OPHTHALMOLOGY TRANSFORMATION – FUTURE MODEL OF CARE

1. Purpose

1.1 This report provides members with an overview of the CCG’s transformation plans for ophthalmology services for the next five years.

1.2 In summary the CCG proposed plans are to procure an integrated service that will provide:

- a complete ophthalmology service for our population
- an efficient and effective eye service closer to home
- a sustainable eye service for the future population needs
- a service which promotes self-care
- eye care services within NICE guidance
- eye care services within our cost envelope
- eyecare in line within RCOphth/ CoO guidelines

1.3 Members are specifically requested to note:

- the patient engagement undertaken
- the CCGs new proposed model of care.
- the strategic context for planned care and the Clinical Transformation Group process
- the transformation approach and next steps for delivery of the integrated model of care

2. Background

2.1 Over the last ten years, the Department of Health has increasingly encouraged the delivery of more routine and minor emergency eye care outside hospital in community optical practices. New national guidelines for the management of glaucoma published in 2009 by the National Institute for Health and Clinical Excellence (NICE) identified the increasing pressures on secondary eye care services. There is also evidence that with the right safeguards, many ophthalmology services traditionally referred to secondary care for monitoring and treatment can now be performed safely and effectively by specialist optometrists in community settings. Around the UK, community optical practices are successfully and safely delivering local enhanced services in primary care with high levels of patient satisfaction, as part of local integrated pathways linking into secondary care as appropriate. A key benefit of implementing these enhanced services is a reduction in referral rates to GPs, A&E and hospital eye departments.
The aim of this is to free up hospital capacity to cope with increasing demand from both the ageing population and new technologies e.g. wet Age-related Macular Degeneration (AMD) treatments. It is therefore important for NHS commissioners to consider the transformation and continued development of their local ophthalmology services.

2.2 Suffolk has been innovative in developing its Eye Services:

- the first county to implement direct referral from optometrist to hospital
- the first area to test a single point of access referral platform on behalf of Local Optometric Committee Support Unit (LOCSU) a national body that supports Local Optical Committees (LOCs) across England in developing local eye health services and community optometrists and opticians work with local commissioners to make community eye services accessible for patients and cost effective for the NHS. This includes policy and direction of service development.
- New Community Glaucoma – I-Van services have been cited in the Dalton Review, NICE Quality Care Study and BMJ Award shortlisting.
- Consultant led Community Clinics for Ophthalmology, commenced as a pilot on 1 September 2015

2.3 Ipswich and East Suffolk is committed to commissioning the provision of the most effective ophthalmology services to the population of Suffolk. In 2010 McKinsey & Co. Ltd. undertook a deep dive review of ophthalmology. This review identified that the Hospital Eye Services (HES) were oversubscribed both with first and follow up appointments. Outpatient costs per capita in Suffolk were found to be some of the highest in the east of England at £1.91 compared to the national average of £1.78. Based on this, NHS Suffolk explored options for a viable alternative to secondary care ophthalmology services in Suffolk that would improve patient experience, value for money and increase the breadth of service provision within a community setting. Commissioners considered new alternative models emerging in other parts of the country including Essex which had implemented a system for triage and increased monitoring of referrals and an enhanced range of service providers in community settings.

2.4 The Local Optometric Committee (LOC) was keen to look at an enhanced services model where they would monitor suspected glaucoma and only send those with proven glaucoma for stabilisation to HES. With further training it was decided that optometrists could look and treat minor eye conditions in the community reducing further input to hospital eye care services. The Local Optical Committee Support Unit (LOCSU) also reviewed the proposed referral management concept for the pilot and recommended that the concept was tested.

2.5 Working with the local optometry committee, its support service LOCSU and a computer software company Evolutio (formerly Accipiter) a community service structure was designed. This service consisted of: a single point of access referral platform, optometry led triage and a series of community based services performed by enhanced service providers such as: high intraocular pressure (IOP) monitoring, general refinement (GR) and children’s services. This concept was tested as a pilot and evaluated by an outside organisation, before being used as the base for our community services today.

