed the call for evidence questions. In most cases this was straightforward, such as CCGs addressing questions about CCGs and so on.
* However, some submissions represented combined responses from CCGs and STPs which addressed questions to both sectors.
* For example, the submission from Cambridgeshire and Peterborough CCG, North West Anglia Foundation Trust (NWAFT) and Cambridgeshire and Peterborough STP. In this case they have been counted as two separate responses respectively under the CCG and STP columns.
* Where submissions have represented combined responses they have been listed together.
* Where submissions have provided individual entries within a combined response they have been listed separately, for example, the submission from Surrey Heartlands STP also included individual responses from Surrey Downs CCG, Guildford and Waverley CCG and North West Surrey CCG, so these have been individually listed under the respective columns.
* Where a submission is from an umbrella or representative body they have been listed once, for example VISION 2020 UK.

Endnotes

1. **.** There are 44 STPs across England which have been developed by local NHS organisations and councils to draw up plans to improve NHS services and population health in their geographical area. Their aim is to help deliver better health, transformed quality of care delivery and sustainable finances in line with the NHS “Five Year Forward View” (2014) ([www.england.nhs.uk/](file:///C%3A/Users/AFRENCH/Documents/www.england.nhs.uk/)). [↑](#endnote-ref-1)
2. . Foot B, MacEwen C. (2017). “Surveillance of sight loss due to delay in ophthalmic treatment or review: frequency, cause and outcome”. Eye, 31: 771–775. [↑](#endnote-ref-2)
3. **.** **Diabetic retinopathy is a complication of diabetes, caused by high blood sugar levels damaging the back of the eye (retina). It can cause blindness if left undiagnosed and untreated (www.nhs.uk/conditions/Diabetic-retinopathy/).** [↑](#endnote-ref-3)
4. . Public Health England’s other responsibilities as stated on its website are: protecting the nation from public health hazards; preparing for and responding to public health emergencies; and researching, collecting and analysing data to improve our understanding of public health challenges, and come up with answers to public health problems ([www.gov.uk/government/organisations/public-health-england/about](http://www.gov.uk/government/organisations/public-health-england/about)). [↑](#endnote-ref-4)
5. . The CCEHC is an independent advisory body providing evidence-based national clinical leadership, advice and guidance to policy makers in health, social care and public health, and those commissioning and providing eye health services in England. It is recognised as such through a Memorandum of Understanding with NHS England. (<https://www.college-optometrists.org/the-college/ccehc.html>). [↑](#endnote-ref-5)
6. **.** “Uveitis, or inflammation of the uveal tract, is a term used to describe inflammation inside the eye. It can lead to blindness either through direct damage to the light-sensitive retina, or through secondary complications such as glaucoma and cataract….Anti-TNF agents are antibodies directed against Tumour Necrosis Factor α, a cytokine which has been shown experimentally to be involved in the pathogenesis of uveitis….Adalimumab: Is an anti-TNF alpha treatment licensed and NICE approved for the treatment of adults with inflammatory arthritis.” (NHS England (2015) “Interim Clinical Commissioning Policy: Adalimumab for Children with Severe Refractory Uveitis”). [↑](#endnote-ref-6)
7. **.** NICE, the National Institute for Health and Care Excellence is an executive non-departmental public body of the Department of Health and Social Care, which publishes guidelines on the use of health technologies within the NHS (such as the use of new and existing medicines, treatments and procedures) and clinical practice (guidance on the appropriate treatment and care of people with specific diseases and conditions) (www.nice.org.uk/). [↑](#endnote-ref-7)
