West Yorkshire and Harrogate
Health and Care Partnership

West Yorkshire & Harrogate Joint Committee of Clinical Commissioning Groups

Summary report			
Date of meeting: 14 January 2020		Agenda item: 72/20	
Report title:	**West Yorkshire and Harrogate Regional Cataract Surgery Pathway and Policy**		
Joint Committee sponsor:	Matt Walsh		
Clinical Lead:	James Thomas		
Author:	Nicky Moss, WYAAT Project Manager and Helen Lewis, Lead Commissioner (Leeds)		
Presenter:	James Thomas		
Purpose of report: (why is this being brought to the Committee?)			
Decision	✓	Comment	
Assurance	✓		

Executive summary

The West Yorkshire and Harrogate Elective Care and Standardisation of Commissioning policies programme addresses clinical thresholds and criteria for clinical procedures, including the development of standardised policies and pathways.

The purpose of the eye care work stream is to standardise clinical pathways for a range of conditions and harmonise the clinical thresholds for policies within these pathways. We present here a proposal for a single WY&H pathway and policy for Cataract Surgery for recommendation by the Joint Committee. Background information about the wider eye care programme is attached at Appendix 8.

Recommendations and next steps

The Joint Committee is asked to:

1. Agree the WY&H cataract surgery pathway and policy and
2. Approve the principle of using primary care/community optometrists to carry out shared decision-making and post-operative checks for routine patients in order to release capacity within Hospital Eye Services (HES) and free up ophthalmologists to be able to see higher risk patients with potentially sight-threatening conditions.

Delivering outcomes: describe how the report supports the delivery of STP outcomes

Health and Wellbeing: The programme adopts a 'right care, right place, right time' approach to the planning and delivery of planned care services.

Care and Quality: Introducing this pathway and policy will ensure that patients across West Yorkshire and Harrogate who undergo a cataract procedure all follow the same pathway. This will reduce unnecessary referrals, free up hospital clinical time, reduce waiting times and reduce variation in healthcare across the region.

Finance and Efficiency: The financial impact of the Cataract Surgery Pathway will vary by place based on existing pathways along with existing contracting and payment arrangements in place locally.

Impact assessment (please provide a brief description, or refer to the main body of the report)	
Clinical outcomes:	See paragraph 5 to 18, and 24 to 27 and appendix 5
Public involvement:	See paragraph 19 to 21
Finance:	See paragraph 29 to 32, and appendices 3 and 7
Risk:	See paragraph 33 to 34, and appendix 6
Conflicts of interest:	Dr James Thomas: GP Chair of NHS Airedale, Wharfedale and Craven CCG; partner of Modality GP partnership; Dr Kate Thomas (spouse) is also a partner of Modality GP partnership. Dr Matt Walsh: Chief Officer of NHS Calderdale CCG Catherine Thompson: none declared

N.B. All members of the cataracts working group, eye care working group and programme board who have been involved in the development of this policy have completed declarations of interest.

West Yorkshire and Harrogate Health and Care Partnership Elective Care and Standardisation of Commissioning Policies Programme: Regional Cataract Surgery Pathway and Policy

Introduction

1. The West Yorkshire and Harrogate Elective Care and Standardisation of Commissioning policies programme addresses clinical thresholds and criteria for clinical procedures. The purpose of the eye care work stream is to standardise clinical pathways for a range of conditions and harmonise the clinical thresholds for policies within these pathways.

2. The Elective Care and Standardisation of Commissioning Policies (SCP) programme of the West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP) has reviewed the current approach to cataract surgery across WY&H taking into consideration;

    - The National Institute for Health and Care Excellence, Cataracts in adults: management NICE Guideline [NG77], October 2017 and;
    - The RCOphth Way Forward Report (Cataract)

3. The proposed pathway and policy has been developed through clinical engagement across the whole system taking account of these guidelines and recommendations. The WY&H Elective Care and SCP programme recommends the adoption of this pathway and policy across all CCGs within WY&H. This is presented here for consideration and recommendation by the Joint Committee.

West Yorkshire and Harrogate Policy Development Process

4. The Elective Care and SCP Programme has developed a governance process to support decision making through the Joint Committee of WY&H CCGs as set out in the scheme of delegation appended to the WY&H Memorandum of Understanding. This has been discussed during presentations of the Elective Care and SCP Programme at the WY&H Clinical Forum and Joint Committee meetings and agreed as an acceptable approach. The process is detailed here for clarity. See also the governance diagram at Appendix 1, which provides additional detail e.g. specific working groups.

    - Each policy or pathway is developed in the relevant working group using the ‘do once and share’ approach i.e. one place / CCG / the programme team leads the development of the policy or pathway.
    - Clinical involvement is secured by the place leading the pathway / policy development, and the draft policy / pathway shared for comment and development with relevant clinicians across WY&H.
    - The developed policy or pathway is shared with members of the working group to ensure agreement of all working group members.
    - Mapping of the differences between the proposed pathway and the current pathway and policies in each of the nine WY&H CCGs and an assessment of issues and risks.[1]

[1] The mapping of the differences between the proposed pathway and the current pathway and policies in each of the nine WY&H CCG’s is at Appendix 2.

- Mapping of engagement findings from across the nine WY&H CCGs and assessment of the need for consultation or further engagement.
- Completion of the WY&H Quality and Equalities Impact Assessment (agreed at the January 2019 Joint Committee).
- The policy or pathway is presented at the Elective Care and SCP programme board to ensure representation and agreement from all nine CCGs within WY&H prior to recommendation to the Joint Committee.
- Development and discussion at Joint Committee and / or Clinical Forum.
- Decision at Joint Committee.

Cataract Surgery

5. Cataract is a clouding of the lens inside the eye, causing vision loss that cannot be corrected with glasses which may occur in one or both eyes. Cataract surgery is currently the only effective treatment to improve or maintain vision whereby the natural lens is replaced by a clear intraocular lens implant. The standard surgical technique used in the NHS is Phacoemulsification where an ultrasound device is used to break up the cloudy lens into small pieces, which are then gently removed from the eye using suction.

6. Cataract surgery is the most commonly performed elective surgical procedure in the UK. In our region this accounts for around 25,000 procedures annually. The requirement for cataract surgery is anticipated to increase with increasing life expectancy and associated population numbers.

7. Cataract surgery improves visual function and the benefits are lifelong unless negated by another eye disease. Cataract surgery is associated with improvements in quality of life, visual acuity, contrast sensitivity, depth perception, activity, anxiety, depression, visual disability, confidence, disability and reduction in falls. Health economic modelling has shown cataract surgery is highly cost effective. NICE guidance confirms it is not cost effective to delay cataract surgery in people with symptomatic cataracts until a visual acuity threshold is met.

8. Currently all NHS Hospital Eye Services (HES) in WY&H offer cataract surgery, along with a variety of Independent Sector providers. The proportion of cataract patients seen in NHS Trusts versus Independent Sector providers varies significantly between CCGs and the balance is shifting further towards Independent Sector providers each year.

9. In June 2019, the WY&H Elective Care and Standardisation of Commissioning Policies Programme together with the West Yorkshire Association of Acute Trusts brought together relevant stakeholders from across the system through the creation of a regional cataracts project team. This multi-disciplinary team have worked closely together to agree what the WY&H cataract pathway and policy should be.

10. The WY&H agreed pathway requires referral directly from a community optometrist. In most cases this is already current practice, but in some instances a referral is initiated via the GP. It is expected that the community optometrist will be more closely involved in the early decision making process through adoption of an agreed 'shared decision-making tool'. It is anticipated that this will lead to fewer unnecessary referrals/ improved conversion rate for a variety of reasons e.g. patients will be better informed about the procedure and likely benefits and risks before seeing the consultant. The optometrists will spend more time assessing the patients' suitability and willingness for surgery.

11. Through the production and adoption of an agreed regional standardised referral form this will help to improve the quality of referrals and ensure that when patients are seen in clinic the ophthalmologists have the right level of information available thus making the clinic time more productive. The referral form presents the opportunity to include questions to identify patients who have had previous refractive laser surgery and/or who wear contact lenses, and to request that the referring optometrist asks the right questions. The form also offers further guidance to the optometrist to ensure that they have considered relevant factors such as whether the patient may require transport or a translator.

12. The pathway specifies that the biometry and the consultation should be on the same days. By ensuring biometry is available to the consultant at the point of surgical assessment (first visit to HES) this will assist with the advice given and decisions made regarding lens selection. It also improves patient experience by reducing the number of appointments required in hospital. We are aware that some patients are currently seeing the consultant before their biometry, which means they then need a 3rd appointment. This group of patients also often require patient transport, so reduced attendances will reduce the demand on this scarce resource.