2.6 In tandem a community based stable glaucoma monitoring service with a mobile component was commissioned, monitoring the cohort of stable glaucoma patients in the community, only reverting to hospital care when disease progression dictates.

2.7 The contracts that deliver these services, both expire in July 2016. The governing laws around procurement leave us with no opportunity to extend or renew without a full procurement. This provides us with an opportunity to review and redesign all ophthalmology services and develop an integrated pathway and service model for patients.
3 Current Services

3.1 Since 2011, an optometry-led community service has been operating pan Suffolk, consisting of a single point of entry into ophthalmology, services via an electronic platform, a remote triage of all referrals by a locally based optometry led triage team and a series of community optometry led enhanced services provided by enhanced service providers (ESP). Services provided are:

- Monitoring of high intraocular pressure
- General enhanced services
- Cataract referral services and cataract post-operative services

3.2 The electronic platform gives clear sight of referrals and their progress at all times throughout community care. The community services are well used being based within current high street optician shops, providing a service to patients closer to home within 2-6 weeks at a sub-payment by results (PbR) acute tariff. This is a prime contractor model with sub contracts that enables the CCGs to have a single structure for governance and management.

4 The Rationale for Change

4.1 Ophthalmology Service Transformation is one of the key redesign programmes for the CCG. Ophthalmology services were prioritised as an area for change due to a number of factors:

- Increasing elderly population (over 65 age group is predicted to rise 5% year on year)
- NICE Guidance decreased treatment thresholds for Glaucoma and Wet AMD which led to increased demands on eye care services
- Increases in activity and spend
- New technologies to prevent sight loss are raising expectations for treatment
- Changes to treatment modality means delivery of care is much more amenable to community delivery and care closer to patients home
- Hospital services are experiencing high demand and long waits
- Capacity issues in current service delivery
- Contracts for our current community providers will expire in May and July 2016

4.2 The CCG is now actively leading a transformation process including: the development of a new model of care with the majority of service provision available in the community. Building on the foundations for the successful Enhanced Service Provider contracts with our local optometrists who are able to provide a wider range of services to patients in their own optician practice rather than referring onto hospital. This has allowed more patients to have care closer to home. The Community Glaucoma Service has been shortlisted for national awards and provides a one stop shop approach for patients with low risk/stable glaucoma within their own neighbourhood.

5 Proposed Model of Care

5.1 In 2015, the CCG introduced Clinical Transformation Groups (CTGs) as part of a new way of engaging partners within the local health economy to participate in the development of new models of care. Planned Care service transformation is working to a set of commissioning principles:

- We will commission where possible at a whole specialty level
- We will commission as a whole pathway of care from prevention through to acute care
- We will commission where possible and appropriate as an outcome based approach and not a process approach
We will utilise the most effective contract mechanism to achieve the outcomes we have set including exploring prime and alliance contracting and longer contract lengths e.g. 5 years. We will align finances across a whole pathway of care moving away from a PbR model to a programme budget of other alternative approach and offer incentives as part of this against outcomes achieved.

5.2 The role of these Clinical Transformation Groups (CTGs) is to map current provision and develop a set of issues/improvements required which can translate into a new clinical model, or a series of supporting clinical pathways (where appropriate/needed), a set of outcomes measures contained within an outline service specification or business case for procurement. The Clinical Executive then explore and advise the appropriate set of options for commissioning for future service delivery.

