Saving money, losing sight.

RNIB campaign report

November 2013

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Foreword

Sight is precious. Sight is the sense we most fear losing. However, today, patients are going blind unnecessarily because of capacity problems in eye clinics across England. This is the shocking reality as eye clinics are simply too busy to keep up with demand.

Patients are of course incredibly grateful to ophthalmology staff who work long hours, under intense pressure, even putting free time to one side in order to run extra clinics. Many patients describe the service they receive as ‘marvellous’ and ‘ first class’. However, they also express concerns about aspects of their care including cancelled and delayed appointments, over-subscribed clinics, long waits to see a professional at each appointment and rushed consultations.

These problems are frequently caused by lack of capacity in eye clinics - where staff are being asked to do ever more with the same resources. Staff describe their working conditions as “chaotic” and “running from one crisis to another.” Despite raising alarm bells and asking for additional support, their requests are not being heard. Hospital managers are all too often ignoring the capacity crisis, putting patients’ sight at risk and their staff on course for burnout.

This situation is made worse by the fact that commissioners, who plan and fund healthcare services locally, are not always working with accurate information on the eye care needs of their local populations. Department of Health guidance states that commissioners should refer to local authority Joint Strategic Needs Assessments (which analyse the health and wellbeing needs of the local community) when making decisions. However, less than half of these assessments contain information on eye health. This inevitably means eye care service planning is a hit or miss affair. Whether you lose or keep your sight depends simply upon where you live - a terrible “postcode lottery.”

This situation cannot continue - urgent action is needed to stop people losing their sight unnecessarily.

Lesley-Anne Alexander CBE
RNIB Chief Executive

Acknowledgements

We would like to express our gratitude to the commissioners, staff from across the NHS and patients who gave their time to share their personal experiences and insights. My thanks also go to Fazilet Hadi, Steve Winyard, Tara Melton, Victoria Armitage and Rachel Harby at RNIB for their input.

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About RNIB

Royal National Institute of Blind People (RNIB) is the leading charity in the UK offering information, support and advice to almost two million people with sight loss.

We are a membership organisation with over 10,000 members who are blind, partially sighted or the friends and family of people with sight loss.

Our three main priorities are set out by our five year strategy (2009-2014):

- stopping people losing their sight unnecessarily
- supporting independent living
- creating an inclusive society.

As a campaigning organisation, we fight for the rights of blind and partially sighted people across the UK and push for better access to diagnosis and treatment to prevent avoidable sight loss.

1. Executive summary

Introduction

Losing sight can have an enormous emotional and financial toll. Some patients report feeling depressed, anxious and emotionally distraught.

Without sight, people are at risk of losing their employment and their ability to travel independently as well as having to rely on carers to undertake day to day tasks. They are also at higher risk of experiencing falls and accidents which require further NHS health and social care services.

Over the last decade, many new treatments have been developed, saving the sight of thousands of people who would previously have gone blind. This is an enormous and welcome step forward. However, despite these advances, a worrying development is now placing patients' sight at risk - a looming capacity crisis in ophthalmology.

Patients are incredibly grateful to the hard working staff in eye clinics but do have significant concerns about aspects of their care such cancelled and delayed appointments, long waits to see a professional at each appointment and rushed consultations. Patients we have spoken to realise that staff are doing everything they can to save their sight but are under considerable pressure. For example, we hear that:

> **"The eye hospital clinics are total chaos! The appointment time bears no relationship to when you will be seen. I find it so hard to sit for hours not knowing what is happening. The staff are nice but totally overrun."**
>
> **"I knew delays would lead to permanent damage that could never be reversed - I started to think I would never gain access to what I needed to save my sight before I lost it forever."**
>
> **"When the specialist says he wants to see you in three months, you should see him in that timeframe, instead of having to wait for seven months during which time your condition has worsened."**
>
> **"I attend the eye clinic every three months. I have laser, it's like a cattle market and I feel I am just another number."**

Anecdotal evidence suggests that lack of capacity in eye clinics is to blame for the delays to diagnosis and treatment, and that this could be putting the sight of tens of thousands of people at risk. To investigate, we undertook research to examine ophthalmology staff views on capacity. Additional

research was conducted to gather intelligence on the mechanisms used by local authorities and commissioners to assess, plan and deliver eye care services for local populations.