13. Discharging non-complex patients for post-operative follow-up by a community optometrist will reduce low-value activity within specialist services, and thereby increase capacity available within the HES. This capacity will help to reduce waiting times for clinic and could be utilised to see higher risk patients with potentially sight-threatening conditions such as glaucoma, diabetic retinopathy or AMD.

14. Patients who are considered complex (e.g. complications with surgery, co-morbidity, rapid sequence 1st & 2nd eye or patient identified complications) will be seen in hospital for their post-operative follow up. To ensure a standardised approach, the project team plan to draft a policy for identifying these patients.

15. The Regional pathway recognises that some routine patients will still need to be seen within the HES to ensure that ophthalmologists in training are offered the opportunity to gain enough experience in post-operative consultations as well as performing surgery.

16. The West Yorkshire and Harrogate Elective Care and Standardisation of Commissioning Policies Programme has considered restricting access in line with visual acuity but has chosen not to do so. Instead, in line with the Royal College of Ophthalmologists whilst we recognise that visual acuity is a useful component of the assessment of visual disability from cataract, cataract surgery should be considered in the first eye or second eye of a patient who has disabling visual symptoms attributable to cataract even if the visual acuity is not low. For instance, a patient who experiences disabling glare due to cataract when driving may still achieve a visual acuity of better than 6/9 under different conditions of illumination.

17. This should create a more equitable and person-centred approach as it allows for consideration of the total circumstances of an individual rather than just a single dimensional test. For example, in patients with learning disabilities or cognitive impairment, it may not be possible to measure visual acuity accurately and in these cases, clinicians should base the clinical decision to offer cataract surgery on clinical examination findings and information provided by carers.

18. The proposed pathway is included at Appendix 4 and the policy in Appendix 5.

Engagement and Consultation

19. CCG Planned Care Leads; Consultant Ophthalmologists, Ophthalmic nurses, Optometrists, ECLOs and service managers from across WY&H have been engaged in the development of the cataract surgery pathway and policy. Please see Appendix 6 for details of stakeholders involved in creation of the pathway.

20. Local engagement and consultation has not been undertaken to date, and it is the opinion of the programme communications team that this is not required to agree the pathway. This pathway is already in place in many CCGs across the country and within Wakefield CCG and is in use with a number of our Independent Sector providers already. We do not therefore believe any local public engagement is required.

21. At its meeting on 14 October 2019, the Joint Committee's Patient and Public Involvement (PPI) Assurance Group considered an update on the Elective Care Programme, including the approach taken by the Eye Care Programme regarding engagement on proposed regional pathways and policies. The group noted the reasons why local engagement had not been required and noted that communication and engagement with the local population would be necessary to support implementation. The group supported the approach to PPI of the Programme.

Quality and Equality Impact Assessment

22. To support the governance processes for the Elective Care and SCP programme a single approach to Quality and Equality Impact Assessment has been developed by the Leeds CCG and shared across the other CCGs including relevant Quality Leads and Equality leads.

23. The groups of people affected by this pathway and policy are:

- Patients who require cataract surgery.

- NHS Trusts including operational/business managers, finance managers and clinicians who will need to implement this pathway at place. They will need to review existing practice/processes and update where necessary. Consideration will also be required to identify how to utilise the available capacity created through the reduction in unnecessary referrals and the transfer of straightforward post-operative appointments to community optometrists.

- Primary care staff, particularly community optometrists. Not all areas currently adopt a 'shared decision making' process before referral and several areas do not commission post-operative follow-ups. Some community optometrists may need to 'upskill' to become accredited to provide the services but there is general agreement that the skills required for routine follow-up are within the core skills of a community optometrist. General Practitioners will also need to be informed of changes to the pathway as their involvement in referrals should reduce over time.

24. The QEIA (see Appendix 6) demonstrated that the introduction of this pathway and policy will have a positive impact on patient experience, effectiveness and equality. Patients will benefit from greater choice, more timely treatment, reduced number of visits, treatment closer to home and a more personalised service at initial diagnosis and follow-up.

25. Enhanced focus on early shared decision making should improve clinical outcomes by ensuring that only those suitable and willing to have surgery are referred and may result in a small number of referrals being avoided. The magnitude of this is not easily quantifiable and is unlikely to be significant compared with anticipated growth. More efficient use of resource availability/capacity across the system will free up appointments in HES thereby enabling patients to be seen in the most appropriate setting depending on their clinical need.

26. The impact is largely positive on the workforce however it is anticipated that there may be some unease for hospital staff who experience a change in their role.

27. It will ensure that patients across West Yorkshire and Harrogate who require cataract surgery follow the same pathway thereby reducing variation in healthcare provision across the system.

Impact of Implementation in West Yorkshire and Harrogate

28. Early benchmarking and analysis has taken place to estimate the likely impacts of implementing the new pathway. This includes the potential costs and benefits to each CCG.

Modelling:

29. Initial modelling has taken place, based on an assumed cost of:

    - £30 per patient for referral refinement and shared decision making.
    - £45 for a community optometry follow up
    - £15 saving to each CCG for follow-ups currently funded to Independent Sector (IS) providers but delivered by community optometrists.

30. This modelling has assumed that 70% of DGH patients and 90% of IS patients would be suitable for optometry follow-up. To estimate the numbers of patients who would require a pre-referral work up we have assumed a 90% conversion rate for primary care referrals (working back from the numbers of procedures) and assumed that around 30% of DGH referrals originate internally rather than through optometrists. These assumptions around case mix are based on a brief audit of LTHT data and may not be generalizable to all providers.

31. The initial modelling evidences that for those areas where there is currently no follow-up scheme in place, with these prices each CCG would 'free up' NHS Trust capacity at a cost of between £65 and £70 per slot. This is broadly equivalent to the national PBR tariff for a single professional follow up (including Market Forces Factor payments). The initial modelling identifies the following slots might be freed up annually at current demand levels:

    Harrogate and Rural District CCG = 900

    Leeds CCG = 2757
    N.B. LTHT does not routinely follow up 2nd eyes already, which reduces the potential for 'freeing up' where already realised

    Calderdale and Greater Huddersfield = 1642

    Bradford and Airedale CCGs = 1782

    The modelling for Wakefield and N Kirklees is more difficult because these pathways are already in place, so there will be far fewer NHS slots to free up, and the prices used in these calculations which are in line with national benchmarking via our LOC colleagues are higher than those currently in place in their local schemes.

32. A task and finish group is being convened with finance, commissioning and contracting colleagues. This group will undertake more detailed analysis of the current and future service provision having the following remit:
    - To validate this modelling work
    - To review the financial impacts for CCGs and NHS Trusts
    - To further discuss the contracting models for community optometry
    - To agree the extent to which CCGs can unify their approach to this pricing and service specifications in line with the proposals in this paper and along what timeline

Risks to implementation

33. There are several potential risks associated with moving to the proposed regional pathway. These are as follows:

- In areas where the pathway is not already in place, there is a risk that optometrists will not want to take on the additional work for the proposed regional fee.
- The predicted financial impact is perceived by commissioners as being too significant leading to an unwillingness to adopt the pathway. It should be noted that while the overall cost to the system is likely to increase, the benefit of additional ophthalmology capacity must be measured.
- NHS Trusts may wish to continue to carry out the cataract follow up work rather than release this capacity for more complex work
- IT solutions to enable results to flow back to Trusts and alerts to identify that patient wishes to proceed to 2nd eye may take time to implement and may require costs that have not yet been identified – we hope that by doing this across the ICS there will be economies of scale

34. There are also risks associated with <u>not</u> moving the follow up work to community providers:

- It may not be possible to create sufficient further NHS Trust capacity for the growing chronic eye care patients without incurring step costs in staffing, accommodation or equipment.
- Patients may prefer the independent sector pathway of care closer to home and fewer separate appointments, driving further activity to the independent sector at full cost

Implementation Plans

35. The more rapidly that the optometrist follow up is implemented, the sooner the HES will free up clinic capacity for other patients who require secondary care. We would anticipate, therefore, that given the significant constraints on follow-up capacity most places will wish to implement this component of the pathway as soon as possible. Some NHS providers have noted specific concerns about the ability to create a one stop shop approach to first hospital appointments. We would hope that systems can move as quickly as possible on this because of the improved patient experience and reduction in duplication it will enable. We do not believe that any service should take more than 3 years to implement this pathway in full. The timeline on this may depend on agreement on contract and procurement options and any delays in identifying approach technology solutions for communications between optometrists and Trusts around clinical outcomes and readiness for 2nd eye.