5.3 The new integrated ophthalmology model of care has been developed as part of this Clinical Transformation Group process. There were three multi-organisation CTGs which worked on the required framework for a new service model and a 4th provider only session. A new model of care was developed this consists of a 6 tiered arrangement (see Appendix 1):

- The first tier is associated with primary prevention and self-care
- The second tier is associated with interventions delivered by GPs, optometrists, opticians, pharmacists, school nurses and health visitors
- The third tier is for specialist community based services delivered by ESPs and underpinned by a community consultant
- Tier four will take all of the services that need to see an ophthalmologist but do not need the infrastructure of the hospital/eye unit
- Tier five is the complex cases that need increased infrastructure to support their delivery.
- Tier six remains as specialised commissioning eye care.

5.4 From the Suffolk-wide Clinical Transformation Group workshops, meetings with providers and working directly with the Royal College of Ophthalmologists, a clear-tiered model has emerged (Appendix B), which is an adaptation of the suggested model laid out in the Royal College of Ophthalmologists (RCOph.) Commissioning Primary Care Ophthalmology Care (2013).

6 Options for consideration

6.1 A range of options were considered by the Planned Care Workstream and Clinical Executive which included 1.) Fully Integrated Service as a Prime contractor/alliance model 2.) Intermediate Level Service only as a Prime contractor/alliance model 3.) Separate Lots - Tiers 1-4 services only to be procured individually or as aligned lots 4.) Do nothing

6.2 Based on the principles of the Planned Care Strategy (see Appendix 2 – Planned Care Strategic Diagram) the purpose of service transformation is to align finances across a whole pathway of care, moving away from a PbR model to a programme budget or other alternative approach and offer incentives as part of this against outcomes achieved as part of an agreed framework. Procuring separate lots does not facilitate an end to end pathway for patients. To have triage via a single point of access with shared patient records, integrated IT systems and providing care at the right place, time and level an integrated model of care delivers more of these benefits.
6.3 Options on the model were considered by the Planned Care Workstream and Clinical Executive and a whole integrated service option was preferred commissioned. A joint venture pan Suffolk or an integrated service option for Ipswich and East Suffolk only were also assessed. The geographical coverage is pending a decision to be taken by West Suffolk CCG on the 15 September 2015.

7 Public Engagement Plans

7.1 Evaluation of ophthalmology services in Suffolk has been an on-going process over many years, using public feedback to direct the evolution of ophthalmology services. Following a review of services in 2010, the emerging themes from this engagement included: too many follow ups; a large back log of patients awaiting follow –up; inefficiencies within the booking team; a shortage of clerical support; missed appointments due to delayed letters; no referral feedback; over-crowded clinics; and the need for more space. In response to this feedback we introduced:

- A training scheme to allow those patients who had cataract surgery to be done by optometrists in the community
- A single point of access and referral refinement platform
- Optometrist triage
- Up-skilling of optometrists to become enhanced service providers (ESP)
- Community based enhanced service provider (ESP) pathways
- A community and mobile based Glaucoma stable monitoring service

7.2 In 2012 we employed the services of Enable East to perform an external evaluation of the services recently introduced alongside the existing services. As part of the Clinical Networks in 2012-14, we undertook a series of workshops to identify the current service shortfalls and identify the elements of a new service that would improve eye services, incorporating them into a new efficient service that would allow a better patient experience for the allocation of public funds.

7.3 In 2015 for the new model of care to ensure appropriate engagement with our stakeholders we have used social media by posting a questionnaire, on our website and using Facebook and Twitter as signposts. 22 people responded to the questionnaire sharing their stories, most were happy with the care, but had issues predominately for the East services with long waiting times, cramped clinic conditions and parking shortages at the hospital. At the Suffolk Show 2015, wider engagement was possible, this time targeting the youth element, requesting feedback on experiences and what they would like to see from the service. Face to face feedback has been conducted in eight locations across Ipswich and East Suffolk via our “feet on the street” campaign. In total, 18 people shared their specific views on ophthalmology experiences which were mainly positive. We have also conducted a ‘live clinic’ review sessions at Ipswich Hospital for direct patient feedback on the day of appointment. Our local community glaucoma service provides routine patient feedback.

