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Foreword

As the population ages, promoting and protecting eye health is vital to maximising people's independence and to minimising the costs falling on both health and social care, even before the repercussions of the diabetes epidemic are felt.

The delivery of eye health services is complex. Spanning primary, secondary, social care and public health; and drawing on the expertise of private and NHS providers, the challenge involved in providing an integrated patient experience is greater than usual. There are already signs that the system is struggling to cope with rising demand and to deliver consistently high quality eye care.

Members of the eye care community largely recognise that service reconfiguration holds the key to meeting these challenges. Indeed, many areas have already seen a migration of certain services from hospital settings into the community, provided either by community optometrists or through hospital outreach programmes. The degree and success of change is largely dependent on the presence or absence of local leadership, which has resulted in varied progress across the country.

I welcome the publication of Better Vision For All, which proffers timely analysis and recommendations around commissioning; prevention and awareness; and access to treatment and services. This report rightly identifies the need for change to be cohesive and holistic in order to standardise patient experiences of care and optimise outcomes.

To achieve these objectives in the face of growing financial constraints, strong leadership is required and a National Clinical Director, supported by an advisory National Eye Health Network, would be well placed to provide direction and drive change, copying a model proven in other services like cancer and cardiovascular disease.

Timely adoption of the measures contained in this report will stand the eye health sector in good stead to face the major challenges that lie ahead. I commend it to all concerned in NHS England and the wider health service for urgent consideration.

Lord Low of Dalston, CBE.

Executive summary

With an aging population and conditions such as diabetes and obesity on the rise, demand for eye health services is set to increase markedly over the next few years. Against a backdrop of rising costs, there are worrying signs of a worsening service for those requiring treatment. For example, rationing cataract operations by visual acuity thresholds and delaying glaucoma follow-up appointments, which both reduce the chances of preventing avoidable sight loss, were prevalent within PCTs. As Sir Bruce Keogh commented to the Public Accounts Committee in January 2013, it is striking that many of these decisions have been made without clinical justification. This short term approach to cost cutting is unacceptable, adversely affecting patient outcomes and storing up greater costs for the future.

It is therefore surprising that eye health has a low profile from the policy perspective compared to some other largely age-related conditions, such as dementia. The eye health sector has collaborated through Vision 2020 and its UK Vision Strategy, successfully leading initiatives on a number of important issues, such as the eye health public health indicator. However, government and NHS leadership has been lacking, materially hampering progress. Despite the excellent work of the UK Vision Strategy, necessary change would be expedited by having an accountable clinical leader to make sure that plans are implemented to a consistently high standard, drawing on experience in fields like cancer and cardiovascular disease. Furthermore, contrary to popular myth, rates of spending growth in these specialties have been at or below the NHS average in recent years.

The complexity of eye care delivery, which spans primary, secondary and social care and involves a mix of private and NHS providers, does not make coordinated, strategic change easy. However, there is strong consensus within the eye care community that change must take place to ensure that service quality is levelled upwards rather than downwards during a time of financial constraint enabling patients to benefit from the new treatments and services that are being developed.

The NHS reforms which took effect from 1 April 2013, make the case for centrally coordinated change in eye care more compelling. With part of the pathway to be commissioned by CCGs but primary care contracts falling under the auspices of NHS England, there is a real danger of increased fragmentation but equally a clear opportunity to provide strategic leadership to the benefit of patients.

Whilst preparing this report, the ABPI Pharmaceutical Ophthalmology Initiative (POPI) has assessed the wealth of research and material developed over the last few years and supplemented and updated this by interviewing a range of key stakeholders in the eye care community. Based on this research, we have come up with a number of recommendations intended to chart a realistic way forward at a time of great change and opportunity. The recommendations are structured around three key themes: commissioning, awareness and prevention and the delivery of treatments and services. All views expressed are those of the ABPI POPI group.

Recommendations:

A. Commissioning:

1. A National Clinical Director (NCD) for Eye Health should be appointed by NHS England to take an overarching approach to eye care and drive change in a systematic and timely manner;
2. A National Eye Health Network comprising representatives from across the eye health community should be established to provide advice to the NCD and enhance the prospects of best practice being adopted across the country;

B. Prevention & Awareness:

3. An eye health awareness campaign should be developed and executed to encourage the public and health care professionals to realise the importance of eye health and emphasise the importance of eye checks;
4. A question on eye health should be developed and added into the NHS Health Check to increase awareness of the importance of sight tests;
5. Public Health England should circulate a fact sheet on the importance of eye health to all Directors of Public Health and request that they ensure eye health is covered adequately in Joint Strategic Needs Assessments;

C. Access to Treatments & Services:

6. The National Clinical Director should be responsible for supporting CCGs in providing patients access to treatments and services based on the best clinical and cost effectiveness evidence;
7. Care plans should be developed for eye care patients, owned by one practitioner, to promote a seamless experience and integrated service;
8. A list of minimum standards should be developed to guide patients on what they should expect from interactions in primary, secondary and social care;
9. New pathways should be subject to audit to ensure that patient safety and outcomes are satisfactory;
10. Digital data sharing best practice should be developed across an eye care pathway as part of the Secretary of State for Health's Digital Challenge;
11. A best practice approach to rationalising and improving eye care service delivery should be developed, based on a systematic demand and capacity gap analysis;
12. The completion of NICE Quality Standards across the four main eye conditions should be expedited. Its completion should trigger the development of integrated commissioning guidance by NHS England;
13. The National Clinical Director should produce an annual report to benchmark different areas and drive further service improvements and best practice;
14. The National Clinical Director should develop a local CQUIN framework to support commissioners in the implementation of best practice eye health pathways.

Background

Types of vision loss

Sight loss can be defined as follows[1]:

- **Blindness** (severe sight loss) is defined as best-corrected visual acuity of <6/60 in the better-seeing eye
- **Partial sight** is defined as best-corrected visual acuity of <6/12 to 6/60 in the better-seeing eye, and is categorised as:
  - mild sight loss – best-corrected visual acuity of <6/12 but better than or equal to 6/18; and
  - moderate sight loss – best-corrected visual acuity of <6/18 but better than or equal to 6/60
- **Sight loss** is defined as partial sight or blindness in the better-seeing eye

Prevalence

The RNIB sight loss data tool[2] records 147,810 people as being registered blind in England and 151,010 as partially sighted (2010/11 figures), totalling 298,820 and representing a 7.5 per cent increase on the year before. The number of people living with sight loss in 2011 was estimated at 1,564,340 or 2.95 per cent of the population as a whole. This is an estimated figure based on prevalence rates, census data and a sight loss definition of best-corrected visual acuity of <6/12 or worse in the better-seeing eye, meaning that it cannot be corrected with glasses. Prevalence of sight loss ranged from a low of 1.31 per cent in the London Borough of Tower Hamlets to a high of 4.42 per cent in Dorset, reflecting the significant association with age.

Main Conditions

Four conditions; glaucoma, cataract, diabetic retinopathy and age-related macular degeneration (AMD) are the leading causes of sight loss in adults[3], accounting for 88.3 per cent of severe sight loss (blindness). There are a number of other less common conditions such as retinitis pigmentosa, retinal detachment and nystagmus which can also lead to severe sight loss. 53.5 per cent of non-severe sight loss, which can be corrected with glasses, is attributable to refractive error, a term which covers common conditions such as astigmatism and myopia. Glaucoma, cataract, diabetic retinopathy and AMD account for 39.2 per cent of less severe sight loss[4].