36. Additional resources are also being developed collaboratively to support implementation:

- A standardised referral form has been developed to address variation in the information sent to departments. This has been developed and agreed with clinicians across all places.
- A single shared consent form has been drafted.
- Single shared patient information.
- A single shared policy to determine which patients should be classed as ‘complex’ will be produced to support implementation of the policy.
- A standard set of expectations for primary care optometrists.

Summary and Recommendations

37. The WY&H Joint Committee of Clinical Commissioning Groups is recommended to:

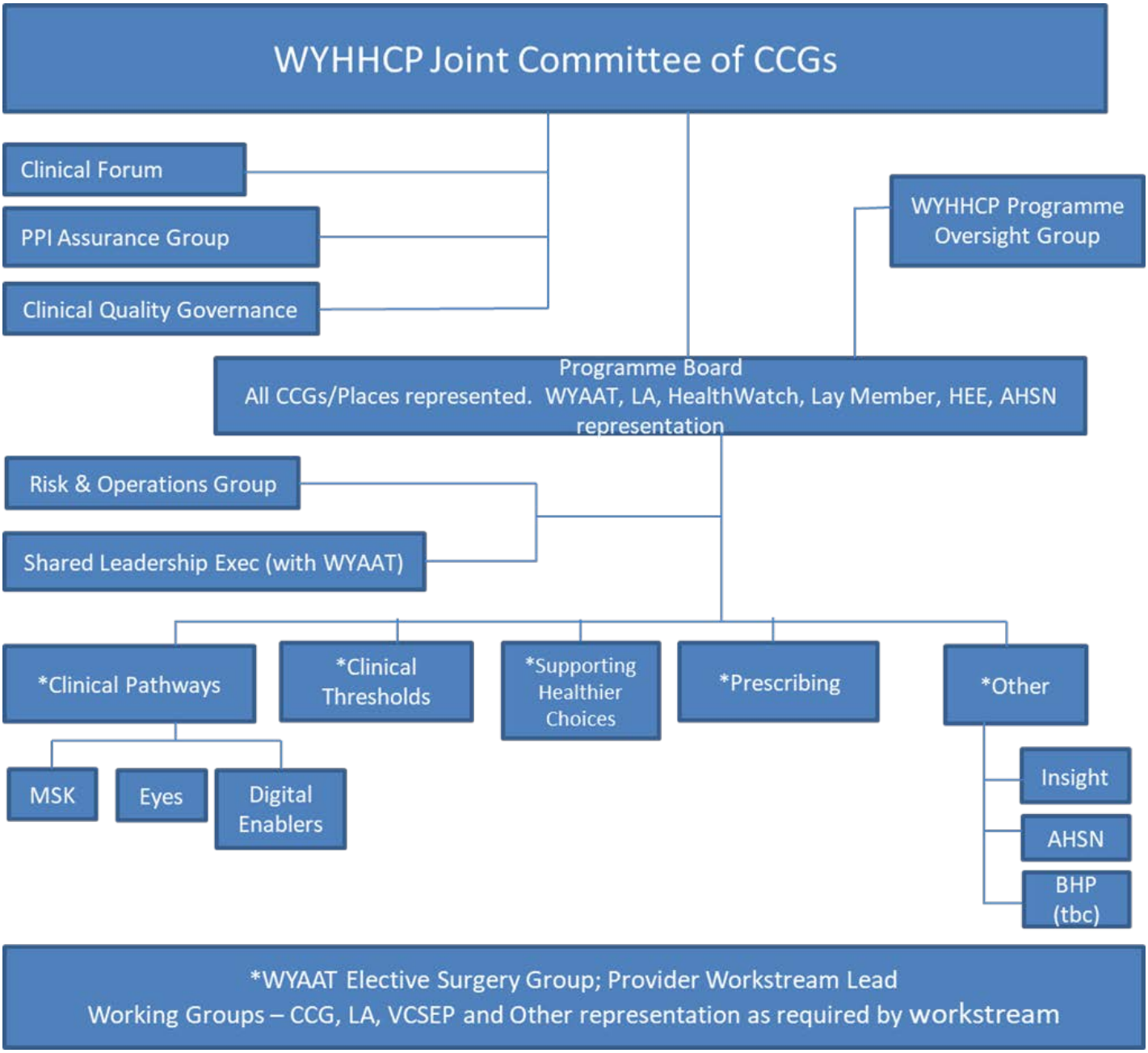
1. Agree the WY&H cataract surgery pathway and policy

2. Approve the principle of using primary care/community optometrists to carry out shared decision-making and post-operative checks for routine patients in order to release capacity within Hospital Eye Services (HES) and free up ophthalmologists to be able to see higher risk patients with potentially sight-threatening conditions.

List of Appendices:

1. **Governance Structure**
2. **Mapping and Gapping of the proposed pathway and the current pathway and policies across the nine WY&H CCG's**
3. **Table A: NOD audit data on pre-op visual acuity by Trust and Graph A: NHS v Independent Sector NHS Funded Cataract Surgeries 2009-2019**
4. **WY&H Cataract Surgery Pathway**
5. **WY&H Cataract Surgery Policy**
6. **WY&H QEIA Cataract Surgery**
7. **WY&H Cataract Surgery Data**
8. **Eye care services - background information**

Appendix 1: Governance Structure



Appendix 2:

The current arrangements for each CCG are as follows:

	Pathway/Policy specification	Leeds	Wakefield	North Kirklees	Calderdale, Greater Huddersfield	Bradford and Airedale	Harrogate
1	**Cataract Commissioning Policy**	Toric lens policy only	Yes, although in practice this allows for significant numbers of exceptions to the VA score	Yes, although in practice this allows for significant levels of exceptions to the VA scores	No policy	No policy	Yes, although in practice this allows for significant levels of exceptions to the VA scores
2	**Policy Inclusions** first eye or second eye of an adult who has disabling visual symptoms attributable to cataract. A person's total circumstances should be considered, not just visual acuity in isolation.	No change to threshold	Cataract surgery should not normally be offered to patients with a visual acuity better than 6/12 in the better eye but with significant exceptions allowed (April 2017 We know that in practice the Visual acuity data for Mid Yorkshire is not significantly different from other Trusts without such a policy in place	Cataract surgery should not normally be offered to patients with a visual acuity better than 6/12 in the better eye but with significant exceptions allowed (April 2017We know that in practice the Visual acuity data for Mid Yorkshire is not significantly different from other Trusts	No change to threshold	No change to threshold	Harrogate's policy specifies that Cataract surgery should not normally be offered to patients with a visual acuity better than 6/12 but with allowances for exceptions? The VA scores for HDFT are slightly lower than for other providers

N.B. While the comparison in row 2 above suggests that there are different policies in place across the ICS which reference thresholds on visual acuity, the National Ophthalmology Database audit data (NOD) from 1st September 2016 to 31st August 2017 (Table A, Appendix 3) demonstrates that in practice there are significant proportions of patients where this is not the case. Given NICE does NOT recommend using visual acuity, we have chosen not to do so.

It is not anticipated that this decision will materially impact on volumes as the NOD data evidences that even where there is no threshold in place, most patients are below the level of visual acuity in current policies. The main driver of volumes is capacity, not demand. Growth in independent sector provision over recent years has substantially driven increases in activity despite no changes in thresholds. Graph A, Appendix 3 demonstrates the trend of cataract surgery activity over recent years.

3	**Pre-cataract assessment scheme and shared decision making** (to reduce unnecessary cataract referrals)	Optometrists paid a fee of £30 for referrals, choice offers and post-operative data entry but does not specify Shared Decision Making	Optometrists paid a fee of £41 for pre-cataract assessment (referral) *Providers that refer to SpaMedica are paid £43 for a Post Cataract Assessment. The Enhanced Optical Service (EOS) provider then claims £12.30 from the CCG for the Pre-Cataract Assessment*	Optometrists paid a fee of £47.24 for pre-cataract assessment	Optometrists paid a fee of £47.24 for pre-cataract assessment	Optometrists paid a fee of £30 for pre-cataract assessment (referral). This includes referral refinement to ensure patient is fit for surgery.	Optometrists paid a fee of £12 for referrals made using our referral form/criteria Would require enhanced payments for a more robust scheme
	Biometry and surgical assessment undertaken on the same day.	No policy in place although this is the aim and, in most cases, does occur. Some practical operational barriers will make immediate implementation in all cases challenging although this is already the aspiration	Yes, done on same day	Yes, done on same day	Yes, done on same day wherever possible. One-stop clinic to commence in December 2020	This is the aspiration however currently this does not occur most of the time. Having this specified in a regional pathway should help the trust to move closer to this way of working.	No policy in place. Some practical operational barriers will make immediate implementation challenging
	Consent for 2nd eye at first surgical assessment	Each eye consented separately. Consent for 1st eye and discuss 2nd eye but not consented at that stage.	Each eye consented separately. Consent for 1st eye at 1st assessment. If the 2nd eye is deemed necessary at post-op the patient is seen in a nurse-led cataract	Each eye consented separately. Consent for 1st eye at 1st assessment. If the 2nd eye is deemed necessary at post-op the patient is seen in a nurse-led cataract	Each eye consented separately. Consent for 1st eye initially then review. Decide on 2nd eye and gain consent at post-op appt.	Each eye consented separately. Consent for 1st eye initially then review. Decide on 2nd eye and gain consent at post-op appt.	Consent for the second eye is done at post op visit with advanced ophthalmic practitioner.