7.4 We are also meeting with a broad range of user groups to help formulate our patient outcomes framework and work to determine what good quality of care needs to incorporate, in particular for the significantly visually impaired. Healthwatch is also conducting engagement on our behalf in support of the new integrated model of care.

8 Next Steps

8.1 The key next steps are to complete the public engagement in support of the new model. To continue

- to work with stakeholders to move towards integration.
- to hold a market development day as part of the pre procurement process. Provisional date 13 October 2015
- to continue the transformation programme timetable with procurement likely to commence from November 2015 –April 2016.
- to award the contract in the period April- May 2016
- to implement the changes in the period May-October 2016
- to commence the service between October –November 2016

9 **Recommendations**

9.1 Members are specifically requested to:

- approve the CCGs new proposed model of care.
- note the strategic context for planned care and the CTG process
- approve the public engagement work
- note the transformation approach and next steps for delivery of the integrated model of care

**Authors:**
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### Appendix 1: Proposed Ophthalmology Clinical Model

<table>
<thead>
<tr>
<th>Primary prevention and self-care Tier 1</th>
<th>Primary Care Tier 2</th>
<th>Specialist Community Based Services Tier 3</th>
<th>Consultant led Intermediate Ophthalmology services Tier 4</th>
<th>Acute Care Tier 5</th>
<th>Specialised Commissioning Tier 6</th>
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<tbody>
<tr>
<td><strong>Primary Prevention Working with:</strong></td>
<td>Delivered by:</td>
<td></td>
<td>Comprising of:</td>
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<tr>
<td>• GP</td>
<td>• GP</td>
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<td>• all patients that have no clear pathway</td>
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<td>• Optometrist</td>
<td>• Optometrist</td>
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<td>• OCT and diagnostics to aid diagnosis</td>
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<tr>
<td>• Opticians</td>
<td>• Opticians</td>
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<td>• A “see and treat” approach to patients</td>
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<tr>
<td>• Pharmacists</td>
<td>• Pharmacists</td>
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<td>• Onward referral to discrete services</td>
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<td>• School nurses</td>
<td>• School nurses</td>
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<td>• A support service to GPs, optometrists and ESPs</td>
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<td>• Health visitors</td>
<td>• Health visitors</td>
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<td>Discrete services could include:</td>
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<td>Information and support</td>
<td>Working with:</td>
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<td><strong>Consultant led intermediate Glaucoma service:</strong></td>
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<tr>
<td>including reactive advice on:</td>
<td>• Clear clinical pathways and protocols in place for management of ophthalmology patients</td>
<td>• For newly diagnosed/ unstable/follow up monitoring</td>
<td>• Cataract services, YAG, Minor ocular plastics</td>
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<td>• self-management</td>
<td>• Open education and constructive feedback for Primary Care for the management of patients with ophthalmology related conditions</td>
<td>• Diagnosis of type of AMD</td>
<td><strong>Consultant led intermediate retinal clinic:</strong></td>
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<tr>
<td>• eye health promotion publicity</td>
<td>• Support to GPs in skills and knowledge to support patients with stable eye conditions</td>
<td>• Onward referral to treatment</td>
<td>• Diagnosis of type of AMD</td>
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<tr>
<td>• availability and awareness of other advice including the voluntary sector</td>
<td>• Promotions of primary and secondary education</td>
<td>• Consulting by consultant</td>
<td><strong>Discrete consultant led intra-ocular injection service:</strong></td>
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<tr>
<td>• Information about available support options</td>
<td>• Holistic care plans including self-management and education</td>
<td>• Follow up treatment where necessary</td>
<td>• Treating and intraocular injections</td>
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<td></td>
<td>• Information about available support options</td>
<td>• Psychological support</td>
<td><strong>Consultant led optometry delivered community AMD follow up service:</strong></td>
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</tbody>
</table>

### Complex cancer treatment
- Diabetic retinal screening