At Risk Groups

Certain groups are at higher risk of suffering from sight loss and are encouraged to seek eye tests regularly[5], including those:

- above 60 years old
- from certain ethnic groups; for example, people from African-Caribbean communities are at greater risk of developing glaucoma and diabetes, and people from south Asian communities are at a greater risk of developing diabetes. Diabetic retinopathy, in which the retina becomes damaged, is a common complication of diabetes
- with a learning disability
- from a family with a history of eye disease

[1] Access Economics 2009, *Future sight loss UK (1): The economic impact of partial sight and blindness in the UK adult population*, July 2009
[2] RNIB, Sight Loss Data Tool: www.rnib.org.uk/aboutus/Research/statistics/Pages/sight-loss-data-tool.aspx, accessed March 2013
[3] RNIB, Key Information & Statistics: http://www.rnib.org.uk/aboutus/research/statistics/Pages/statistics.aspx
[4] Access Economics 2009, *Future sight loss UK (1): The economic impact of partial sight and blindness in the UK adult population*, July 2009
[5] NHS Choices, Look After Your Eyes: http://www.nhs.uk/Livewell/Eyehealth/Pages/Lookingafteryoureyes.aspx, accessed March 2013

Increasing Demand

A number of factors are contributing to rising demand for eye care services, which is expected to continue apace:

- **Demographics:**

  Over the period 1985-2010 the number of people aged 65 and over in the UK increased by 20 per cent to 10.3 million; in 2010, 17 per cent of the population were aged 65 and over. The number of people aged 85 and over more than doubled over the same period to 1.4 million. Population ageing will continue for the next few decades. By 2035 the number of people aged 85 and over is projected to be almost 2.5 times larger than in 2010, reaching 3.5 million and accounting for 5 per cent of the total population. The population aged 65 and over will account for 23 per cent of the total population in 2035[6].

  One in every nine people aged over 60 are currently living with sight loss and over the age of 85 that figure rises to one in three[7]. Evans et al[8] found a steep gradient in the prevalence of blindness and partial sight loss from 20 per cent in those aged 80-84 to 35.3 per cent in those aged 85-89 and 53.1 per cent in those aged 90-94. The sharp increase in the elderly population is therefore an important predictor of the future burden of blindness and partial sight and the associated impact on health services.

- **Related Conditions:**

  Obesity, diabetes and smoking are all associated with sight loss. Prevalence of obesity and diabetes is increasing rapidly, indicating a further source of future demand pressure on eye care services, as shown in figure 1. Diabetes is particularly concerning as retinopathy can affect more than 75 per cent of patients who have had diabetes for 20 years or more[9].

Figure 1: Obesity, Diabetes, Smoking and Sight Loss[10, 11, 12]

	Related Conditions			Growth Forecasts	Detail
	AMD	Cataracts	Retinopathy		
Obesity	✓	✓	✓	**High**	If no action taken, 60% men, 50% women and 25% children in UK obese by 2050
Diabetes	✗	✗	✓	**High**	100% increase expected from 2012 to 2025 > 5 million sufferers
Smoking	✓	✓	✗	**Low**	Smoking is currently on a downward trend

✓ Proven Link

✗ No proven Link

[6] Office of National Statistics: http://www.statistics.gov.uk/hub/population/ageing/older-people, accessed March 2013

[7] RNIB, Sight loss UK 2012 – The Latest Evidence, 2012

[8] Evans JR, Fletcher AE, Wormald RPL, Siu-Woon Ng E, Sterling S, Smeeth L, Breeze E, Bulpitt CJ, Nunes M, Jones D, Tulloch A, 'Prevalence of partial sight and blindness in people aged 75 years and older in Britain: results from the MRC trial of assessment and management of older people in the community', British Journal of Ophthalmology, Vol. 86, pp. 795-800, 2002

[9] World Health Organisation, Prevention of Blindness from Diabetes Mellitus, 2006

[10] Department of Health, Healthy Lives, Healthy People, October 2011

[11] Cancer Research UK, Smoking: http://www.cancerresearchuk.org/cancer-info/cancerstats/types/lung/smoking/lung-cancer-and-smoking-statistics#percent, accessed March 2013

[12] Diabetes UK, State of the Nation 2012, 2012

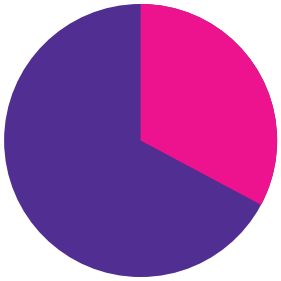
- **New Treatments:**

  In the past few years a number of innovative treatments have become available for patients with conditions including wet AMD, glaucoma and diabetic retinopathy. This has placed increased demands on NHS services, particularly in secondary care. The speed with which patients are referred and treated can have a significant impact on outcomes which highlights the need for regular sight testing throughout life and the importance of having appropriate pathways in place.

Cost of sight loss

The most comprehensive analysis of the cost of sight loss was conducted by Access Economics on behalf of the RNIB[13]. This estimated that in 2008, for the UK as a whole, the direct healthcare related costs were £2.14 billion, the indirect costs £4.34 billion (see figure 2) and the impact on Disability Adjusted Life Years £15.51 billion or £22 billion in all.

Figure 2: Direct and Indirect Costs of Sight Loss (2008, UK)



Direct costs

Indirect costs

- **Direct Costs:** including hospital, non-admitted, prescribing in primary care, ophthalmic services, research and development, residential care and community care
- **Indirect Costs:** including lost employment and informal care costs

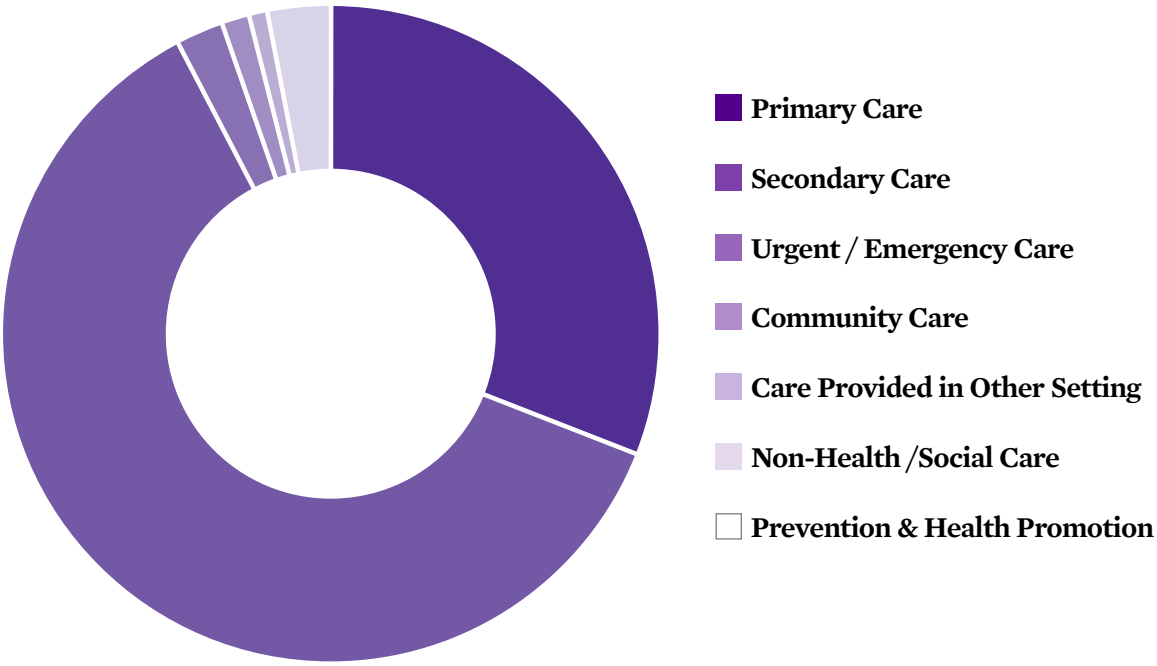
NHS costs involved in providing eye care are significant and rising. Over the five years between 2005/6 and 20010/11, spend on vision loss increased by 58 per cent to £2.14 billion, representing one of the fastest growing categories in the programme budgeting data, well above the growth of the total budget, which grew by 33 per cent[14].