Methodology

In summer 2013, RNIB carried out a survey of staff in eye clinics across England. We asked about current and future capacity, the impact of insufficient capacity on patient care and possible solutions. By September 2013, 172 responses were received from a range of eye health professionals including 91 ophthalmologists and 59 ophthalmic nurses.

As local authorities and clinical commissioning groups (CCGs) work together to assess the health needs of their local populations; RNIB decided to undertake additional research to supplement the findings of the staff survey and examine the commissioning process as a whole. To do this, online research was conducted to assess which local authority Joint Strategic Needs Assessments (JSNAs) include information and data on eye care and sight loss. JSNAs are important as CCGs must refer to them when making commissioning decisions.

Finally, a Freedom of Information request was sent to all CCGs across England seeking information on the evidence they use to commission eye care services.

Our findings show that:

So what did our research reveal? Is capacity a major problem in ophthalmology and is it having a detrimental impact on patient care? The simple and unfortunate answer is yes. Our findings show that:

- **Patients are going blind due to sizeable capacity problems in ophthalmology clinics across England:**

  37 per cent of respondents said that patients are "sometimes" losing their sight unnecessarily due to delayed treatment and monitoring caused by capacity problems. A further four per cent of respondents said this is happening "often". These statistics are shameful as nobody should lose sight from a treatable condition simply because their eye clinic is too busy to treat them in a clinically appropriate timescale.

  In relation to these findings, Nicola Wainwright, a partner at leading clinical negligence law firm Leigh Day, told us: "As clinical negligence specialists, we have acted for clients whose long term vision has been permanently

affected when, for example, their diagnosis, treatment or follow-up has been delayed. In such cases, lack of capacity in the eye clinic seems to have contributed to fundamental breaches of care, giving rise to claims in clinical negligence."

In addition to sight loss, lack of capacity gives rise to other negative implications for patient care and by far the biggest problem (according to 82 per cent of respondents) is rescheduled and cancelled appointments. Other issues include long waits to see a professional at each appointment, which can be two to three hours, and rushed appointments, leaving little time for the patient to discuss their eye condition and its treatment with their professional. This leads to misunderstandings and considerable amounts of stress for both the patient and professional. It also hampers the patient's ability to make an informed choice about their care.

- **The capacity crisis in ophthalmology is countrywide with clinics under extreme pressure to meet demand:**

  Staff in all regions of England responded to the survey and over 80 per cent of respondents said their eye department has insufficient capacity to meet current demand. Over half said the problems are so significant that they have to undertake extra clinics in the evenings and at weekends to keep up with demand. Many departments report a huge backlog of patients and chronic understaffing. It is clear that eye clinics are in fire fighting mode and that the relentless schedule, resulting in long working hours, is putting staff at serious risk of burnout.

  The situation gets worse when respondents were asked about capacity in the longer term, with 94 per cent reporting that future capacity will not meet rising demand.

Lack of capacity is of course a complex issue and many factors contribute to the problem. However, our research has uncovered four reasons which seem to be the main drivers:

1. **A significant increase in demand for services across a broader range of conditions:**

   The majority of survey respondents agreed that the ageing population (87 per cent) and availability of new treatments (88 per cent) have led to a rapid increase in demand for services.

   A new type of treatment, known as anti-vascular endothelial growth factor (anti-VEGF), has resulted in greater numbers of patients needing regular monitoring and treatment. This development is a warmly welcomed and

has saved the sight of many patients who would otherwise have gone blind. It has also placed sizable strain on eye departments. Staff report being “overwhelmed” by anti-VEGF clinic appointments and many (70 per cent of respondents) say this has impacted upon other eye care services, as managers re-direct funding and staff resources into these clinics. Some respondents warn that the focus on conditions that can be treated with anti-VEGFs mean that people with other chronic eye conditions are going blind while they wait for an appointment. This is despite the fact that potential numbers of patients were predicted well in advance.

Potential treatments for dry AMD – currently an untreatable disease – are also likely to be available within the next five to ten years. This will be a significant and hugely welcomed development but will place additional strain on eye clinics, with even greater numbers of patients needing regular monitoring and treatment. This is why it is so important to manage capacity sooner rather than waiting for the crisis to get worse.

2. **No clear strategy for coping with current and future demand:**

Just over half (52 per cent) of survey respondents said their department reviews current need to ensure service provision meets demand. This number drops to 44 per cent when asked if they also consider future need. In the case of departments that do not plan, respondents suggest that heavy workload prevents them having time to review resourcing needs.