			clinic where 2nd eye consent is obtained.	clinic where 2nd eye consent is obtained.			
	Post-op scheme	Post- op follow-up for NHS Trust patients is delivered by Trusts (LTHT does not currently follow up routine 2nd eyes) No CCG funded follow-ups by community optometry *Independent sector providers already use optometrists and pay them directly for these follow ups from the funding for follow ups from the CCG* *Would require funding for additional community follow ups*	Post-op scheme in place. Optometrists claim a fee of £15.38 for follow-up *Providers that refer to SpaMedica are paid £43 for a Post Cataract Assessment. The Enhanced Optical Service (EOS) provider then claims £12.30 from the CCG for the Pre-Cataract Assessment* Might require additional funding or change in tariff structures if we agree we need a consistent tariff	Post-op scheme in place. Optometrists claim a fee of £20.54 for follow-up *Independent sector providers also use optometrists.* Might require a shift in tariff structure or additional funding if we agree we need a consistent tariff	Post-op scheme in place. Optometrists claim a fee of £20.54 for follow-up *Independent sector providers also use optometrists.* Might require a shift in tariff structure or additional funding if we agree we need a consistent tariff	No post op scheme in place for NHS Trust providers NHS Trusts are following up first eyes internally although clinicians have indicated that they intend to move towards using optometrists for 2nd eye follow-up. *Independent sector providers do use optometrists and pay them directly for these follow ups from the funding from the CCG.* Would require funding for additional community follow ups	No post op scheme in place for NHS Trust providers *Independent sector providers do use optometrists and pay them directly for these follow ups from the funding from the CCG* Would require funding for additional community follow ups

Appendix 3

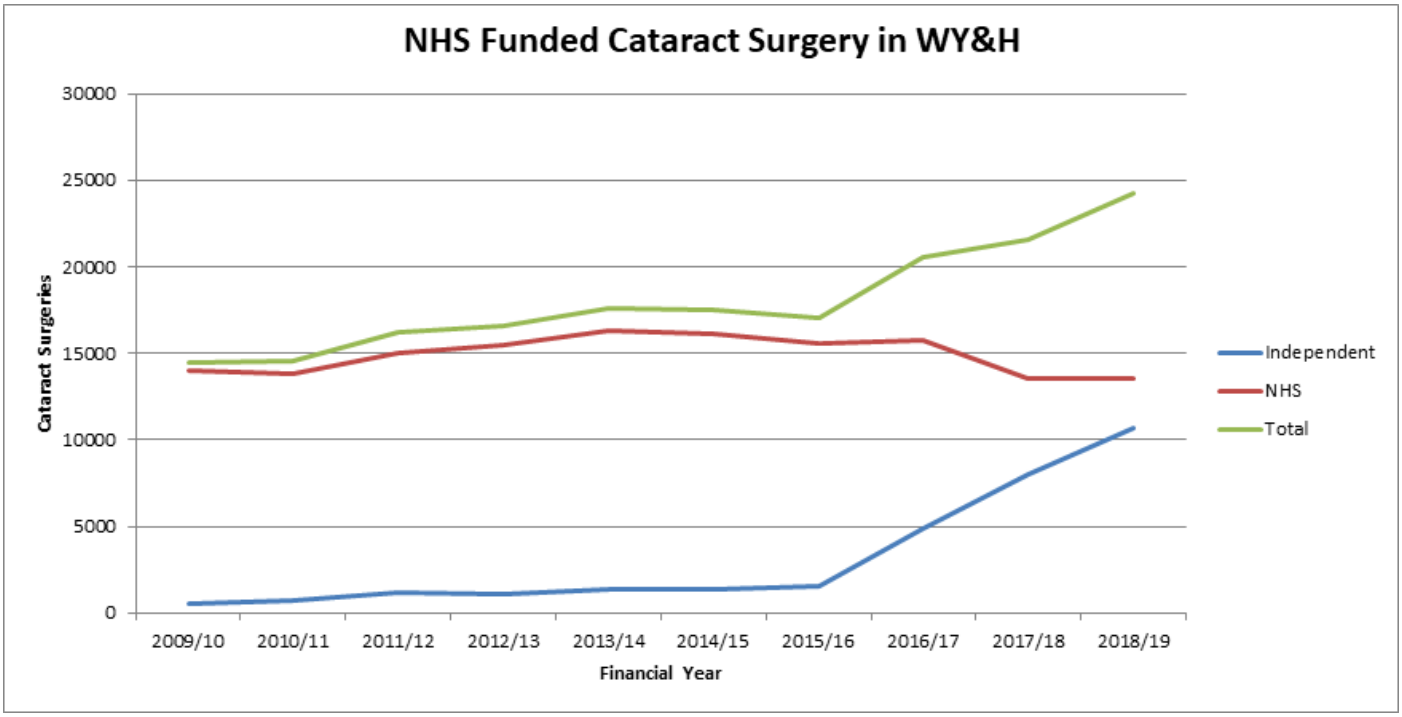
Table A – NOD audit data on pre-op visual acuity by Trust

National Ophthalmology Database Audit - West Yorkshire & Harrogate Summary — NHS Funded Cataract Surgery: 01 September 2017 to 31 August 2018