Current configuration of expenditure

In 2010, Professor Nick Bosanquet from Imperial College wrote an eye care focused report in response to the government's white paper, *'Equity and Excellence: Liberating the NHS.'* In particular, he discussed the potential of community optometry to fulfil some of the ambitions laid out in the government's white paper. Set against the Bosanquet report's recommendation[15] that community optical services should be expanded to relieve pressure on NHS services and that 50 per cent of vision impairment should be preventable through regular testing, the configuration of expenditure recorded by National Programme Budgeting is instructive. Figure 3 shows how the NHS budget for problems of vision was spent between different care settings during 2011/12.

[13] Access Economics - The economic impact of partial sight and blindness on the UK adult population, July 2009
[14] Department of Health, Programme Budgeting Benchmarking Tool, Aug 2012
[15] Bosanquet, N, Liberating the NHS: Eye Care, Making a Reality of Equity and Excellence, 2010

Figure 3: 2011/12 Programme Budgeting Problems of Vision Loss Spend by Care Setting



The national average for expenditure at PCT level on health prevention and promotion in the field of vision is negligible (0.08 per cent of the total vision problems category spend). Excluding prescription costs, vision expenditure classified under primary care, which would include care delivered by optometrists, averages 22 per cent. Location is often cited as a key factor in determining primary care spend, with rural areas thought to make more use of local optometrists in the delivery of eye care pathways. Although primary care spend varies significantly between PCTs, it is not obviously influenced by urban versus rural settings. For example, rural Norfolk spent 19.3 per cent of its total vision loss budget on primary care services whilst urban Leicester City PCT spent 39.1 per cent of its total budget in primary care settings[16].

[16] Department of Health, Programme Budgeting Benchmarking Tool, Aug 2012

A. Commissioning Considerations

Commissioning Responsibilities:

As the reforms enshrined in the 2012 Health & Social Care Act took effect on 1 April 2013, responsibilities for eye care commissioning were split between NHS England, Clinical Commissioning Groups (CCGs) and Local Authorities (see Figure 4).

Figure 4: Eye Health Commissioning Overview

Care Setting	Primary	Secondary	Social Care
Commissioning Responsibility	NHS England	Clinical Commissioning Groups	Local Authorities
Details	• Responsibility for primary ophthalmic services, NHS sight tests and optical vouchers • Eye Health Local Professional Networks to be hosted by the Board's 27 Area Teams to provide advice to CCGs when required	• Any community-based eye care services and secondary ophthalmic services not covered by the NHS CB	• Public health prevention activity • Responsibility to support and provide services for people registered as blind or partially sighted • In cases of 'continuing care', where vision loss issues are related to a specific health issue, then the NHS would be expected to meet the cost

The Area Teams of NHS England hold around 7000 contracts with ophthalmic practices and will need to be assured that these practices are delivering services to an acceptable standard. CCGs are primarily focused on commissioning of eye care delivered through hospitals and hospital outreach programmes. Local Authorities will have a role to play in leading prevention activities and delivering care to those with vision loss who require support in the community, although this would be commissioned by the NHS in cases of continuing care.

Local Eye Health Networks:

Local Eye Health Networks (LEHNs) for eye care, dentistry and pharmacy have been announced to provide support to NHS England in its direct commissioning responsibilities. LEHNs will be required to work closely with other stakeholders, such as CCGs and Health and Wellbeing Boards (HWBs), primarily to develop primary care commissioning strategy and seek better outcomes through improving service delivery.

Figure 5: Local Eye Health Network Proposed Vision[17]

Key Functions	Detail
Facilitating Improvement Delivery	Provide a vehicle for clinically led and clinically owned delivery of: • Quality improvement • Best outcomes for patients that reflects local need • Best use of NHS resources • Planning and designing integrated care pathways • Strategies for service planning and health improvement • Leadership and engagement
Providing Clinical Leadership	Ensure clinical leadership at the heart of the local operating model
Supporting Shared Vision	Provide a system for commissioning managers and clinicians to deliver NHS England vision together to a common purpose

There will be one Eye Health Network in each of the 27 Area Teams of NHS England. Each will have a chair from within the Area Team and a limited amount of funding for activities. Early pilots suggest that priorities might include developing local eye health needs assessments and improving services in line with the key national eye health pathways.

New Commissioning Structure Implications:

The changes taking place to how services are commissioned in England herald a more local approach where the needs of particular communities can be taken into account and decision-making should be clinically led. This certainly presents significant opportunities for services to be improved in line with local needs. However, in the case of eye care, where commissioning will be split across NHS England, CCGs and Local Authorities, there is a danger of fragmentation, lack of integration and poor outcomes for patients.

> *"The NHS reforms are unhelpful for Ophthalmology. They will inevitably lead to greater fragmentation in delivery. There is a danger that coherent and comprehensive hospital eye departments will become a thing of the past. Someone with three different eye conditions may well have to travel regularly between three different providers. It will also make it much more difficult to deliver a quality emergency eye care service. I am not at all sure the new model of "any willing provider" will work in Ophthalmology."*
> **Steve Winyard, Head of Policy & Campaigns, RNIB**

Indeed, there is already a significant degree of variation across England in the way that services are being developed. The LOCSU Atlas of Optical Variation[18] demonstrates that uptake of enhanced service pathways, where certain activities traditionally performed in hospital settings have been moved into the community, has been varied throughout the country. In addition, although there is evidence of the spread of good practice, best practice has not been systematically implemented.

[17] NHS Commissioning Board, Commissioning Development Programme, Local Eye Health Networks Briefing Pack, Oct 2011
[18] LOCSU, Atlas of Optical Variation: http://www.locsu.co.uk/enhanced-services-pathways/enhanced-services-map, accessed March 2013

> *"The main weakness in the way eye care services are currently delivered is that they are very patchy; the amount of money spent on eye care is very variable and this variance is not based on need. It is about the success of local people being able to articulate the issue and so that is incredibly varied."*
> **Angela Tinker, Chief Executive, Visionary - Linking Local Sight Loss Charities**

The LEHNs will play an important role in primary care but at present, an integrated approach across all care settings is likely to remain dependent on the presence or absence of suitable local leaders and their attitudes towards service improvement.

Leadership in Eye Health

Since it successfully developed and championed the 'Action on Cataract' report in 2000, which is credited with having transformed cataract services in England[19], the Department of Health has taken a less prominent role in the delivery of service improvements. The 2009 *'Improving Community Based Eye Care Services'*, part of the World Class Commissioning initiative developed by the last Labour government, had a less dramatic impact.

The UK Vision Strategy, a Vision 2020 UK initiative[20], was launched in 2008 in response to the World Health Organisation VISION2020 resolution to reduce avoidable blindness by the year 2020 and improve support and services for blind and partially sighted people. It has successfully brought together stakeholders across the eye health community and is widely regarded as having done a good job at pushing forward the eye health agenda. However, this collaborative effort has seen the Department of Health take a back seat and whilst supportive, this lack of ownership and implementation has diminished the impact of the well led and well informed UK Vision Strategy initiatives.