When eye clinics do review demand and produce business cases seeking extra resources, their requests are often dismissed by hospital trust management, usually due to financial constraints. Survey respondents report that ophthalmology is only seen as a minor issue by Hospital Trust Boards and is rarely given the priority it deserves. Many respondents state that management only address problems when departments are at breaking point and that this often involves short term solutions such as recruiting expensive locums to alleviate immediate staff shortages.

3. **A lack of local planning of eye health and sight loss services:**

Although preventing unnecessary sight loss has been prioritised in the Government's Public Health Outcomes Framework, our research reveals a lack of eye health population planning in many areas of the country. Only 40 per cent of all Joint Strategic Needs Assessments (JSNAs) in England contain information on sight loss and eye health. Some regions are worse than others, for example, 93 per cent of JSNAs in the West Midlands and 82 per cent in the North West have little or no information on sight loss. This is problematic as local authorities have been asked to demonstrate

improvements in public health outcomes against the issues listed within their JSNA.

4. **An inconsistent approach to commissioning eye care services:**

   There is no consistent approach to commissioning eye care services across England. Department of Health guidance states that CCGs must refer to their local JSNAs and local authority public health advice when making decisions about commissioning services. However, our Freedom of Information (FOI) survey reveals that only 64 per cent actually do. In some cases, CCGs are using JSNAs that do not contain information on eye health and sight loss, which is the case with NHS Birmingham South and Central CCG and NHS Knowsley CCG.

   Findings also show that CCGs are making commissioning decisions based on very different levels of evidence. Some, such as NHS South Devon and Torbay CCG, are to be applauded for undertaking in-depth, independent evaluations of the eye health needs of their local populations, while others rely solely on JSNAs and public health advice from their local authorities. Between these two extremes, CCGs are referring to an array of sources to facilitate their commissioning decisions and these differ both in quality and quantity. Such inconsistent use of evidence can only lead to a decision making postcode lottery and be detrimental to patient care.

   Our findings also reveal that a quarter of commissioning groups have no lead for eye care. Poor dialogue between CCGs and ophthalmology specialists is reported to be hampering commissioners' ability to plan and deliver high quality eye care.

Recommendations

These shocking results should act as a wake-up call to the Government, NHS England, commissioners and hospital trusts alike. Urgent action is clearly needed to prevent people losing their sight needlessly and ensure effective and efficient eye care services are in place to meet rising demand. To do this, RNIB calls for action against the following six recommendations:

1. **NHS England must undertake an urgent inquiry into the quality of care in ophthalmology**

   <u>Recommendation for NHS England</u>

   RNIB calls on the Medical Director of NHS England to undertake an independent inquiry into the quality of patient care in ophthalmology. This

must be done rapidly and produce viable recommendations that put an end to unnecessary sight loss.

It is profoundly wrong that people are going blind unnecessarily simply because ophthalmology clinics are unable to meet rising demand within existing budgets. There should not be a price on sight. Giving evidence to the Public Accounts Committee earlier this year, Sir Bruce Keogh acknowledged that commissioners ration cataract surgery without using the best available evidence. RNIB is now calling on Sir Bruce to go a step further and use the findings of this report as the basis of an independent investigation into the standards of care in ophthalmology. Patients deserve high quality care and NHS staff deserve access to sufficient resources in order to deliver those standards.

2. **National leadership is put in place to address unacceptable variation in eye care provision**

   Recommendation for Health Ministers and NHS England

   NHS England must create a National Clinical Director (NCD) for eye care. This will ensure clinical leadership is at the heart of NHS decision making and ready to meet the challenges that lie ahead as the population ages and the prevalence of eye conditions increases.

   Eye health was the most obvious gap in the list of 24 NCD appointments announced in December 2012, which covered almost all of the other major areas of NHS expenditure. Not only would an NCD be "inside the tent" arguing the case for greater prioritisation of eye health, they would also play a key role in co-ordinating services, delivering system re-design and making optimum use of scarce resources.

3. **Hospital managers and staff must work together to identify and address capacity problems in their eye clinics**

   Recommendation for hospital managers and ophthalmology staff

   Hospital trust managers and ophthalmology staff (at all levels) must urgently meet to discuss capacity issues in their eye clinic. Problems should be rapidly identified alongside the resourcing requirements needed to address any issues. These meetings must continue on a regular basis to keep the capacity situation under review. Suggested questions to assist with strategic planning can be found in appendix four of this report.