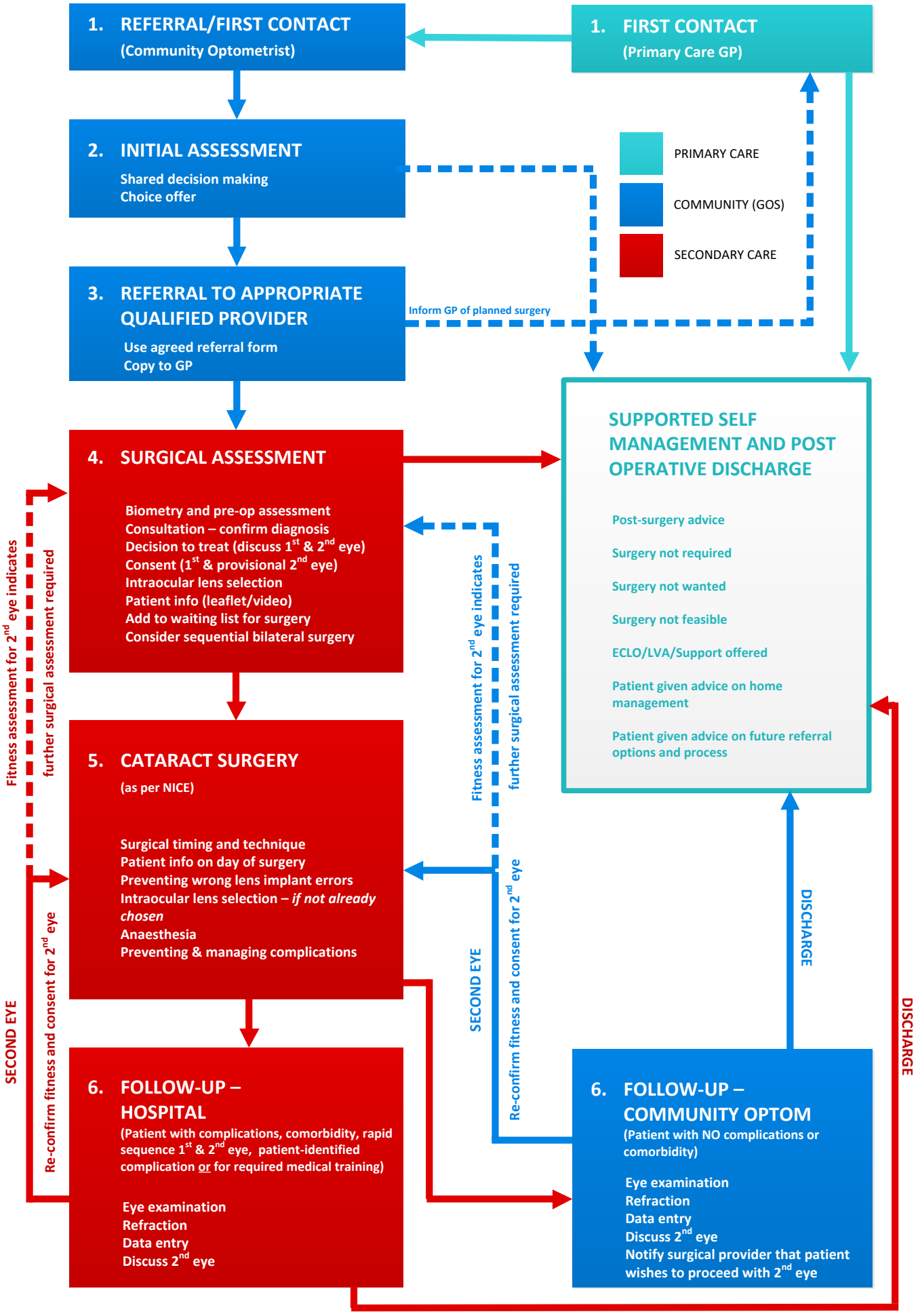
Pre- Operation Visual Acuity Assessment

TrustName	PercentageOpsWithPreOpVA	Q1PreOperativeVA	MedianPreOperativeVA	Q3PreOperativeVA
Bradford Teaching Hospitals NHS Foundation Trust	94.5	0.3	0.5	0.8
Calderdale and Huddersfield NHS Foundation Trust	97.1	0.3	0.5	0.8
Harrogate and District NHS Foundation Trust	95.9	0.2	0.3	0.6
Leeds Teaching Hospitals NHS Trust	97.2	0.3	0.5	0.8
Mid Yorkshire Hospitals NHS Trust	98.5	0.38	0.5	0.8

Graph A – NHS vs Independent Sector NHS Funded Cataract Surgeries 2009-2019



Appendix 4: WY&H Cataract Surgery Pathway



West Yorkshire and Harrogate Health and Care Partnership					
Policy	Cataract Surgery in adults			**X CCG Ref**	(as per CCG policy library)
First Issue Date		**Current version:**	1.1	**Last reviewed:**	
Review date		**Contact**			
Clinical Reviewer		**Approved by**			

Policy exclusions

Children under 19

Policy inclusion criteria

Cataract surgery should be considered for the first eye or second eye of an adult who has disabling visual symptoms attributable to cataract. A person's total circumstances should be considered, not just visual acuity in isolation. The use of visual acuity in isolation can underestimate visual disability because it does not take account of symptoms such as glare or reduced contrast sensitivity. It may also not always be possible to measure visual acuity accurately, for example, in patients with learning disability or cognitive impairment for other reasons.

Significant improvements in visual function may occur after cataract surgery, even where preoperative visual acuity is 6/6 or better. However, the risk of worse visual acuity after surgery also increases where the preoperative visual acuity is very good, so surgery should be considered at this level of visual acuity only where the patient is experiencing significant symptoms attributable to their cataract.

Consideration of visual disability includes the impacts of the cataract on activities of daily living including driving, and any history of falls. The assessment needs to assess whether a cataract is present and the extent to which the symptoms of visual disability are caused by the cataract rather than some other eye condition.

There may be some circumstances where it is still appropriate to operate in the absence of a significant visual disability. These would include aiding the management of other eye conditions, for instance to facilitate surveillance or treatment of diabetic retinopathy or angle closure glaucoma or occupational legal requirements such as driving.

The risks of operative complications and a poor visual outcome can vary by 10-fold or more depending on the presence of a range of common ocular and systemic risk factors. These risks therefore need to be discussed with the patient by an appropriately qualified and skilled member of the cataract team responsible for the patient's operative care who can help them assess the risks and benefits of the surgery.

To ensure a consistent approach to service delivery across our population and a level playing field between providers, the CCGs within the West Yorkshire and Harrogate ICS only commission cataract surgery from providers who are compliant with their current service specifications for cataract surgery.

Toric Lenses

Where there is 3D or more pre-operative corneal astigmatism, the management of that

astigmatism should be considered at the time of the cataract surgery. Where toric lenses would assist in this management, they should be used instead of a standard lens.

Multifocal intraocular lens
Multifocal intraocular lenses are designed to provide good near and distance vision and to minimise the need for reading glasses. They can be associated with adverse symptoms, have a significant cost premium and are not recommended by NICE. The West Yorkshire and Harrogate ICS does NOT routinely commission the insertion of multifocal intraocular lenses.

Blue light filtering intraocular lenses
Blue light filtering intraocular lenses have been hypothesised to reduce the incidence or progression of AMD in people after cataract surgery. To date, NICE review has concluded that there is a lack of evidence of their efficacy. The West Yorkshire and Harrogate ICS does NOT mandate the insertion of such intraocular lenses

Laser assisted cataract surgery
Lasers can automate some of the steps of cataract surgery with claims of potentially greater precision and consistency than can be achieved by a manual technique. NICE recommends 'Only use femtosecond laser-assisted cataract surgery as part of a randomised controlled trial that includes collection of resource-use data, comparing femtosecond laser-assisted cataract surgery with ultrasound phacoemulsification'. In line with this recommendation the West Yorkshire and Harrogate ICS does NOT routinely commission laser assisted cataract surgery.

Summary of evidence / Rationale	***Cataract treatment and prevalence*** Cataract is the presence of visually impairing opacity in the eye's natural lens, which may occur in one or both eyes. Symptoms include blurred vision, glare (particularly in bright daylight or night time vision) and refractive change resulting in more frequent updates in spectacle prescription. Risk factors for cataract include increasing age, diabetes mellitus, corticosteroid use, female gender, socio-economic status, ethnicity, smoking and alcohol. Cataract is the leading cause of blindness in the world. Cataracts may be classified into several types based on appearance. These include nuclear, cortical, posterior subcapsular and mixed. Nuclear cataracts result in progressive opacification of the central lens, typically causing impaired distance vision. Cortical and posterior subcapsular cataracts typically cause disabling glare, even before visual acuity is markedly impaired and can progress rapidly. Cataract surgery, whereby the natural lens is replaced by a clear intraocular lens implant, is currently the only effective treatment for cataract. Phacoemulsification (removal of the cataractous lens using ultrasound) is the standard surgical technique and is used in over 99.7% of cataract operations in the NHS.) There are no recent estimates of expected cataract surgery rates based on need. However, The Way Forward Cataract Report (2017) provided a crude estimate of demand, that average expected rates of adult cataract surgery should be approximately 7.30 per 1,000 population and anticipated '…that the number of cataract operations

	we are expected to deliver to increase by 50% from 2015 to 2023' . Historical data from the North London Eye Study in 1998 estimated that 30% of people 65 years or older had visually impairing cataract in one or both eyes. An additional 10% of people in this age group had already had cataract surgery. Some populations have a much higher prevalence of cataract. For instance, 77% of British people originating from the Indian Subcontinent age 42 years old or more have cataract. Diabetes is a risk factor for the development of cataract and cataract is the most common reason for failure to obtain a gradable photographic image for diabetic retinopathy screening. ***Benefits of cataract surgery*** Cataract surgery improves visual function and the benefits are lifelong unless negated by other eye disease. Cataract surgery is associated with improvements in quality of life, visual acuity, contrast sensitivity, depth perception, activity, anxiety, depression, visual disability, confidence, disability and reduction in falls. Health economic modelling has shown cataract surgery is highly cost effective. NICE guidance confirms it is not cost effective to delay cataract surgery in people with symptomatic cataracts until a visual acuity threshold is met. Approximately 40% patients undergo cataract surgery on both eyes. A systematic review funded by the National Institute for Health Research concluded that second eye cataract surgery was associated with a clinically meaningful improvement in stereopsis (depth perception). A detailed analysis of patients who were unhappy with their vision after their first cataract operation found that anisometropia and cataract in the fellow eye accounted for more than a third of such cases. NICE has concluded second eye cataract surgery is highly cost effective and should be offered using the same criteria as for first eye surgery. If a patient has cataract in both eyes, surgery on both eyes may be performed at the same admission (immediate sequential bilateral cataract surgery ISBCS) or over two admissions. A Randomised Control Trial comparing both techniques found surgical outcomes and patient satisfaction were similar in both groups and cost analysis suggested significant savings for cases that underwent surgery at the same sitting after accounting for travel and paid home-care costs. NICE recommends that ISBCS should be considered for people who are at low risk of operative and postoperative complications. However, it is important that the potential benefits and harms of ISBCS are fully discussed with patients and their carers pre-operatively. These include potential immediate visual improvement in both eyes but that there would not be the option for IOL power selection for the second eye based on the outcome of the first. Although it is extremely rare, there is also the risk of a complication in both eyes associated with the same theatre sitting. Where a patient requires a general anaesthetic for their surgery, ISBCS should be actively considered because of the enhanced risks of a GA.
References	Royal College of Ophthalmologists Clinical Council for eye health commissioning (2018), Commissioning Guide: Adult Cataract Surgery

https://www.rcophth.ac.uk/wp-content/uploads/2018/02/Cataract-Commissioning-Guide-January-2018.pdf

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Healthcare Improvement Scotland (2014) *'Is it clinically and cost effective to perform second-eye cataract surgery in the absence of other ocular co-morbidities in patients who have already had the first-eye surgery?'* [Internet]. 2012 [cited 2018/PROF/368 17 2014 Feb 22]. Available from: http://www.healthcareimprovementscotland.org/our_work/technol

West Yorkshire and Harrogate Health and Care Partnership
Quality and Equality Impact Assessment

This summary sheet provides an overview of the staff involved, proposed change and a summary of the findings. This assessment consists of five domains: Patient Experience, Patient Safety, Effectiveness, Equality and Workforce.