> *"The UKVS has been a great success but there is a limit to what it can achieve. I am not naive, I see the problems of government but I think the eye care sector as a whole has been very good at putting things together, working together and being quick at changing. Nonetheless, it is important to have people across the NHS who see it as their priority to look after eye care."*
> **Kamlesh Chauhan, President, College of Optometrists**

> *"We have been pushing the UK Vision Strategy and Government Ministers have always said they support it. However, a strategy that is not owned and driven by either the Department or NHS England can be problematic. What we need is a powerful voice within the new NHS - a national clinical director for eye care."*
> **Steve Winyard, Head of Policy & Campaigns, RNIB**

As demonstrated in the background section of this report, demand pressures on the delivery of eye care services are evident and likely to be exacerbated over the next few years due to the aging population, increased prevalence of obesity and diabetes and the development of new treatments and services. At the same time, commissioning and eye care pathways are becoming more fragmented.

[19] Royal College of Ophthalmologists, Current Issues & Opportunities – Cataract: http://www.rcophth.ac.uk/page.asp?section=632&sectionTitle=Current+issues+and+opportunities+-+cataract, accessed March 2013

[20] UK Vision Strategy has been developed in response to the World Health Assembly VISION 2020 resolution to reduce avoidable blindness by the year 2020 and improve support and services for blind and partially sighted people. http://www.vision2020uk.org.uk/ukvisionstrategy/

Without central leadership, the challenge of delivering high quality eye care services in the face of these pressures will be greater. An inconsistent approach that fails to consider all elements of the pathway, ensure that these are fully integrated and that best practice is systematically disseminated will risk further fragmentation and the potential for unnecessary expenditure and increased costs. A National Clinical Director for Eye Health would play an important role in ensuring that initiatives across England were well coordinated and making the optimum use of scarce resources.

> *"It would be very useful to have a national lead in NHS England. This would really help to focus the agenda. There are benefits to having a figurehead – an individual who everyone expects to serve the needs of the eye care community – that person would give more impetus to the issues."*
> **Dr Waqaar Shah, GP and ophthalmology expert**

Job descriptions issued for National Clinical Directors by NHS England focus on driving transformation, promoting a balanced approach to service improvement and working to 'maximise coherent system change'[21]. This is particularly important in eye health where divergent interests have resulted in an inconsistent approach to service improvement so far. The interests of optometrists and ophthalmologists would need to be reconciled to enable the development of a robust, national approach.

National Clinical Directors will be in a unique position to work effectively with all relevant stakeholders. Obesity and diabetes; dementia; integration and frail elderly; rural and remote care services; and neurological conditions (learning disabilities) all have direct relevance to eye health and will be governed by National Clinical Directors. Developing close, collaborative working relationships across these areas would serve to improve outcomes and coordination in a manner not possible from outside NHS England. The National Clinical Directors will also be powerfully placed to drive change within the NHS, ensuring that well considered plans are consistently implemented and service levels are driven upwards across the country. The 'dynamic,' 'strategic' individuals sought for these posts would be required to take a balanced approach and would be expected to build consensus across all stakeholder groups.

> *"A lead who helped improve integration would be good. One of the things I have often felt quite stubborn about is that we see a lot of eye health agendas around but they are not fully integrated."*
> **Sarah Buchanan, Research Director, Thomas Pocklington Trust**

National Clinical Directors have been part of the NHS landscape for several years and have achieved some impressive results. Under the leadership of Sir Mike Richards, improvements in cancer survival rates and care standards have been widely noted[22]. Equally, Sir Roger Boyle previously National Director for Heart Disease and Stroke, played a pivotal role in improving outcomes. He drove the development and implementation of the 2007 National Stroke Strategy with input from a wide coalition of stakeholders. The Strategy put forward a clear plan for the development of stroke services. In particular, it recommended more specialised acute and hyper acute care for stroke patients. In London, where stroke service performance had previously tended to be below the national average, radical service configuration took place with positive outcomes. In 2010:

[21] British Medical Journal, NHS Commissioning Board, Major announcement of national appointments, December 2012: http://careers.bmj.com/careers/view-job.html?id=20081350 accessed March 2013
[22] ONS, Statistical Bulletin: Cancer Survival in England - Patients Diagnosed 2005-2009 and Followed up to 2010, Nov 2011

- 75 per cent of London hyper acute stroke units achieved all seven standards for quality acute stroke care versus a national figure of seven per cent
- 75 per cent of London stroke patients were directly admitted to a stroke unit versus a national figure of 39 per cent[23].

The success of national directors has often been attributed to disproportionate investment in the associated services. National Programme Budgeting Data[24] suggests otherwise. For example, in the years 2005/6 to 2010/11 during which spending on vision rose 58 per cent, the rate of growth in cancer services was 35 per cent and in cardiovascular services 21 per cent, suggesting that national leadership is not associated with rapidly rising costs. Furthermore, whilst spend on problems of vision appears to be on an upward trend, spend on cancer and cardiac services has tapered off in recent years.

Indeed, this principal seems to have been accepted with NHS England's decision to appoint 24 National Clinical Directors for virtually all the major areas of clinical care by spend, except vision. Figure 6 shows that out of the fifteen programme budgeting categories with the highest spend, problems of vision and dental problems are the only two therapy area specific categories that will not have a National Clinical Director in the new system.

Figure 6: 2011-12 Programme Budgeting Data Top Spend Categories National Clinical Director Summary

Rank	Programme Budget Category	Total Gross Expenditure /£m	National Clinical Director
1	Other	16,258.9	N
2	Mental health disorders	11,157.2	Y
3	Problems of circulation	6,919.0	Y
4	Cancers and tumours	5,501.1	Y
5	Problems of the musculoskeletal system	5,159.6	Y
6	Problems of the genito urinary system	4,621.3	Y
7	Problems of the gastro intestinal system	4,599.8	Y
8	Problems of the respiratory system	4,412.1	Y
9	Neurological	4,264.6	Y
10	Problems due to trauma and injuries	3,764.0	Y
11	Maternity and reproductive health	3,573.2	Y
12	Dental problems	3,415.0	N
13	Endocrine, nutritional and metabolic problems	2,938.0	Y
14	Social care needs	2,826.5	N
15	**Problems of vision**	**2,255.0**	**N**

Eye health is a clear omission from this list. Based on Earl Howe's response to a parliamentary question about the absence of a National Clinical Director for Eye Health, there is a strong case for a suitable appointment to be made. Earl Howe stated that decisions related to NCD appointments would be taken by NHS England, which would be *"guided by the objectives set for it in the Mandate and a desire to provide clinical leadership across a broad range of fronts, focusing more on people and patient pathways than specific conditions.*[25]*"*

[23] Royal College of Physicians, National Sentinel Stroke Clinical Audit 2010, Round 7, May 2011, also reported in the HSJ, May 2012
[24] HSJ, http://www.hsj.co.uk/resource-centre/best-practice/care-pathway-resources/how-to-implement-evidence-based-stroke-care/5044455.article, accessed March 2013
[25] Hansard, column WA216, 25 Feb 2013

The delivery of eye health services relies on particularly complex and nuanced patient pathways spanning primary, secondary, social care and public health. A National Clinical Director would be required to take a comprehensive approach, considering all conditions, rather than focusing on any particular one. Furthermore, as shown in figure 7, of the five key priorities laid out in the Mandate, three have high, direct relevance to eye health. Sight loss has a disproportionate impact on older people and the major causes of sight loss, such as AMD and glaucoma, are long term conditions that require careful management over time. 66 per cent of registered blind and partially sighted people of working age are not in employment[26] and the cost of reduced employment is estimated to be around £1.6 billion a year[27].