4. **CCGs must properly assess and adequately fund eye clinics so they can meet rising demand for services**

   Recommendation for NHS England, CCGs and CCG Accountable Officers

   CCGs should undertake an independent assessment of the eye care needs of their local population to supplement the public health advice they receive from local authorities and their JSNA. There are good practice examples of this from the UKVS project "Commissioning for Effectiveness and Efficiency" covering Torbay, Bedfordshire and Gateshead. Commissioners must work with hospital managers and ophthalmology staff to ensure they fully understand patients' needs and the resourcing requirements needed by ophthalmology departments.

   Once need is established, it is vital that commissioners provide proper funding to eye clinics to ensure that no patient loses their sight unnecessarily. Introducing innovation and efficiencies into service provision may help ease the strain but will not solve the capacity problems unless coupled with extra investment. Appropriate levels of funding will enable ophthalmology departments to recruit sufficient staff with the right skill mix, purchase appropriate equipment, acquire new clinic space and, most importantly, offer diagnosis and treatment in clinically appropriate timeframes

   NHS England should include a clause in the standard NHS contract requiring ophthalmology providers to use clinical management systems. This will make it easy to retrieve eye care data relating to patient outcomes and clinic activity, and help CCGs monitor and understand the service they are commissioning and the resource requirements needed to run effective and efficient ophthalmology services.

5. **National Institute for Health and Care Excellence (NICE) must prioritise the production of its eye health clinical guidelines and Quality Standards**

   Recommendation for the Government, NHS England and NICE

   The Government, NHS England and NICE must bring forward the development of the clinical guideline and Quality Standards (QS) for cataract and age-related macular degeneration. RNIB understands that development of these, along with the refresh of the Glaucoma guideline and Quality Standard, will not commence before 2018. This is simply unacceptable as there is widespread variation in eye care services and major delays in accessing timely diagnosis and treatment. Five years is too long to wait for a problem that needs resolving now.

There is also a clear gap in the development of guidance and a Quality Standard for diabetic eye conditions. These conditions are the leading cause of blindness among the working age population and a standard on diabetic retinopathy/maculopathy must be added to the NICE library for development.

RNIB is working with the Royal College of Ophthalmologists on the production of cataract and glaucoma commissioning guidance (using a NICE accredited process); however, these will not replace official NICE guidance. NICE Quality Standards help commissioners plan and deliver high quality services and eradicate unacceptable variation. They also assist providers in monitoring service improvements and explain to patients what to expect so they can act if the system fails them.

6. Eye Clinic Liaison Officers (ECLOs) must be an integral part of the patient pathway

Recommendation for commissioners, hospital trust managers and providers

Survey respondents unanimously agree that capacity pressures mean patients have less time to spend with professionals at each appointment. Consultation times are constantly being whittled away by the pressure to see more patients in the same amount of time.

ECLOs provide an obvious solution to this problem, as they work closely with medical and nursing staff in the eye clinic and have the time to dedicate to patients following their consultation. They help patients understand their condition, its treatment and connect them to further practical and emotional support, helping to integrate health and social care services. Patients regularly tell RNIB that they do not want to be given leaflets as a substitute for high quality communication and face to face time with a professional. At present, 56 per cent of eye clinics in England do not have ECLO support in place, which is why RNIB calls for ECLOs to be made an integral part of the eye care patient pathway and ophthalmology team.

In their own words ….

Mark Jonson, 42, East of England

Mark lives in the East of England and was diagnosed with diabetic macular oedema (DMO) in late 2012. The condition resulted in his sight becoming blurry, making it hard to watch TV or read. As a diabetic, he needs to count the carbohydrates he eats and with DMO this was almost impossible.

Concerned for his sight and the effect losing it might have on his job and life, he was relieved to discover that a new sight saving treatment was available under his private medical cover. Mark started treatment in January 2013 but after three months his insurer refused to pay for further treatment as it had been approved for use on the NHS.

This good news meant that in July 2013, Mark had his first treatment as an NHS patient. However, the good news did not last long as the doctor said the treatment was no longer available because the hospital was not ready to provide it. Despite having a legal right to this treatment, Mark was still waiting for a follow-up appointment in October 2013.