8. **.** Argus II is an electronic retinal implant which is used as a visual prosthesis to improve the vision of people with severe cases of retinitis pigmentosa. [↑](#endnote-ref-8)
9. . Retinitis pigmentosa (RP) is the name given to a group of inherited eye conditions called retinal dystrophies. A retinal dystrophy such as RP affects the retina at the back of a person’s eye and, over time, stops it from working. This means that RP causes gradual but permanent changes that reduce a person’s vision. (“Understanding Retinitis Pigmentosa and Other Inherited Retinal Dystrophies”, RNIB and RCOphth (2017)). [↑](#endnote-ref-9)
10. **.** Glaucoma is an eye condition where the optic nerve is damaged by the pressure of the fluid inside the eye. This may be because eye pressure is higher than normal, or because of a weakness to the optic nerve (“Understanding Glaucoma”, RNIB and RCOphth (2016). [↑](#endnote-ref-10)
11. **.** Age-related macular degeneration (AMD) affects a tiny part of the retina at the back of the eye, called the macula. A person develops wet-AMD when the cells of the macula stop working correctly and their body starts growing new blood vessels to fix the problem. As these blood vessels grow in the wrong place, they cause swelling and bleeding underneath the macula – which is why it is called ‘wet’ AMD. It causes more damage to the macula and eventually leads to scarring. Both the new blood vessels and the scarring damage the central vision and may lead to a blank patch in the centre of their sight. Wet AMD can develop very quickly, causing serious changes to your central vision in a short period of time, over days or weeks (“Understanding AMD”, RNIB and RCOphth (2016). [↑](#endnote-ref-11)
12. **.** The PHOF for England sets out the Government’s priorities for public health. It includes an indicator to highlight the rate of preventable sight loss in the population which is based on the total number of new CVIs issued per 100,000 people. It also reports on certificates issued to people, in certain age groups, as a result of AMD, glaucoma and diabetic eye disease [(www.gov.uk/government/collections/public-health-outcomes-framework](file:///C%3A/Users/AFRENCH/Documents/%28www.gov.uk/government/collections/public-health-outcomes-framework)). [↑](#endnote-ref-12)
13. **.** Receiving a CVI enables a person to register they are blind or partially sighted with their local authority, entitling them to an assessment of needs and access to services. [↑](#endnote-ref-13)
14. **.** Joint Strategic Needs Assessments are assessments of the current and future health and social care needs of the local community. These are needs that could be met by the local authority, CCGs, or the NHS Commissioning Board. They are produced by health and wellbeing boards and are unique to each local area. [↑](#endnote-ref-14)
15. . The aim of an Eye Health Needs Assessment (EHNA) is to identify the main priorities for improving eye health, reducing preventable sight loss and narrowing eye health inequalities. [↑](#endnote-ref-15)
16. **.** “To drive progress against the eye health indicator and for better eye health outcomes generally, Local Eye Health Networks (LEHNs) are being established as LPNs across every NHS Area Team (AT) in England. LEHNs provide the opportunity for the eye health professions – together with patients and the voluntary sector – to show leadership, identify priorities and re-design services and pathways to meet patient and population needs.” (“Local Eye Health Networks, Improving eye health and services - A Getting Started Guide” LOCSU and NHS England (2013)). [↑](#endnote-ref-16)
17. **.** NHS England’s website states: “In England, under the NHS Constitution, patients ‘have the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible’. The NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment” (<https://www.england.nhs.uk/resources/rtt/>). [↑](#endnote-ref-17)
18. **.** NHS RightCare is a national NHS England supported programme which advises local health economies to:

Make the best use of their resources – by tackling over use and underuse of resources

	* Understand their performance – by identifying variation between demographically similar populations so they can adopt and implement optimal care pathways more efficiently and effectively
	* Talk together about the same things – about population healthcare rather than organisations and encouraging joint decision-making
	* Focus on areas of greatest opportunity by identifying priority programmes which offer the best opportunities to improve healthcare for people and ensuring taxpayer money goes as far as possible, and
	* Use tried and tested evidence based processes to make sustainable improvement to reduce unwarranted variation.

RightCare Value Packs are resources designed to provide commissioners and STPs by providing them with up to date support data [↑](#endnote-ref-18)
19. (<https://www.england.nhs.uk/rightcare/what-is-nhs-rightcare/>).

. RNIB’s Sight Loss Data Tool is the UK’s biggest collection of eye health datasets, which provides information about blind and partially sighted people and those at risk of sight loss at a local level throughout the UK. It provides by local authority, region or country including: the estimated number of people living with severe sight loss; projected change in sight threatening eye conditions over the next 15 years; the number of ophthalmology appointments in local NHS Trusts; and the number of working age people registered blind ([www.rnib.org.uk/professionals/knowledge-and-research-hub/key-information-and-statistics/sight-loss-data-tool](http://www.rnib.org.uk/professionals/knowledge-and-research-hub/key-information-and-statistics/sight-loss-data-tool)). [↑](#endnote-ref-19)
20. **.** Local Optical Committees are statutory bodies established within the NHS to represent the interests of community optometrists and opticians. There are 78 Local Optical Committees in England. They are supported by the Local Optical Committee Support Unit which provides a link to the national bodies the Association of British Dispensing Opticians, the Association of Optometrists and the Federation of (Ophthalmic and Dispensing) Opticians. [↑](#endnote-ref-20)
21. **.** Health and wellbeing boards were established under the Health and Social Care Act 2012 to act as a forum in which key leaders from the local health and care system could work together to improve the health and wellbeing of their local population. They are a formal committee of the local authority charged with promoting greater integration and partnership between bodies from the NHS, public health and local government. [↑](#endnote-ref-21)
22. **.** In England, the General Ophthalmic Mandatory Services (GOS) model is used to commission NHS primary eye care services. There are two types of GOS contract: (1) Mandatory services contract for fixed premises and (2) Additional contract for mobile services. Service providers contracted to provide the service are optometrists or ophthalmic medical practitioners. The GOS-contract says they must do a sight test to check whether a person’s vision needs correcting, e.g. with glasses; and there is an additional duty to examine their eyes for any injury, disease or abnormality, and refer them to hospital eye services, if appropriate. In England people are eligible for GOS-sight tests if aged under 16; aged 16-18 and in full-time education; aged 60 or over; registered blind or partially sighted; diagnosed with diabetes or glaucoma; aged 40 or over with a first degree relative with glaucoma; or if they receive a specified means tested social benefit (“General Ophthalmic Mandatory Services Model Contract”, Department of Health (2010)). [↑](#endnote-ref-22)
23. **.** Eye Clinic Liaison Officers (ECLOs) (also known as sight loss advisers or Vision support service officers), work closely with medical and nursing staff in the eye clinic, and the sensory team in social services. They provide people recently diagnosed with an eye condition with the practical and emotional support which they need to understand their diagnosis, deal with their sight loss and maintain their independence ([www.rnib.org.uk/ecloinformation](http://www.rnib.org.uk/ecloinformation)). [↑](#endnote-ref-23)
24. **.** A cataract is a clouding of the lens in the eye which sits just behind the iris, the coloured part of the eye. Normally the lens is clear and helps to focus the light entering the eye. Developing cataracts will cause a person’s sight to become cloudy and misty (“Understanding Cataracts”, RNIB and RCOphth (2016)).

 [↑](#endnote-ref-24)
25. . The Quality, Innovation, Productivity and Prevention programme was a large-scale programme developed by the Department of Health to drive forward quality improvements in NHS care, at the same time as making up to £20 billion of efficiency savings by 2014/15. [↑](#endnote-ref-25)
26. . The Care Quality Commission is an executive non-departmental public body of the Department of Health and Social Care of the, which is the independent regulator of health and social care in England. It **registers** care providers; **monitors, inspects and rates** services; takes **action to protect people** who use services; and publishes its views on major quality issues in health and social care. (www.cqc.org.uk/). [↑](#endnote-ref-26)
27. . Disability life year’s statistics are defined by The World Health Organisation in terms of a Disability-Adjusted Life Year (DALY): “One DALY can be thought of as one lost year of "healthy" life. The sum of these DALYs across the population, or the burden of disease, can be thought of as a measurement of the gap between current health status and an ideal health situation where the entire population lives to an advanced age, free of disease and disability. DALYs for a disease or health condition are calculated as the sum of the Years of Life Lost (YLL) due to premature mortality in the population and the Years Lost due to Disability (YLD) for people living with the health condition or its consequences” ([www.who.int/healthinfo/global\_burden\_disease/metrics\_daly/en/](http://www.who.int/healthinfo/global_burden_disease/metrics_daly/en/)). [↑](#endnote-ref-27)
28. **.** An OCT or optical coherence tomography scan uses special rays of light to scan a patient’s retina and produce an image of it. It can provide detailed information about the macula. For example, it will tell your ophthalmologist whether your macula is thickened or abnormal, and whether any fluid has leaked into the retina ([www.nhs.uk/conditions/macular-degeneration/diagnosis/](http://www.nhs.uk/conditions/macular-degeneration/diagnosis/)). [↑](#endnote-ref-28)
29. . Fundus photography involves capturing a photograph of the back of the eye which is known as the fundus, and is used to inspect anomalies associated with eye diseases and to monitor their progression. [↑](#endnote-ref-29)
30. **.** Chronic obstructive pulmonary disease or COPD is the name for a group of lung conditions that cause breathing difficulties. It includes: emphysema, damage to the air sacs in the lungs; and chronic bronchitis, long-term inflammation of the airways. [↑](#endnote-ref-30)
31. . The NHS England website states: “The NHS Five Year Forward View was published in October 2014 and set…out a new shared vision for the future of the NHS based around the new models of care…[it was] developed by the partner organisations that deliver and oversee health and care services including [the] Care Quality Commission, Public Health England and NHS Improvement…Patient groups, clinicians and independent experts…also provided their advice to create a collective view of how the health service needs to change over the next five years if it is to close the widening gaps in the health of the population, quality of care and the funding of services” (www.england.nhs.uk/publication/nhs-five-year-forward-view/). [↑](#endnote-ref-31)
32. **.** The data is said to show preventable sight loss because research by RNIB suggests that 50 per cent of cases of blindness and serious sight loss could be prevented if detected and treated in time. Whilst this is mainly due to uncorrected refractive error and untreated cataract, the research implies that the take-up of sight tests is lower than would be expected. This is particularly the case within areas of social deprivation. Low take-up of sight tests can lead to later detection of preventable conditions and increased sight loss due to late intervention.