Figure 7: Mandate Priorities Relevance for Eye Health[28]

	Mandate Priorities	Relevance
1	Improving standards of care and not just treatment, especially for older people and at the end of people's lives	High
2	The diagnosis, treatment and care of people with dementia	Medium
3	Supporting people withmultiple long-term physical and mental health conditions, particularly by embracing opportunities created by technology, and delivering a service that value mental and physical health equally	High
4	Preventing premature deaths from the biggest killers	Low
5	Furthering economic growth, including supporting people with health conditions to remain in or find work	High

RECOMMENDATION:

1. A National Clinical Director should be appointed to NHS England to take an overarching approach to eye care and drive change in a systematic and timely manner.

Collaborative Support

A National Clinical Director for Eye Health would naturally require the skills necessary for drawing together all stakeholders in the eye health community, however, that is not to say that they would operate in isolation. The collaborative approach to improving eye care services that has been pioneered by the UK Vision Strategy effectively brings together stakeholders from across the optometry, ophthalmology and voluntary sector communities to consider developments holistically.

> *"We went [to a meeting] with a representative for the patients, one from optometry and one from ophthalmology so we had that cross sector approach and I think that this is important. The NHS is focused on being centred on the patient and to achieve this, you need primary care, secondary care and the patient voice - if they are all saying the same thing then you have a powerful voice."*
> **Anita Lightstone, Chief Operating Officer, Vision 2020 UK and Programme Director, UK Vision Strategy**

[26] Douglas G, Corcoran C and Pavey S, Network 1000: Opinions and circumstances of visually impaired people in Great Britain, 2006
[27] Access Economics - The economic impact of partial sight and blindness on the UK adult population, July 2009
[28] The Mandate, A mandate from the Government to the NHS Commissioning Board April 2013 to March 2015, Nov 2012; 2.8

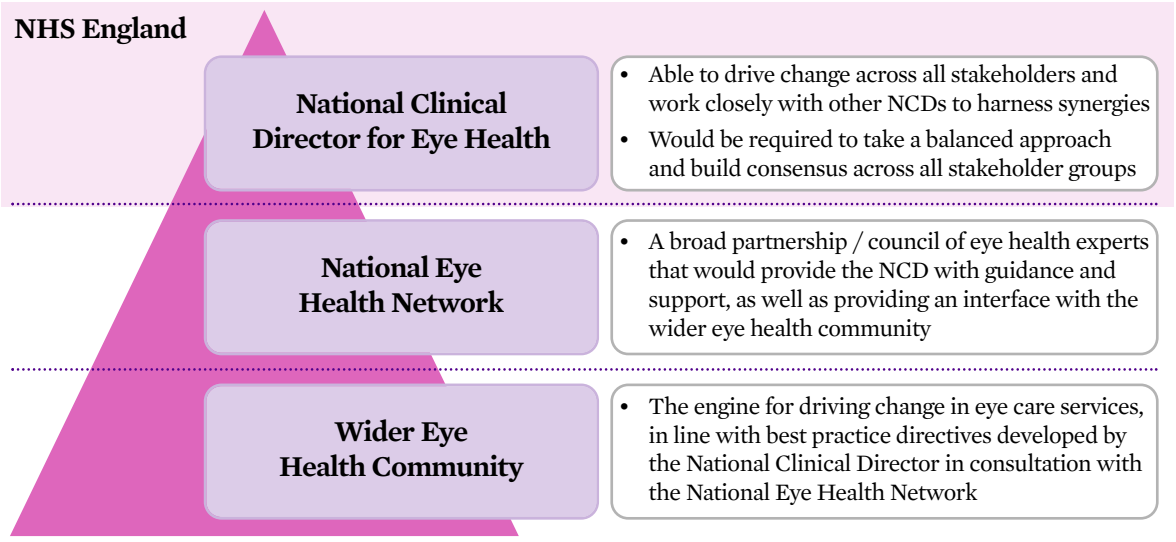
The diversity of interests within the sector led some to favour a collaborative approach but a National Clinical Director along with such a coalition would seem to provide the ideal combination. Such a National Eye Health Network would require a broad partnership of eye health experts from across primary, secondary and social care, along with support from key professional bodies and patient organisations.

> *"Where we have not got very far is that there are lots of local initiatives that have worked very well but I am not sure that they have then been thoroughly publicised and audited in order to improve them and make them more widespread."*
> **Kamlesh Chauhan, President, College of Optometrists**

The Network would provide the eye care lead with guidance and support to ensure that the Area Teams of NHS England were working successfully with their equivalents in CCGs and Local Authorities with a view to the consistent implementation of best practice.

Figure 8 shows how the different elements of the eye health community would come together to support the National Clinical Director. Such a structure would ensure that a balanced approach was taken and that initiatives across the community were streamlined to maximise the chances of progress being made.

Figure 8: Proposed Eye Health Community Structure



RECOMMENDATION:

2. A National Eye Health Network comprising representatives from across the eye health community should be established to provide advice to the National Clinical Director and enhance the prospects of best practice being adopted across the country.

B. Prevention & Awareness:

Current State:

It is estimated that 50 per cent of sight loss is preventable if detected and treated in time[29]. Identifying people with symptoms of preventable sight loss is crucial. This can help them avoid issues associated with sight loss such as mobility problems and social isolation; problems taking medicines correctly; and significantly higher risk of falls and subsequent hospitalisation or even transfer into residential care . However, with the exception of screening for diabetic retinopathy, eye health has historically been largely overlooked from a public health perspective. The national aggregate spend on prevention and health promotion related to problems of vision loss was £2.2 million in 2011/12 representing less than 0.1 per cent of all such spending, with several PCTs registering no spend at all. This compares unfavourably with public health spend on dental problems, which registered as over eight times more than spend on problems of vision, at £13.8 million in 2011/12[31].

Lack of public engagement on eye health has resulted in a number of widely held perceptions that prevent people from getting regular eye tests. In particular:

- People accept that their sight deteriorates as they get older[32]
- There is a strong association with sight tests and the cost of buying glasses[33]
- There is a lack of understanding of the importance of sight tests, particularly within high risk groups, who may not be aware of their increased risk.[34, 35]

> *"False teeth work but false eyes don't. People have their teeth checked whether they hurt or not. We need to achieve a cultural shift [in eye care] and stimulate the public to take personal responsibility and have an eye health check on a regular basis as many of the blinding conditions are treatable at an early stage, pre-symptomatic, before the patient becomes aware there is anything wrong. Early detection is a highly efficient and preferable way of managing quality of life, cost of care and support."*
> **Anita Lightstone, Chief Operating Officer, Vision 2020 UK and Programme Director, UK Vision Strategy**

Public Health initiatives can play an important role in changing perceptions and encouraging preventative activity, such as seeking regular eye tests, not smoking, wearing sunglasses to protect against exposure to the sun[36].

> *"If we can shift the thinking from reactive treatment to preventive care, and then link that into challenging people perceptions of old age, that would be a way forward and it fits into the government's agenda about recognising the value of the elderly population."*
> **John Nawrockyi, Co-Chair, Association of Directors of Adult Social Services Disabilities Network**

[29] Bosanquet, N, Liberating the NHS: Eye Care, Making a Reality of Equity and Excellence, 2010
[30] RNIB, Older People & Eye Tests, 2007
[31] Gov.uk, England level data by programme budget: https://www.gov.uk/government/uploads/.../dh_131856.xls.xls accessed March 2013
[32] Visibility, Deteriorating vision, falls and older people: the links, May 2005
[33] RNIB, Older People & Eye Tests, 2007
[34] RNIB, Older People & Eye Tests, 2007
[35] College of Optometrists, Britain's Eye Health In Focus, Feb 2013
[36] RNIB, Feeling Good, Looking Great, 2006

Vision 2020 and the UK Vision Strategy successfully worked with the Department of Health to develop an eye health indicator that has been included in the Public Health Outcomes Framework (see figure 9), marking a significant advance for eye health. However, there is still more work to be done: despite recognition in the outcomes framework, recent publications such as the NHS Constitution Public Health Supplement[37], fail to include eye health on the list of local authorities' commissioning responsibilities.