During this time Mark's sight deteriorated to the point where he could no longer drive, which restricted the business meetings he could attend and began to affect his personal life - many of Mark's friends and family live far away so he has to travel to visit them. Commenting on this period, Mark said: "I felt very worried, if not terrified, as I really thought I was going to lose my sight. I am relatively young and have only just started my family. I got very depressed thinking of all the things I wouldn't be able to see - my daughter's first steps, my daughter walk down the aisle in her wedding dress, my grandchildren. I was aware of how many blind people struggle to find work and although I did not plan it, I had considered if my life insurance would be better for my family than the burden I felt I would become."

In October 2013, Mark wrote to the hospital and was told that lack of capacity in the eye clinic was to blame for the delay. The hospital said that the newly approved treatment "will result in a significant increase in activity for the hospital" and that "the eye clinic is very busy... the busiest clinic in the hospital." He was also told that "subject to final contractual issues, the treatment should be made available to DMO patients over the coming weeks" and that "patients will then be contacted to make appointments."

Mark finally contacted RNIB, who in turn sent a letter to the hospital trust pointing out its legal obligations to provide NHS patients with approved treatments. Mark has now been given further treatment.

Danielle Green, 45, Hull

Danielle was diagnosed with diabetes at 13. She had always been aware of the need to be careful with her eyesight and has regularly experienced problems getting appointments for diabetic retinopathy check-ups (especially during her pregnancies despite pregnancy creating extra risks for diabetics). These delays and cancellations have left her frustrated and worried.

When attending hospital appointments, Danielle says she is regularly told that she must be seen within three months. However, letters offering appointments are often delayed, if they arrive at all. Danielle says that in the past she has had to wait a whole year to be seen despite being told by the doctor to return in several months.

Danielle notes: "I constantly have to chase for appointments and I know that other people, less confident people, might not be strong enough to do all the chasing." She adds that: "Every time my eye bleeds, I'm at risk of losing more of the remaining sight I have left. I have three children and when I lose more sight, this impacts on them as well as on me."

Ronald Norris, 80, London

Ronald has been attending his local eye clinic for 35 years.

After being diagnosed with Glaucoma in 1997, Ronald was supposed to have regular appointments. However, they were often cancelled or postponed – sometimes he would not find out until he arrived at the hospital, which was very frustrating as it takes him a long time to get to each appointment. During the 35 years, Ronald has had cataracts removed from both eyes and a trabeculectomy (a surgical procedure used in the treatment of glaucoma to relieve pressure inside the eye).

In March 2013, he developed an eye infection and was referred to a large London hospital. There were problems transferring Ronald's medical notes and when it did happen he was sent a copy. He was very angry to see that the documents noted a 'failed' operation in his left eye. He had never been told there were problems and said that if he had realised this, he would have pushed for more treatment in his left eye and perhaps not ended up losing the sight in it. The sight loss has had a huge impact on Ronald's life and he has had to give up voluntary work, which he really enjoyed.

2. About sight loss

Every day 100 people in the UK start to lose their sight. For some people, it's a gradual process. For others, it happens overnight. For all, it is life changing and can have a huge emotional and financial impact.

2.1 The impact of sight loss

Fortunately, many sight conditions are now treatable but without access to timely diagnosis, treatment and follow-up appointments patients risk:

- losing their sight needlessly
- losing their income and spending their life depending on state benefits
- losing their ability to drive
- becoming dependent on carers and their spouse
- experiencing increasing difficulty with daily living tasks such as reading important information (including utility bills) and self-administering medications
- being unable to cook safely, maintain good quality nutrition and read labels to see when food is out of date
- becoming subject to increased costs for visual aids, transport and domestic help
- an increased probability of falls and accidents requiring further NHS treatment
- social isolation
- loss of confidence and self-esteem which may lead to clinical depression requiring NHS treatment
- being unable to undertake hobbies such as gardening and knitting
- being unable to recognise the faces of loved ones.

2.2 Sight loss prevalence in the UK

There are almost two million people in the UK living with sight loss. It is predicted that by 2050 that number will double to nearly four million (Access Economics, 2009). The prevalence of many sight threatening conditions increase with age and people from black and minority ethnic communities are at greater risk of developing conditions such as glaucoma and diabetic eye diseases (Access Economics, 2009).

The leading causes of blindness are age-related macular degeneration (AMD), glaucoma, diabetic retinopathy, cataract and uncorrected refractive error. Table one shows that the prevalence of these conditions is increasing rapidly, especially as the population ages, and this in turn will create higher demand for health and social care services.