Comparison between areas using PHOF data does not reflect the different age profile, ethnicity and deprivation of the populations in different areas. The PHOF data only measures one type of outcome, that of being certified as being visually impaired. The PHOF says that the data measures a ‘crude rate of sight loss’.

The PHOF also state that “Incidence may vary due to the risk of sight loss being influenced by health inequalities, including ethnic, deprivation and age profiles of the local population” (PHOF).

Details of the PHOF sight loss data can be found at <https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data>. [↑](#endnote-ref-32)
33. **.** Hospital Episode Statistics data is collected during a patient's time at hospital and submitted to allow hospitals to be paid for the care they deliver. It contains details of all admissions, outpatient appointments and A&E attendances at NHS hospitals in England ([content.digital.nhs.uk/hes](http://content.digital.nhs.uk/hes)). [↑](#endnote-ref-33)
34. **. “**Patient Reported Outcome Measures (PROMs) assess the quality of care delivered to NHS patients from the patient perspective. Currently covering four clinical procedures, PROMs calculate the health gains after surgical treatment using pre-and post-operative surveys.

The four procedures are:

	* hip replacements
	* knee replacements
	* groin hernia
	* varicose veinsPROMs measure a patient’s health status or health-related quality of life at a single point in time, and are collected through short, self-completed questionnaires. This health status information is collected before and after a procedure and provides an indication of the outcomes or quality of care delivered to NHS patients” (www.england.nhs.uk/statistics/statistical-work-areas/proms/). [↑](#endnote-ref-34)
35. **.** The RCOphth’s “Three Step Plan” seeks to tackle preventable sight loss due to postponed treatment as a consequence of delayed review appointments and to improve access to eye services overall, and focuses on the following three areas to address the challenges facing hospital eye services:.

	* **Collect and Report Data – make it mandatory**
	* **Maximise capacity – use all resources effectively, and**
	* **Empower and Inform Patients – promote personal responsibility**(www.rcophth.ac.uk/2016/05/rcophths-three-step-plan-to-reduce-risk-for-eye-patients/).

 [↑](#endnote-ref-35)
36. . The purpose of VISION2020 UK’s “Ophthalmic Public Health Committee: Portfolio of Indicators for Eye Health and Care”, is to review and monitor population eye health, care and wellbeing (at national and local level), and to embed an eye health perspective in the use and interpretation of mainstream Outcome Frameworks (www.visionuk.org.uk/vision-2020-uk-ophthalmic-public-health-committee-portfolio-of-indicators-for-eye-health-and-care/). [↑](#endnote-ref-36)
37. . “Charles Bonnet syndrome (CBS) causes people who have lost a lot of sight to see things that aren’t there. Medically, this is known as having hallucinations. CBS hallucinations are only caused by sight loss and aren’t a sign that you have a mental health problem.

The kinds of things people see with CBS seem to fall into two main types:

	* simple repeated patterns or shapes, such as grids or brickwork patterns
	* complex hallucinations of people, objects and landscapes.CBS hallucinations do not involve hearing things or feeling things that aren’t there, and people are usually aware that what they are seeing isn’t real.