Figure 9: Public Health Outcomes Indicator For Eye Health[38,39]

DOMAIN 4: Healthcare Public Health & Preventing Premature Mortality		
Condition	**Indicator**	**Comments**
Age Related Macular Degeneration	Crude rate of sight loss due to Age Related Macular Degeneration (AMD) in persons aged 65 and over per 100,000 population	Most prevalent of the three main eye diseases, which can result in blindness or partial sight if not diagnosed and treated in time
Glaucoma	Crude rate of sight loss due to glaucoma in persons aged 40 and over per 100,000 population	One of the three main eye diseases that can result in blindness or partial sight if not diagnosed and treated in time
Diabetic Retinopathy	Crude rate of sight loss due to Diabetic Eye Disease in persons aged 12 and over per 100,000 population	• One of the three main eye diseases, which can result in blindness or partial sight if not diagnosed and treated in time. • Early detection through screening halves risk of blindness.
Sight Loss Certifications	Crude rate of sight loss certifications per 100,000 population	This indicator relates to completions of CVI (all causes both preventable and non-preventable) by a consultant ophthalmologist, which initiates the process of registration with a local authority and leads to access to services

The inclusion of this indicator in the Outcomes Framework is intended to ensure that avoidable sight loss is recognised as a critical and modifiable public health issue[40]. However, due to the aging population, it is almost inevitable that a trend for annual increases against these indicators will emerge. Inert acceptance of increases needs to be avoided and the rate of increase needs to be managed and minimised, as discussed in section C (see recommendation 13: The National Clinical Director should produce an annual report to benchmark different areas and drive further service improvements and best practice).

Prevention and awareness will play an important part in ameliorating the major causes of sight loss. This will require work to drive increases in public and wider professional awareness of the importance of eye health.

RECOMMENDATION:

3. An eye health awareness campaign should be developed and executed to encourage the public and health care professionals to realise the importance of eye health and emphasise the importance of eye checks.

[37] Department of Health, Local Government Association, Public Health England, Public Health Supplement to the NHS Constitution, April 2013
[38] Department of Health, Improving Outcomes & Supporting Transparency Part 2: Summary technical specifications of public health indicators, November 2012
[39] CVI refers to a 'Certificate for Visual Impairment.' These are used to register sight loss and can have an impact on the services a person can access.
[40] Department of Health, Improving Outcomes & Supporting Transparency Part 2: Summary technical specifications of public health indicators, November 2012

However, in cash constrained times, awareness raising activities should leverage existing platforms to maximise value for money. From a general population perspective, one mechanism that could be effectively deployed is the NHS Health Check programme. Whereas the priority given to eye health at a national policy level was considered inadequate by those who we interviewed, NHS Health Checks have received significant policy support and are included in the Mandate from the Department of Health to NHS England. Although the NHS Health Check was originally focused on cardiovascular disease, its remit has recently been expanded and now includes questions related to other conditions and public health issues such as alcohol consumption.

RECOMMENDATION:

4. A question on eye health should be developed and added into the NHS Health Check to increase awareness of the importance of sight tests.

A question on eye health would be appropriate and is well aligned with dementia and diabetes, both of which are included in NHS Health Check assessments. The risk of developing eye health related conditions rises with age, which further supports the use of the NHS Health Check as a mechanism for raising awareness as it is targeted at people between the ages of 40 and 74. In particular, the advice given for early detection of glaucoma, particularly if an individual is at high risk, is that they should be regularly reviewed by their optometrist from around age 40 years as this is when it may be clinically detectable or glaucomatous damage may develop[41].

There is also potential to increase awareness by using eye health messages to reinforce broader health promotion campaigns. For example, messages about the increased risk of sight loss due to smoking have been used as a powerful weapon in smoking cessation work[42].

Raising awareness in healthcare professionals is also important and it is encouraging to see that the Royal College of General Practitioners (RCGP) has selected eye health as one of its three-year clinical priorities. It is likely that work will be conducted to engage GPs and raise awareness of the key issues to enable them to signpost patients more appropriately and to help commissioners communicate more effectively with people with sight loss.

Directors of Public Health will be optimally placed to integrate public health and health care activities. Required to sit on Health & Wellbeing Boards, Public Health Directors will regularly liaise with other key commissioning partners. As well as ensuring that they have an adequate understanding of their public health responsibilities in relation to eye health, Public Health Directors should take the lead in ensuring that eye health is covered in Joint Strategic Needs Assessments. A clear, concise fact sheet should be developed and circulated to Public Health Directors through Public Health England to facilitate this process.

RECOMMENDATION:

5. Public Health England should circulate a fact sheet on the importance of eye health to all Directors of Public Health and request that they ensure eye health is covered adequately in Joint Strategic Needs Assessments.

[41] Department of Health, Improving Outcomes & Supporting Transparency Part 2: Summary technical specifications of public health indicators, November 2012

[41] Commissioning For Eye Care, Eye Care: A Public Health Issue, http://www.commissioningforeyecare.org.uk/commhome.asp?section=165&sectionTitle=Eye+care%3A+a+public+health+issue – from Wilson, NA et al.: Smoking and blindness advertisements are effective in stimulating calls to a national quitline. BMJ 2003

C. Access to Treatments & Services

Maintaining Quality

The infrastructure through which eye health services are currently delivered is already struggling to meet demand. For example, PCTs have introduced rationing of cataract surgery based on more or less arbitrary visual acuity levels. The RNIB found that 58 per cent of PCTs surveyed have restrictions on access to cataract surgery based on visual acuity thresholds and of those, 81 per cent have a very restrictive policy which has little or no leeway for patients outside the visual acuity threshold[43].

There is evidence that rationing occurs without clinical justification, as Sir Bruce Keogh told the Public Accounts Committee in January 2013: *"We do know that about 50 per cent of PCTs have restricted access to cataract surgery, and we do know that the bulk of policies used by PCTs actually haven't used the best evidence that's available in order to ration that care*[44]*."*

In addition, glaucoma follow up appointments have been subject to severe delays[45] and patients have experienced difficulty in accessing NICE approved treatments[46], as highlighted by Sir Michael Rawlins, outgoing Chair of NICE[47]. These restrictions represent short term cost savings resulting in worse outcomes for patients and additional downstream costs for the NHS.

> *"Acuity thresholds that block what is a cheap cost effective (cataract) operation leave a lot of older people living unnecessarily with sight loss. This is wholly unjustifiable."*
> **Steve Winyard, Head of Policy & Campaigns, RNIB**

Given agreement that prevention of sight loss is a priority, as evidenced in the Public Health Outcomes Framework, it is important that local areas understand their obligations regarding the provision of treatments and services for patients.

RECOMMENDATION:

6. The National Clinical Director should be responsible for supporting CCGs in providing patients access to treatments and services based on the best clinical and cost effectiveness evidence.

Service Improvement & Reconfiguration

There was strong consensus amongst those interviewed that continuing with the status quo is not an option if current standards of care are to be maintained and ideally improved in the face of rising demand and financial constraints.