Table one: Prevalence of the common sight threatening conditions in the UK in 2010 and 2020 (Minassian and Reidy, 2009):

Sight condition	UK prevalence 2010	UK prevalence 2020
Wet AMD	415,000	516,000
Dry AMD	194,000	240,000
Glaucoma	266,000	561,000
Early stage diabetic retinopathy	748,000	938,000
Diabetic maculopathy	188,000	236,000

Data on cataract prevalence is not readily available although statistics show that in 2012/13, 340,809 cataract operations were performed by the NHS (HESonline, 2013).

2.3 Ophthalmology services in England

In 2011/12, ophthalmology had the second highest number of outpatient attendances of any speciality, accounting for 8.9 per cent of all outpatient appointments (6.8 million).

In the same period, there were 620,000 finished inpatient consultant episodes related to ophthalmology (HSCIC, 2012). The vast majority were carried out as day cases, without the need for an overnight stay in hospital (HSCIC, 2012).

3. Background and policy context

The Health and Social Care Act 2012 brought many changes to the NHS in England, both strategically and structurally. Primary Care Trusts and Strategic Health Authorities have been abolished and new bodies established in their place.

Another big change is that decision making has shifted from central to local level. Commissioners, public health professionals and providers are now expected to meet outcomes provided in a number of Government Frameworks.

3.1 Commissioning services at national level

As part of the reforms, a new special health authority - NHS England - has been established to oversee budgeting, planning, and the day-to-day operation of the health service. It took up its statutory duties on 1 April 2013.

It directly commissions specialised services (including specialised adult and paediatric ophthalmology to treat rare eye conditions) and primary care services including sight tests offered at opticians. NHS England is supported by four regional directorates and twenty seven local area teams which facilitate commissioning at local level.

The Government holds NHS England to account through its Mandate, which sets out the objectives the NHS must achieve such as helping people to live longer, managing ongoing mental and physical conditions and improving each person's experience of care.

3.2 Commissioning services at local level

As part of the health reforms, 211 Clinical Commissioning Groups (CCGs) have been established to plan and deliver services at local level including planned ophthalmology care in the hospital.

CCGs are accountable to NHS England through the NHS Outcomes Framework, which outlines what outcomes each CCG must achieve. The Framework is divided into the following five domains:

- Domain one: preventing people from dying prematurely.
- Domain two: enhancing quality of life for people with long-term conditions.
- Domain three: helping people to recover from episodes of ill health or following injury.
- Domain four: ensuring that people have a positive experience of care.

- Domain five: treating and caring for people in a safe environment and protecting them from avoidable harm.

Reducing avoidable sight loss relates to each domain directly and indirectly. For example, sight loss is a factor in many conditions that lead to premature death such as stroke and diabetes (domain one) and people with sight loss have specific care needs, such as requiring information in accessible formats, which is related to their experience of care (domain four). This means that commissioners have a duty to plan and provide services that prevent people losing their sight unnecessarily.

Commissioning Support Units provide the vast majority of commissioning support to CCGs including human resources and legal services. Local Eye Health Networks also provide expertise to CCGs and comprise professionals from across the eye care sector.

3.3 Public health services

In the new health system, local authorities are responsible for public health. Ultimate responsibility rests with the Director of Public Health who now sits within the local authority.

A new Public Health Outcomes Framework (2013-2016) sets out the overarching vision and outcomes the Government wants local authorities to achieve. It is divided into the following four categories and contains a number of indicators which will be used to measure how public health is improving and protecting the health of local communities:

- Category one: improving the wider determinants of health.
- Category two: health improvement.
- Category three: health protection.
- Category four: healthcare and preventing premature mortality.

The Government has made a commitment to eye care by making it a public health priority and including a sight loss prevention indicator in the Framework. This indicator tracks rates of sight loss from three leading causes of blindness - glaucoma, age-related macular degeneration and diabetic retinopathy. Local authorities must take this indicator into account, track rates of sight loss from these conditions and take action to reduce unnecessary sight loss and provide services for blind and partially sighted people in their area.

Local authority Health and Wellbeing Boards, along with a representative from each local CCG, produce Joint Strategic Needs Assessments (JSNAs)

to assess the health and wellbeing needs of their local populations and commission services accordingly. In addition, these Boards develop Health and Wellbeing Strategies, based on their JSNA, setting out the priorities and actions they will undertake to improve the health and wellbeing of people living in their area.