CBS can be frightening, but the hallucinations usually get less frequent with time” (“Understanding Charles Bonnet Sydrome”, RNIB and RCOphth (2017)). [↑](#endnote-ref-37)
38. . Receiving a CVI enables a person to register they are blind or partially sighted with their local authority, entitling them to an assessment of needs and access to services. [↑](#endnote-ref-38)
39. **.** From 1st August 2016 onwards, all organisations that provide NHS care and / or publicly-funded adult social care are legally required to follow the Accessible Information Standard. The Standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss ([www.england.nhs.uk/ourwork/accessibleinfo/](file:///C%3A/Users/AFRENCH/Documents/www.england.nhs.uk/ourwork/accessibleinfo/)). [↑](#endnote-ref-39)
40. . ‘Ask & Tell’ is an RNIB campaign which is being supported by the Macular Society, The IGA and the RCOphth, to encourage patients to **ask** their eye doctor when they should next be seen, then **tell** the eye clinic if their next appointment falls beyond this time. The aim of ‘Ask & Tell’ is to empower patients and encourage a better understanding of their eye condition and personal treatment plans, and to help reduce avoidable sight loss by improving access to timely diagnosis and effective treatment (www.rnib.org.uk/askandtell). [↑](#endnote-ref-40)
41. . The National Reporting and Learning System (NRLS) is a central database of patient safety incident reports. All information submitted is analysed to identify hazards, risks and opportunities to continuously improve the safety of patient care (https://report.nrls.nhs.uk/nrlsreporting/). [↑](#endnote-ref-41)
42. **.** The National Patient Safety Agency (NPSA) was a special health authority of the NHS in England. It was established in 2001 to monitor patient safety incidents, including medication and prescribing error reporting, in the NHS.The NPSA developed the NRLS to collect and analyse information from staff and patients, as well as incorporating information from other sources. In 2012 the key functions and expertise for patient safety transferred from the NPSA to the NHS Commissioning Board Authority. [↑](#endnote-ref-42)
43. **.** The treatment available on the NHS for wet-AMD is a group of medications called anti‑vascular endothelial growth factor (anti‑VEGF) drugs. As new blood vessels form in the eye, the body produces a chemical which encourages further new blood vessel growth. Anti-VEGF drugs interfere with this chemical and stop the vessels from growing, preventing further damage to your sight. The medication has to be injected into the vitreous, which is a gel-like substance inside the eye (“Understanding AMD”, RNIB and RCOphth (2016)). [↑](#endnote-ref-43)
44. **.** Health Education England is an arm’s length body of the Department of Health, which provides national leadership and coordination for education and training within the health and public health workforce within England (www.hee.nhs.uk/). [↑](#endnote-ref-44)
45. . “Specialty and associate specialist (SAS) doctors are non-training roles where the doctor has at least four years of postgraduate training, two of those being in a relevant specialty. SAS doctors are usually more focused on meeting NHS service requirements, compared to trainee or consultant roles. For example, they often have considerably fewer administrative functions compared to consultants” (www.healthcareers.nhs.uk/explore-roles/doctors/career-opportunities-doctors/sas-doctors). [↑](#endnote-ref-45)
46. . The Ophthalmology Common Clinical Competency Framework provides standards and guidance for the knowledge and skills required for non-medical eye healthcare professionals to deliver patient care. It was developed by the RCOphth,the Royal College of Nursing, the College of Optometrists, British and Irish Orthoptic Society, the Association of Health Professions in Ophthalmology (AHPO) and others ([www.rcophth.ac.uk/professional-resources/new-common-clinical-competency-framework-to-standardise-competences-for-ophthalmic-non-medical-healthcare-professionals/](http://www.rcophth.ac.uk/professional-resources/new-common-clinical-competency-framework-to-standardise-competences-for-ophthalmic-non-medical-healthcare-professionals/)). [↑](#endnote-ref-46)
47. . NHS Education for Scotland (NES) is an education and training body and a special health board within NHS Scotland, with responsibility of developing and delivering education and training for the healthcare workforce in Scotland ([www.nes.scot.nhs.uk/](http://www.nes.scot.nhs.uk/)).

 [↑](#endnote-ref-47)
48. . T**he National Institute for Health Research is** funded by the Department of Health and Social Care to improve the health and wealth of the nation through research (www.nihr.ac.uk/). [↑](#endnote-ref-48)
49. . The Medical Research Council is responsible for co-coordinating and funding medical research in the UK (<https://mrc.ukri.org/>). [↑](#endnote-ref-49)
50. . RNIB and Specsavers (2017) “State of the Nation Eye Health 2017: A Year in Review” (https://[www.rnib.org.uk/state-nation-2017](http://www.rnib.org.uk/state-nation-2017)). [↑](#endnote-ref-50)
51. . The RCOphth was commissioned by the Health Quality Improvement Partnership (HQIP) and funded by NHS England and the Welsh Government to manage the National Ophthalmology Database (NOD) Audit. It collects, collates and analyses a standardised, nationally agreed cataract surgery dataset from all centres providing NHS cataract surgery in England & Wales to update benchmark standards of care and provide a quality improvement tool ([www.rcophth.ac.uk/standards-publications-research/audit-and-data/national-ophthalmology-database/](http://www.rcophth.ac.uk/standards-publications-research/audit-and-data/national-ophthalmology-database/)). [↑](#endnote-ref-51)