[43] RNIB, Save Our Sight, May 2012
[44] Oral evidence given to the Public Accounts Committee: Progress in Delivering Efficiency Savings, Monday 14 January 2013: http://www.publications.parliament.uk/pa/cm201213/cmselect/cmpubacc/uc865-i/uc86501.htm
[45] RNIB, Glaucoma Campaign, http://www.rnib.org.uk/getinvolved/campaign/yoursight/saveoursight/Pages/Glaucoma_SOS.aspx accessed March 2013
[46] RNIB, Save Our Sight, May 2012
[47] HSJ, Michael Rawlins: Playing fair for treatments, http://www.hsj.co.uk/opinion/columnists/michael-rawlins-playing-fair-on-treatments/5047276.article, July 2012

"It is becoming apparent that there are not enough ophthalmologists or hospital facilities to achieve the desired management standards without effective shared care provision. Whilst the shared care concept is developing slowly and, moving care to the community is almost certainly justified to address the capacity issue, this model also raises a number of different issues that need to be considered and addressed."
Russell Young, Chief Executive, International Glaucoma Association

"There seems to be a growing acceptance among ophthalmologists that the only way the increased workload can possibly be managed is to have more services within the community. Obviously, we must ensure that in doing so, the patient still receives a safe and high quality service."
Anita Lightstone, Chief Operating Officer, Vision 2020 UK and Programme Manager, UK Vision Strategy

Moving more elements of care into the community is considered the most likely course and is aligned with wider government objectives to move care closer to home when it makes sense to do so. Already, a number of eye health pathways are being developed, trialled and commissioned for delivery in the community by optometrists and ophthalmic specialists[48]. A pathway approach tends to be followed with local initiatives developed for particular conditions, most frequently providing support for GPs and ophthalmology departments with:

- Referral refinement;
- Post-operation monitoring; and
- Low vision service provision.

However, implementation is patchy. For example, Greater Manchester hosts 18 community pathways related to eye care, including six for cataract referral and six for glaucoma repeat readings. In contrast, Hertfordshire has no community eye care pathways[49].

Integration

With the reconfiguration of eye care pathways across the country there is a danger of an increasingly fragmented service developing. This is likely to be exacerbated by the government's Any Qualified Provider (AQP) policy, which allows patients to choose who provides their care from a list of NHS, private and voluntary providers who have agreed to deliver services to NHS standards and prices. Not only might patients experience a postcode lottery but those living in areas where multiple services have been reconfigured might also find themselves needing to attend multiple clinics and locations to address problems that cannot be neatly categorised by condition.

"With any decisions made, we need to look at patient safety and think about what they want. We need to make sure that patients don't drop off the radar in between providers and that they are part of a pathway that they enjoy and want to be part of."
Dr Waqaar Shah, GP and ophthalmology expert

[48] HSJ, The advantages of community eye care pathways, March 2013 http://www.hsj.co.uk/home/commissioning/the-advantages-of-community-eyecare-pathways/5054857.article accessed March 2013
[48] LOCSU, An Atlas of Variation, http://www.locsu.co.uk/enhanced-services-pathways/enhanced-services-map, accessed 15/03/2013.

Where service reconfigurations take place, it is important that care quality is maintained and that pathways are fully integrated to ensure that the patient experience and outcomes are optimised. Integration is a key policy focus for government, with full support from the Secretary of State for Health and his ministerial team. The Mandate from the government to NHS England provides detail on what integrated care should look like including how "different part of the NHS have to work more effectively with each other and with other organisations such as social services, to drive joined-up care[50]" and "how the focus should be on what we are achieving for individuals rather than for organisations[51]."

Eye care could well serve as a litmus test for integration. Not only will services increasingly be spread across primary, secondary and social care; they will also be provided by a plurality of providers. Patient care standards should be guaranteed whether they are being treated in the NHS or by the NHS in a private setting. Care plans would be an effective way of ensuring patient care is coordinated, services are provided in a timely manner and the chances of individuals 'slipping through the gaps' of a fragmented service are minimised.

However, a care plan needs to be more than just a box-ticking exercise. Executed effectively care plans can be the keystone of integration and they are arguably needed more in vision that anywhere else. An example of good practice in this area is diabetes care, where patients undergo an annual care planning exercise in collaboration with their multi-disciplinary team. This is mandated by the NICE quality standard for diabetes[52]. Alongside care plans, minimum standards of care should be developed to give patients confidence that they are receiving an adequate service along the entire patient pathway.

RECOMMENDATION:

7. Care plans should be developed for eye care patients, owned by one practitioner, to promote a seamless experience and integrated service.

RECOMMENDATION:

8. A list of minimum standards should be developed to guide patients on what they should expect from interactions in primary, secondary and social care.

Assurance would need to be given than any changes made to service delivery were safe and effective. A list of key performance indicators for each condition-related pathway should be developed to facilitate post-implementation assessment and continued improvement.

> *"I would like to see auditing of eye care services becoming much more accurate. There is a real disconnect in the way that information that comes from an optometric environment gets transmitted into a hospital environment. As a result of that there may be no understanding of what has happened to that patient and efficiencies in providing care will be lost".*
> **Kamlesh Chauhan, President, College of Optometrists**

[50] The Mandate, A mandate from the Government to the NHS Commissioning Board April 2013 to March 2015, Nov 2012; 2,.2
[51] The Mandate, A mandate from the Government to the NHS Commissioning Board April 2013 to March 2015, Nov 2012; 2.8
[52] NICE, QS6: Diabetes in adults quality standard, March 2011

"Increase the need for audits because this is the way forward. There is a need for better clinical audit. If you move a service, you must audit the outcomes and see if it provides a good clinical standard and what the downsides are – does it work and is it safe?"
Tony Moore, Vice President, Chair of Scientific, Royal College of Ophthalmologists

RECOMMENDATION:

9. New pathways should be subject to audit to ensure that patient safety and outcomes are satisfactory.

To further facilitate integration, changes already underway should be underpinned by robust communication processes to ensure that all parts of the pathway are linked. In Scotland, the system is considered more integrated between optometry and ophthalmology and this is partly attributed to the electronic management of referrals. In January 2011, 81.4 per cent of referrals were managed electronically against a target of 90 per cent[53]. Managing referrals electronically would reduce risk and speed up communication improving efficiency and supporting better patient care.

"Increasing the speed and directness of communication would be of great benefit and I would like there to be a much more joined up approach to care of eyes in the UK, in the sense that there is a much better cohesion between optometrists and the secondary eye care provider".
Kamlesh Chauhan, President, College of Optometrists

"To effectively move more care into the community, you need proper transfer of data. At the moment the community records are not linked in with the Hospital medical records – for example optometrists cannot see what has been done in the hospital setting."
Tony Moore, Vice President, Chairman of Scientific, Royal College of Ophthalmologists

The Secretary of State for Health recently announced his ambition for the NHS to go paperless by 2018, recognising the role that technology could play in helping to tackle the problems associated with an aging population as well as financial sustainability. The reasoning used chimes with the situation in eye care.

RECOMMENDATION:

10. Digital data sharing best practice should be developed across an eye care pathway as part of the Secretary of State for Health's Digital Challenge.

[53] The Scottish Government, Heat Target: http://www.scotland.gov.uk/About/scotPerforms/partnerstories/NHSScotlandperformance/eReferrals accessed March 2013

Spread of Best Practice

At a local level, the Local Optical Committee Support Unit (LOCSU) has taken steps to facilitate the implementation of good practice in the development of community eye care pathways. However, opportunities exist to build on this through a centrally led evaluation of the mode of implementation and outcomes being achieved.

Ideally, service reconfiguration requires a holistic and considered approach to ensure that any changes made make sense within the context of the whole eye care service rather than an isolated pathway. The new commissioning arrangements for eye health services do not readily facilitate such an approach. Although Local Eye Health Networks will have a role to play in improving services and will be on hand to assist CCGs with the provision of advice and clinical insight, the focus of these Networks is on primary care services in the first instance and there is no guarantee that eye health will be prioritised across the CCG network.