4. Capacity in ophthalmology clinics

In August 2013, we surveyed ophthalmology staff across England seeking their views on capacity in their respective eye clinics. The questions are listed in appendix one of this report and findings are summarised below:

4.1 About the respondents

We received 172 responses from a range of eye health professionals including 91 ophthalmologists and 59 ophthalmic nurses. A number of Eye Clinic Liaison Officers (ECLOs) and department managers also participated in the survey and are listed in table two as "other".

Table two: Respondents' profession

Profession	Response percentage	Response count
Ophthalmologist	52.9	91
Orthoptist	1.2	2
Hospital based optometrist	4.1	7
Nurse	34.3	59
Technical staff	0.6	1
Other	7.0	12

(Please note: 172 respondents answered this question)

Table three shows that staff in all areas of England responded to the survey and that response rates were similar for most parts of the country, with an average 18 responses per region. The North East, however, had the lowest number of respondents (6 in total) and the South East and South West the highest (34 and 27 respectively) .

Table three: Respondents' region of work

Region	Response percentage	Response count
North East	3.5	6
North West	12.8	22
Yorkshire and the Humber	8.1	14
East Midlands	9.3	16
West Midlands	8.1	14
East of England	9.9	17
South East	19.8	34
South West	15.7	27
London	8.7	15
Did not respond	4.1	7

(Please note: 172 respondents answered this question)

4.2 Current capacity in the eye clinic

When asked about current capacity, 81 per cent of respondents said it is insufficient to meet current demand; and over half (51 per cent) said the problems are so significant they have to undertake extra clinics in the evenings and at weekends to keep up with demand.

The situation gets worse when respondents were asked about capacity in the longer term, 94 per cent reported that future capacity will not meet rising demand.

Table four: Current and future capacity in their clinics

Description of capacity in the eye clinic	Response percentage	Response count
There is enough capacity to adequately meet current and expected future demand	5.2	9
There is enough capacity to meet current demand but not any increase in future demand	12.2	21
There is not enough capacity to meet current demand and there will not be enough to meet future demand	30.2	52
Lack of capacity is a significant problem and we undertake extra clinics in the evenings and at weekends in order to meet current demand	51.2	88
Don't know	1.2	2

(Please note: 172 respondents answered this question)

Many respondents said they are not able to meet demand and describe their working environment as “chaos”, "running from one crisis to another" and being "chronically understaffed". Some say this situation is not new and that meeting demand has been an increasing problem for many years. Another respondent said that additional resources "cannot be provided quickly enough to cope with the extra demand."

According to some respondents, seeing patients in clinically appropriate timeframes can be impossible without running extra clinics in the evenings and at weekends, and some are now working six days a week instead of five. Some respondents note that the capacity problems are not just affecting departments delivering treatment and note that demand for low vision services has also dramatically increased.

4.3 Meeting current and future demand in ophthalmology

We asked ophthalmology staff how their eye clinic makes plans to meet current and rising demand. Just over half (52 per cent) of respondents said their department reviews current need to ensure service provision meets demand. However, this number drops to 44 per cent when asked if they also consider future need. Survey findings also show that less than one third of respondents said there is adequate staff in place to cover absences, while just under a quarter said their departments prepare for the introduction of new NICE approved treatments ahead of time.

Table five: Planning for current and future demand

Method for meeting demand	Response percentage	Response count
Modelling current need in order to ensure services meet demand	52.3	90
Modelling current and future need in order to ensure services meet and will continue to meet demand	44.2	76
Ensuring there is adequate staff numbers to cover planned and unplanned absences	31.4	54
Preparing ahead of time for the introduction of new NICE treatments	22.7	39

(Please note: 172 respondents answered this question. Each was asked to indicate which of the above applied to their department, which is why percentages do not total 100.)

It appears that some departments lack a clear strategy for coping with current and future demand. Many report that they simply do not have time to review and make plans to manage capacity. One respondent said: “We have ideas about managing increasing activity with new ways of working but we are swamped and just work all the time to stand still.”

When departments do plan, their needs are not taken seriously or met by their trust, often due to financial constraints. Many respondents said that ophthalmology is only a minor issue for their trust board, particularly as patient do not die directly from eye disease. Respondents feel hospital management is more interested in issues such as hospital acquired infections or excess mortality - anything that grabs media headlines and the attention of Care Quality Commission inspectors.