Title of Scheme:	Cataract Surgery Pathway		
Project Lead:	Helen Lewis		
Clinical Lead:	Keith Davey	Programme Lead:	Catherine Thompson
Senior Responsible Officer:	Matt Walsh	Date:	05-Sep-19

Proposed change:

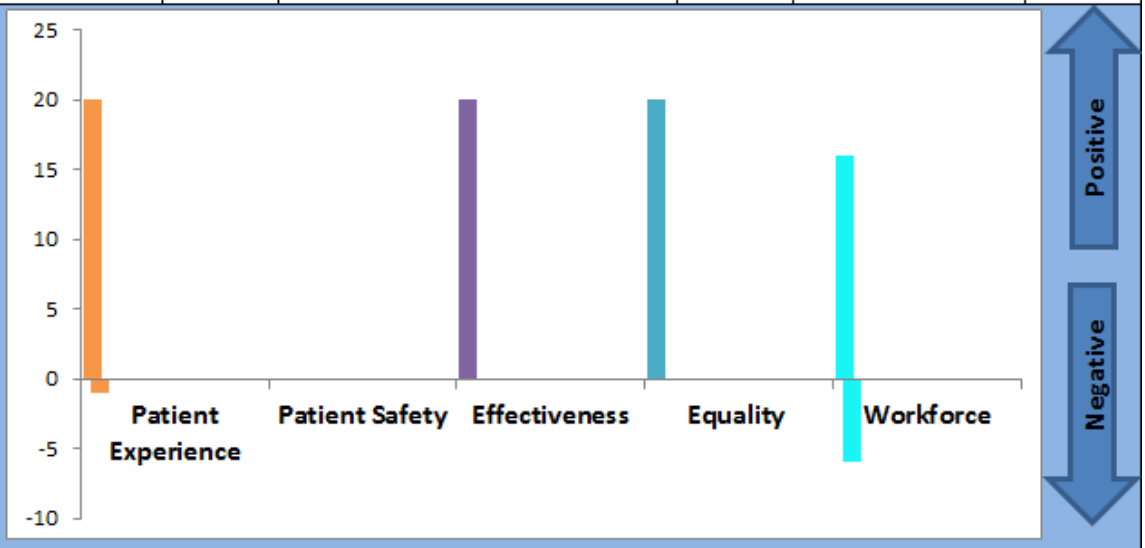
Streamlining referrals into Secondary Care from Optometrists without the need to go via the GP. One stop shop for all pre-surgical assessments to include pre-assessment and consent for surgery for 1st and 2nd eyes if required. Post surgicial follow-up appointments for non-complex patients will be undertaken by local community optometrists.

Which areas are impacted?

Airedale, Wharfedale and Craven CCG	☑	Calderdale CCG	☑	Leeds CCG	☑
Bradford City CCG	☑	Greater Huddersfield CCG	☑	North Kirklees CCG	☑
Bradford Districts CCG	☑	Harrogate and Rural Districts CCG	☑	Wakefield CCG	☑

Summary of Impacts

Patient Experience
Patient Safety
Effectiveness
Equality
Workforce



Summary of findings:

The introduction of this pathway will have a positive impact on patient experience, effectiveness and equality.
Patients will benefit from greater choice, more timely treatment, reduced number of visits, treatment closer to home and a more personalised service at initial diagnosis and follow-up.
Enhanced focus on early shared decision making should improve clinical outcomes by ensuring that only those suitable and willing to have surgery are referred. More efficient use of resource availability/capacity across the system will free up appointments in HES thereby enabling patients to be seen in the most appropriate setting depending on their clinical need.
The impact is largely positive on the workforce however it is anticipated that there may be some unease for hospital staff who experience a change in their role.

Summary of Next Steps:

Communications with providers including community optoms (via LOC) to prepare the workforce for the changes. Community optoms will need to achieve accredited status in cataract management and
staff within trusts will need to prepare for the change in working practices and agree how to utilise the capacity created through the reduction in activity for post-op checks.
Secondary care staff will be assigned to support other pressurised areas and given the opportunity for training and development within their specialism.
Friends and family test. Patient satisfaction questionnaires.

The data in these tables covers one financial year (2018/2019)

AIREDALE CCG

Sum of Superspells	Column Labels
Row Labels	NHS Airedale Wharfedale and Craven CCG
RAMSAY HEALTHCARE UK OPERATIONS LIMITED	676
AIREDALE NHS FOUNDATION TRUST	656
BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST	282
OPTEGRA UK	100
LEEDS TEACHING HOSPITALS NHS TRUST	70
BMI HEALTHCARE	45
SPAMEDICA	34
NEW MEDICAL SYSTEMS LIMITED	8
HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST	0
EAST LANCASHIRE HOSPITALS NHS TRUST	0
WYE VALLEY NHS TRUST	0
HARROGATE AND DISTRICT NHS FOUNDATION TRUST	0
SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	0
MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST	0
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	0
EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST	0
YORK TEACHING HOSPITAL NHS FOUNDATION TRUST	0
CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST	0
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	0
TOTAL	**1871**

NHS Bradford City CCG

Sum of Superspells	Column Labels
Row Labels	NHS Bradford City CCG
BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST	396
RAMSAY HEALTHCARE UK OPERATIONS LIMITED	209
OPTEGRA UK	62
SPAMEDICA	22
MID YORKSHIRE HOSPITALS NHS TRUST	0
CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST	0
AIREDALE NHS FOUNDATION TRUST	0
LEEDS TEACHING HOSPITALS NHS TRUST	0
TOTAL	**689**

NHS Bradford Districts CCG

Sum of Superspells	Column Labels
Row Labels	NHS Bradford Districts CCG
RAMSAY HEALTHCARE UK OPERATIONS LIMITED	1435
BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST	900
OPTEGRA UK	540
SPAMEDICA	190
CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST	99
AIREDALE NHS FOUNDATION TRUST	34
MID YORKSHIRE HOSPITALS NHS TRUST	16
LEEDS TEACHING HOSPITALS NHS TRUST	13
MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST	0
NUFFIELD HEALTH	0
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	0
TOTAL	**3227**

NHS Calderdale CCG

Sum of Superspells	Column Labels
Row Labels	NHS Calderdale CCG
CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST	1076
SPAMEDICA	918
RAMSAY HEALTHCARE UK OPERATIONS LIMITED	87
OPTEGRA UK	12
LEEDS TEACHING HOSPITALS NHS TRUST	7
BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST	6
PENNINE ACUTE HOSPITALS NHS TRUST	0
BMI HEALTHCARE	0
BARNSLEY HOSPITAL NHS FOUNDATION TRUST	0
EAST LANCASHIRE HOSPITALS NHS TRUST	0
MID YORKSHIRE HOSPITALS NHS TRUST	0
NEW MEDICAL SYSTEMS LIMITED	0
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	0
TOTAL	**2106**

NHS Greater Huddersfield CCG

Sum of Superspells	Column Labels
Row Labels	NHS Greater Huddersfield CCG
CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST	1174
SPAMEDICA	923
BARNSLEY HOSPITAL NHS FOUNDATION TRUST	72
LEEDS TEACHING HOSPITALS NHS TRUST	10
RAMSAY HEALTHCARE UK OPERATIONS LIMITED	7
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	0
OPTEGRA UK	0
MID YORKSHIRE HOSPITALS NHS TRUST	0
ROYAL FREE LONDON NHS FOUNDATION TRUST	0
STOCKPORT NHS FOUNDATION TRUST	0
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	0
BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST	0
NEW MEDICAL SYSTEMS LIMITED	0
MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST	0
TOTAL	**2186**