By working with the National Eye Health Network to develop a best practice approach to service development, there would be scope to drive a more consistent approach to change across the eye health sector. A systematic demand and capacity gap analysis would need to be conducted to ensure that future developments were based on a robust understanding of resource and capability needs across the country, focusing on the major causes of visual impairment. Such an analysis would also facilitate the selection of meaningful benchmarks to guide and measure the success of improvement initiatives. Work is underway in Scotland to assess eye care service delivery across all four major conditions with a view to standardising best practice and looking at the wider resource implications[54].

RECOMMENDATION:

11. A best practice approach to rationalising and improving eye care service delivery should be developed, based on a systematic demand and capacity gap analysis.

In terms of service quality, glaucoma and diabetic retinopathy are already covered by NICE Quality Standards and cataract and macular degeneration have both been included in the pipeline for guidance and Quality Standard development. However, dates have not been set for the development of these materials, leading to confusion and delay. Their development should be prioritised and a development schedule confirmed. Their completion should serve as a precursor to the development of integrated commissioning guidance by NHS England.

RECOMMENDATION:

12. The completion of NICE Quality Standards across the four main eye conditions should be expedited. Its completion should trigger the development of integrated commissioning guidance by NHS England.

To successfully address the challenges of the future, this more complete assessment of how changes should be introduced would be beneficial. Indeed, this may lead to consideration of some more radical approaches to service delivery.

[54] Interview with John Legg, RNIB Scotland, February 2013

"We need to deliver services in a more cost effective way, optimising patient throughput and improving the way tests and injections are managed. Lists must be efficiently run, maximising numbers of operations when staff and theatres are available."
Steve Winyard, Head of Policy & Campaigns, RNIB

"In other countries different approaches are being adopted to save time and resources. Some of these involve taking patients two at a time into operating rooms, using mobile clean rooms and widening responsibility for injections. People have not yet explored all of these options here because they have been deemed too radical. However, equivalent options will need to be considered because if we do not do something more radical, then people will lose their sight unnecessarily."
John Legg, Director, RNIB Scotland

Any more complete assessment of eye health service delivery should examine structural barriers to reform and how these might best be addressed. This needs to include the payment system for providers if a move towards optimally located care is to be properly incentivised.

"We must not stop hospitals running casualty units by moving money around. The tariffs for A&E patients do not account for the cost. So if private companies take the easy procedures elsewhere and the cash for that goes, that will be a problem."
Kathy Evans, Chief Executive, Royal College of Ophthalmologists

"The standard business model is based on sight tests and glasses prescriptions – there is a significant cross subsidy between the examination and the glasses. In multiple chains, the cost of the eye exam is frequently downplayed with the anticipation of getting people to buy glasses."
Nick Rumney, recently completed term at the General Optical Council

"Unless [reconfiguration] is handled well, large numbers of cataract operations could go off to private providers leaving hospital eye departments without the volumes for full lists and training."
Steve Winyard, Head of Policy & Campaigns, RNIB

"Optical practices are already successfully delivering accessible patient focused services as part of integrated eye care pathways in many areas. Robust audit arrangements and appropriate funding are important to ensure the sustainability of these services."
Katrina Venerus, Managing Director, LOCSU

The current tariff system does not accurately reflect the cost of treatment. Hospital eye clinics are often required to subsidise complex procedures with income from more routine elements of care. Equally, in the community, some optometrists subsidise eye tests with income from the sale of glasses. Such distortions in pricing can result in biased approaches to service delivery development, blocking optimal service configuration being achieved. It is important that enthusiasm to transform the eye health service so that it is best equipped to meet the challenges of the future is harnessed effectively. To achieve this, income streams need to be aligned to objectives and provide reassurance that those required to deliver elements of a changing pathway will be adequately reimbursed and able to retain the viability of their business whilst delivering high quality patient care.

Monitoring & Evaluation:

Monitoring and evaluation of changes to service delivery are essential for informing future developments and driving continued improvement. Existing arrangements are inadequate. As eye health is regarded as being a low policy priority, there is little incentive for commissioners to champion developments in their local areas or ensure that outcomes measure up to the best. A central assessment of annual performance against the Public Health Outcomes Indicator across the country would encourage comparison across areas and provide impetus for improvement. Supplementing this statistical analysis with information on best practice developments and strategic direction for the following year would enhance the prospects of a more standardised approach to service development.

RECOMMENDATION:

13. The National Clinical Director should produce an annual report to benchmark different areas and drive further service improvements and best practice.

In a potentially fragmented pathway, incentivising providers would help to ensure that best practice in service delivery was consistently applied. Giving commissioners a local CQUIN framework would enable them to support local providers in the delivery of eye care pathways.

RECOMMENDATION:

14. The National Clinical Director should develop a local CQUIN framework to support commissioners in the implementation of best practice eye health pathways.

Appendix 1: About ABPI POPI

ABPI Pharmaceutical Ophthalmology Initiative (POPI) is an industry group that sits within the Association of the British Pharmaceutical Industry (ABPI). The group has been established recently and allows members to work together on some of the overarching issues affecting eye care services in England. Its objective is to work with others to raise the standard of eye care and deliver the best possible outcomes for patients across the UK, which includes access to treatments and the appropriate funding of services, research and innovation. Bausch + Lomb, MSD, Bayer and Novartis are members of the group and JMC Partners provides the secretariat.

Member Companies

Appendix 2: Acknowledgements

With many thanks to the following people who were interviewed during the preparation of this report.

Name	Organisation	Position
Angela Tinker	Visionary	Chief Executive
Anita Lightstone	UK Vision Strategy	Programme Director
Anthony Moore	The College of Ophthalmologists	Vice President
Carl Freeman	Guide Dogs	Policy Manager
David Wright	International Glaucoma Association	Chief Executive
Helen Jackman	Macular Disease Society	Chief Executive
Jim Barlow	NHS Commissioning Board	Optical Advisor
John Legg	RNIB Scotland	Director
John Nawrockyi	Association of Directors of Adult Social Services	Co-Chair, Disability Network
Kamlesh Chauhan	The College of Optometrists	President
Kathy Evans	The College of Ophthalmologists	Chief Executive
Katrina Venerus	LOCSU	Managing Director
Miriam Martin	Action for Blind People	Director of Development
Nick Rumney	General Optical Council	Appointed Member
Peter Corbett	Thomas Pocklington Trust	Chief Executive
Sarah Buchanan	Thomas Pocklington Trust	Research Director
Sheryl Vincent	Somerset Optical LPN	Pilot Lead
Steve Winyard	Royal National Institute of Blind People	Head of Policy & Campaigns
Timothy Rimmer	Royal College of Ophthalmologists	Consultant Ophthalmic Surgeon
Waqaar Shah		GP and ophthalmology expert
David Hewlett	Optical Confederation	

Appendix 3: Acronyms

Acronym	Related Term
ABPI	Association of the British Pharmaceutical Industry
AMD	Age-Related Macular Degeneration
CCG	Clinical Commissioning Group
CVI	Certificate of Visual Impairment
HWB	Health and Wellbeing Boards
LOCSU	Local Optical Committee Support Unit
LPN	Local Professional Network
NCD	National Clinical Director
NPN	National Professional Network
NICE	National Institute for Health and Care Excellence
PCT	Primary Care Trust
POPI	Pharmaceutical Ophthalmology Initiative
RCGP	Royal College of General Practitioners
RNIB	Royal National Institute for the Blind
UKVS	United Kingdom Vision Strategy

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