NHS Harrogate and Rural District CCG

Sum of Superspells	Column Labels
Row Labels	NHS Harrogate and Rural District CCG
HARROGATE AND DISTRICT NHS FOUNDATION TRUST	1135
YORK TEACHING HOSPITAL NHS FOUNDATION TRUST	101
NEW MEDICAL SYSTEMS LIMITED	100
SPAMEDICA	67
OPTEGRA UK	25
LEEDS TEACHING HOSPITALS NHS TRUST	23
RAMSAY HEALTHCARE UK OPERATIONS LIMITED	20
SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	15
AIREDALE NHS FOUNDATION TRUST	0
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	0
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	0
BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST	0
BMI HEALTHCARE	0
NUFFIELD HEALTH	0
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	0
TOTAL	**1486**

NHS North Kirklees CCG

Sum of Superspells	Column Labels
Row Labels	NHS North Kirklees CCG
SPAMEDICA	1110
MID YORKSHIRE HOSPITALS NHS TRUST	768
LEEDS TEACHING HOSPITALS NHS TRUST	83
CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST	30
OPTEGRA UK	14
RAMSAY HEALTHCARE UK OPERATIONS LIMITED	6
BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST	6
ISLE OF WIGHT NHS TRUST	0
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	0
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	0
YORK TEACHING HOSPITAL NHS FOUNDATION TRUST	0
BARNSLEY HOSPITAL NHS FOUNDATION TRUST	0
NEW MEDICAL SYSTEMS LIMITED	0
TOTAL	**2017**

NHS Leeds CCG

Sum of Superspells	Column Labels
Row Labels	NHS Leeds CCG
LEEDS TEACHING HOSPITALS NHS TRUST	5171
SPAMEDICA	1207
OPTEGRA UK	616
NEW MEDICAL SYSTEMS LIMITED	447
HARROGATE AND DISTRICT NHS FOUNDATION TRUST	258
RAMSAY HEALTHCARE UK OPERATIONS LIMITED	86
MID YORKSHIRE HOSPITALS NHS TRUST	78
YORK TEACHING HOSPITAL NHS FOUNDATION TRUST	24
BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST	18
CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST	0
HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST	0
BMI HEALTHCARE	0
NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST	0
CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	0
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	0
MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST	0
EAST LANCASHIRE HOSPITALS NHS TRUST	0
BARTS HEALTH NHS TRUST	0
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	0
TOTAL	**7905**

NHS Wakefield CCG

Sum of Superspells	Column Labels
Row Labels	NHS Wakefield CCG
SPAMEDICA	1578
MID YORKSHIRE HOSPITALS NHS TRUST	1484
PHOENIX HEALTH SOLUTIONS LIMITED HQ	213
LEEDS TEACHING HOSPITALS NHS TRUST	169
BARNSLEY HOSPITAL NHS FOUNDATION TRUST	40
DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST	8
CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST	5
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	4
YORK TEACHING HOSPITAL NHS FOUNDATION TRUST	4
STOCKPORT NHS FOUNDATION TRUST	0
BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST	0
THE ROTHERHAM NHS FOUNDATION TRUST	0
OPTEGRA UK	0
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	0
NEW MEDICAL SYSTEMS LIMITED	0
TOTAL	**3505**

Appendix 8

INFORMATION	**Eye Care Services: Background Information**
Joint Committee sponsor:	Matt Walsh
Clinical Lead:	James Thomas
Author:	Catherine Thompson
Presenter:	N/A

Purpose of report: (why is this being brought to the Committee?)			
Decision		Comment	✓
Assurance		Information	✓

Executive summary

The Eye Care Programme of the Elective Care and Standardisation of Commissioning Policies Programme commenced in 2018. This paper provides background information about the challenges faced in eye care services due to increasing demand and workforce shortages and provides some context for the pathway specific pieces of work which will be presented at Joint Committee during 2020. The first of these, cataracts, is brought to the Joint Committee for consideration in January 2020.

Recommendations and next steps

Joint Committee is asked to note and consider the content of this paper.

Delivering outcomes: describe how the report supports the delivery of STP outcomes (Health and wellbeing, care and quality, finance and efficiency)

Health and Wellbeing: The programme adopts a 'right care, right place, right time' approach to the planning and delivery of planned care services.

Care and Quality: The transformation of eye care services will provide safe and effective services. Optimising the available capacity and creating new capacity will ensure people will be seen and treated in a timely manner, avoiding preventable sight loss. Moving services into the community where it is safe to do so will enable people to receive care closer to home and improve the experience of care.

Finance and Efficiency: Optimising existing 'system' resources such as providing services through community optometry practices avoids additional health care spend on new estate and equipment on NHS sites. Optimising the use of the wider clinical workforce may result in a lower 'cost per patient' although overall spend on eye care services will increase due to rising demand.

Impact assessment (please provide a brief description, or refer to the main body of the report)

Clinical outcomes:	See para 1 – 7
Public involvement:	N/A
Finance:	See para 2, 5, 10
Risk:	See para 4, 11

Conflicts of interest:	Dr James Thomas: GP Chair of NHS Airedale, Wharfedale and Craven CCG; partner of Modality GP partnership; Dr Kate Thomas (spouse) is also a partner of Modality GP partnership. Dr Matt Walsh: Chief Officer of NHS Calderdale CCG Catherine Thompson: none declared

West Yorkshire and Harrogate Health and Care Partnership Elective Care and Standardisation of Commissioning Policies Programme

1. In 2017 Ophthalmology was identified by NHS England as a challenged speciality for the West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP). In early 2018 the Joint Committee of CCGs agreed that the Elective Care and Standardisation of Commissioning Policies programme should address ophthalmology services as part of the programme of transformation. Ophthalmology remains a specialty with one of the largest number of people waiting for assessment or treatment, second only to Trauma and Orthopaedics on a national basis. Data for WY&H from July 2019 suggests that over 1400 people missed the 18 week RTT target in Ophthalmology, around 800 fewer than in July 2017. Nationally the achievement of the 18 week RTT in this specialty is 85.4% (a decrease of 3.9% since July 2017) however the West Yorkshire and Harrogate HCP average stands at 91.4% (commissioner) / 91.2% (provider). There is variation across the footprint ranging from 81.1% - 95.9% (provider) or 81% - 95% (commissioner).

2. Demand for eye care services has increased over recent years and continues to rise. More than 2 million people have reduced vision in the UK and it is estimated that this figure will double by 2050. The incidence of conditions causing sight loss increases with age and the aging UK population demographic is driving the increase in demand at a greater rate than for other services. Maintaining adequate service provision which prevents avoidable sight loss for the population will require increased investment for growth in eye services, both in hospital and community eye services. Public Health England recently completed some analysis for the WY&H HCP to help quantify the anticipated growth in demand for the most common sight-threatening conditions and have provided estimates of likely patient numbers by 2030. The growth in demand is around 25% over the next decade, significantly outstripping the overall expected population growth of 4% for WY&H over the same period. An outline of the data is presented in appendix 1.

3. The direct and indirect costs of blindness in the UK are £8 billion per annum. Nearly 9 million people are treated in hospital eye services annually accounting for about 10% of all patients attending a hospital out-patient department. There are nearly 400,000 cataract operations are performed annually in the NHS and around 25,000 in WY&H.

4. More than 10% of over 65s have some form of visual impairment. People with vision impairment are twice as likely to have falls and sight loss is associated with increased levels of depression and anxiety. Loss of vision is recognised to mean earlier dependency on care homes and care support. Failing to address the

current and future demand for eye care services will increase the indirect costs of visual impairment and blindness.

5. Because of this substantial growth in demand, the financial plans for each place within WY&H will need to make provision for differential investment in eye care services rather than being able to invest equally across all pathways. Diseases such as age related macular degeneration (AMD), cataract and glaucoma are specific diseases of aging where there is ongoing treatment and monitoring that is delivered in hospital / non GP settings and these services will need investment to generate the additional capacity required. For example, a person receiving treatment for AMD may need 8 out-patient appointments / injections a year to prevent further sight loss. Other diseases which increase in prevalence with age e.g. heart failure would frequently be fully managed in primary care and therefore the same scale of additional investment would not be required.

6. Risk factors for sight loss in adults include obesity, smoking, high blood pressure, diabetes, stroke and dementia. Many of these are increasing in prevalence in the population nationally. Incidence of some of these risk factors e.g. smoking, obesity is higher in the more deprived populations which already experience poorer health outcomes and have the added risk of increased risk of preventable sight loss.

7. Risk factors for sight loss in children include premature birth, low birthweight and maternal smoking, drug and alcohol use during pregnancy. Children with learning disabilities are also more likely to have a visual impairment. Children's eye screening at 4-5 years is commissioned by the local authority and practice varies across England. During the past year we have improved to a position where children's eye screening is delivered in all six of the local authority areas within the WY&H HCP.

8. Workforce challenges exist nationally in the numbers of Ophthalmologists in post and in training. The Getting It Right First Time (GIRFT) Ophthalmology report identified that in 2018 there were 1,260 consultant ophthalmologists in England and a further 600 Specialty Doctors, Staff Grades and Associate Specialists. It noted a shortfall of 230 consultants and further shortfalls in numbers across the entire ophthalmology team in Hospital Eye Services. Over three quarters of units in England have unfilled consultant posts; while most use locums to cover, a quarter of new posts are left vacant. Most ophthalmology departments report difficulty in recruiting to consultant posts, and at specialty/staff grade level due to a lack of suitably trained candidates for such posts. These workforce shortages at senior level have been nationally recognised for some time and are becoming a greater problem. The GIRFT report makes recommendations on increasing capacity within the eye care workforce by making better use of available staff

within the Hospital Eye Services and utilising the skills and services of community eye care professionals such as optometrists.

9. At the outset of the programme the WY&H Local Eye Health Network was confident that the wider eye care multidisciplinary workforce is available to increase capacity in WY&H, but needed to be asked to work differently. Through the LEHN the programme has worked closely with Local Optical Committee chairs and members of the eye multidisciplinary team to understand how and where the workforce could be deployed differently to optimise capacity, and have collaborated to establish training programmes and determine standards for advanced practice. We are also working with Health Education England locally to understand the make-up of the current eye care workforce in WY&H and establish plans for workforce development for sustainable services in the future.

10. The ambition of this programme is to deliver improvements in care experience and clinical outcome, whilst delivering system-wide efficiencies through the 'left shift' of services in to primary and community settings where clinically appropriate and viable. The high-level pathway diagram, which was reviewed and agreed by the Joint Committee of CCGs in March 2018 is presented in appendix 2. The full paper is available at https://www.wyhpartnership.co.uk/application/files/4515/7780/5802/46_18_WYHJC_Elective_Care-SCP.pdf . Delivery of this transformation will deliver safe, effective and sustainable services for the future.

11. The Royal College of Ophthalmologists 'The Way Forward' publication from 2017, THE GIRFT Ophthalmology report from 2019 and the NHS England Elective Care Transformation Programme all share common principles which underpin the programme vision for the future of eye care services in WY&H. To:
    - Optimise the capacity which already exists in the WY&H 'system' before investing in the development of new capacity be that workforce, equipment or estate / physical space.
    - Improve referral quality including shared decision making so that fewer patients reach hospital who do not require to be there, reducing false positive, unnecessary referrals and retaining simple conditions in the community
    - Maximise the use of consultant time and expertise with the backing of an effective medical and non-medical multidisciplinary team of eye healthcare professionals
    - Identify optimum flow through hospital clinics, treatment rooms and operating theatres to increase numbers of patients being treated, reduce numbers of review appointments and improve patient experience
    - Develop integrated patient pathways across primary, community and secondary care, using risk stratification of patients, discharge policies and

shared care protocols, enabling more patient care to be delivered through community services and releasing capacity in hospital eye services.
- Establish failsafe mechanisms to prevent people being delayed or lost to follow up, resulting in avoidable sight loss.
- Use technology where available to facilitate the delivery of these ambitions.
- Where possible reduce ‘cost per patient’ by increasing efficiency, reducing waste, optimising the use of the workforce, efficient prescribing and efficient procurement and contracting processes.

12. The programme has five core ‘long term condition’ strands addressing the high-volume areas of eye care need namely cataract, glaucoma, age related macular degeneration, diabetic eye care and children’s eye services. In January 2020 an additional strand will commence to address the urgent and emergency care aspects of eye care services. Each strand of the programme builds on nationally recognised best practice from the Clinical Council for Eye Health Commissioning and will address commissioning policy / thresholds, clinical pathways, clinical quality standards and service specifications, workforce requirements and development needs as appropriate to the service area.

Useful References / Links

https://gettingitrightfirsttime.co.uk/wp-content/uploads/2019/12/OphthalmologyReportGIRFT19P-FINAL.pdf

https://www.rcophth.ac.uk/standards-publications-research/the-way-forward/

https://www.england.nhs.uk/publication/transforming-elective-care-services-ophthalmology/

https://www.college-optometrists.org/the-college/ccehc/safe-systems-assurance-framework-for-eye-health.html

Appendix 1: Predicted growth in demand for common conditions causing sight loss

The most common conditions causing sight loss are Age Related Macular Degeneration (all late stage, and late stage wetwet), cataract, glaucoma and diabetic retinopathy. The tables below show the anticipated increase in people with these conditions who will require treatment by 2030 (based on 2018 population numbers).

Age Related Macular Degeneration (late stage wet, and all late stage)

People living with late stage wet AMD					
Area	Rate per 100,000 population		Estimated number		% change in rate 2018 to 2030
	2018	2030	2018	2030	
England	316	393	176,000	234,000	24.2
Yorkshire and Humber	319	398	17,400	22,600	24.7
West Yorkshire	297	369	7,503	9,757	24.3
Craven	459	621	260	360	35.1
Harrogate	419	568	670	920	35.7
Bradford	260	321	1,390	1,750	23.5
Calderdale	315	408	660	890	29.4
Kirklees	295	379	1,290	1,740	28.3
Leeds	274	315	2,150	2,640	15.0
Wakefield	317	404	1,080	1,450	27.3

People living with late stage AMD					
Area	Rate per 100,000 population		Estimated number		% change in rate 2018 to 2030
	2018	2030	2018	2030	
England	919	1,149	511,000	684,000	25.0
Yorkshire and Humber	927	1,163	50,500	66,000	25.5
West Yorkshire	863	1,077	21,807	28,480	24.8
Craven	1,343	1,810	760	1,050	34.8
Harrogate	1,206	1,654	1,930	2,680	37.2
Bradford	761	941	4,070	5,130	23.6
Calderdale	912	1,187	1,910	2,590	30.2
Kirklees	858	1,101	3,750	5,060	28.4
Leeds	795	920	6,240	7,710	15.7
Wakefield	921	1,180	3,140	4,240	28.1

Cataract

People living with cataract					
Area	Rate per 100,000 population		Estimated number		% change in rate 2018 to 2030
	2018	2030	2018	2030	
England	1,021	1,270	568,000	756,000	24.3
Yorkshire and Humber	1,029	1,286	56,100	73,000	24.9
West Yorkshire	954	1,189	24,109	31,424	24.6
Craven	1,502	2,000	850	1,160	33.2
Harrogate	1,331	1,815	2,130	2,940	36.4
Bradford	834	1,041	4,460	5,680	24.9
Calderdale	1,007	1,311	2,110	2,860	30.1
Kirklees	952	1,212	4,160	5,570	27.4
Leeds	877	1,012	6,880	8,480	15.4
Wakefield	1,030	1,311	3,510	4,710	27.3

Glaucoma

People living with glaucoma					
Area	Rate per 100,000 population		Estimated number		% change in rate 2018 to 2030
	2018	2030	2018	2030	
England	1,016	1,181	565,000	703,000	16.2
Yorkshire and Humber	1,024	1,193	55,800	67,700	16.5
West Yorkshire	954	1,121	24,109	29,639	17.5
Craven	1,396	1,707	790	990	22.3
Harrogate	1,256	1,580	2,010	2,560	25.8
Bradford	873	1,021	4,670	5,570	17.0
Calderdale	1,031	1,233	2,160	2,690	19.5
Kirklees	972	1,143	4,250	5,250	17.5
Leeds	886	973	6,950	8,150	9.8
Wakefield	1,042	1,225	3,550	4,400	17.6

Diabetic Retinopathy

People living with diabetic retinopathy					
Area	Rate per 100,000 population		Estimated number		% change in rate 2018 to 2030
	2018	2030	2018	2030	
England	1,996	1,965	1,110,000	1,170,000	-1.55
Yorkshire and Humber	1,982	1,973	108,000	112,000	-0.43
West Yorkshire	1,960	1,944	49,515	51,405	-0.79
Craven	2,032	2,034	1,150	1,180	0.14
Harrogate	2,006	2,012	3,210	3,260	0.33
Bradford	1,889	1,889	10,100	10,300	0.00
Calderdale	1,981	1,975	4,150	4,310	-0.31
Kirklees	1,960	1,952	8,570	8,970	-0.42
Leeds	1,975	1,933	15,500	16,200	-2.11
Wakefield	1,989	1,982	6,780	7,120	-0.40

Appendix 2: High level eye care pathway