4.4 The impact of capacity problems on patient care

4.4.1 Frequency of unnecessary sight loss due to capacity problems

An alarming number of patients appear to be losing their sight needlessly due to delayed diagnosis caused by capacity problems in eye clinics. Four per cent of respondents reported that patients are "often" losing their sight unnecessarily; 28 per cent said "sometimes" and 31 per cent said "rarely".

Table six: Patients losing their sight unnecessarily due to delayed diagnosis caused by capacity problems

Frequency	Response percentage	Response count
Often	4.4	6
Sometimes	28.3	39
Rarely	31.2	43
Never	4.4	6
Don't know	31.9	44

(Please note: 138 respondents answered this question)

It is a similar story for those losing their sight unnecessarily due to delayed treatment and monitoring. Four per cent of respondents reported that patients are "often" losing their sight unnecessarily; 37 per cent said "sometimes" and 30 per cent said "rarely". Again, this is simply unacceptable. Nobody should lose their sight from a treatable condition simply because their eye clinic is too busy to treat them in clinically appropriate timescales.

Table seven: Patients losing their sight unnecessarily due to delayed treatment and monitoring caused by capacity problems

Frequency	Response percentage	Response count
Often	4.3	6
Sometimes	37.4	52
Rarely	29.5	41
Never	3.6	5
Don't know	25.2	35

(Please note: 139 respondents answered this question)

In relation to these findings, Nicola Wainwright, a partner at leading clinical negligence law firm Leigh Day, told us: "Whilst a lack of capacity may not be the first reason people think of as directly causing their sight loss, it can be an underlying cause. Capacity problems may not be specified as an allegation of negligence in a claim against a Trust for a patient's loss of sight; however,

they could have been a factor in the Trust being held liable in negligence for injuries patients have suffered unnecessarily."

"As clinical negligence specialists, we have acted for clients whose long term vision has been permanently affected when, for example, their diagnosis, treatment or follow-up has been delayed. In such cases, lack of capacity in the eye clinic seems to have contributed to fundamental breaches of care, giving rise to claims in clinical negligence."

4.4.2 Additional impacts on patient care

In addition to sight loss, lack of capacity has a number of other implications for patient care. By far the biggest problem (according to 82 per cent of survey respondents) is rescheduled or cancelled appointments. This is a major problem because many sight threatening conditions develop rapidly and the longer it takes to access diagnosis, treatment and follow-up appointments, the higher the risk of unnecessary damage to the eye. RNIB is also aware that long waiting times are forcing some patients to opt for private treatment.

Another major issue, according 76 per cent of respondents, is the long wait to see a professional at each appointment, which can take two to three hours. Patients tell RNIB that this is one of the most frustrating parts of their care. One patient said: "by the time I reach the professional, I have forgotten all the questions I wanted to ask and just wish to get home as soon as possible."

Other impacts that rated highly include patients not being treated or monitored within clinically appropriate timescales.

Table eight: Impact of capacity problems on patient care

Impact on patients	Response percentage	Response count
Appointments are rescheduled or cancelled	82.0	114
Patients are not diagnosed within clinically appropriate timescales	36.0	50
Patients are not treated within clinically appropriate timescales	56.8	79
Patients are not monitored within clinically appropriate timescales (for example in the case of wet AMD patients)	61.2	85
There are longer waits to see the doctor/professional at each appointment	75.5	105
Patients are turned away and asked to return at a later date for their appointment	11.5	16

Impact on patients	Response percentage	Response count
Patients undergo tests at one appointment and are asked to return for treatment at a later date (i.e. we are unable to offer a one-stop service)	64.8	90

(Please note: 138 respondents answered this question. Each was asked to indicate which of the above applied to their department, which is why percentages do not total 100.)

In addition to the above, rushed appointments are also a significant problem for patients. If there is insufficient time to discuss their eye condition and its treatment, patients will feel less competent and confident about managing their own care and making informed decisions. This can lead to misunderstandings and considerable amounts of stress for both the patient and professional.

Undergoing tests at one appointment and returning for treatment at a later date can also be troublesome for patients, especially those of working age who have to take time off of work for appointments or those with reduced mobility or poor access to transport. Multiple appointments also negatively impact upon carers who may also have to take annual leave to attend appointments or pay expensive travel costs on multiple occasions. Some clinics now offer a "one stop" appointment where assessment and treatment is provided on the same day.

4.5 Reasons why clinics are facing capacity problems

The lack of capacity in ophthalmology is a complex issue and many factors contribute to the problem. According to the great majority of respondents (88 per cent) the increase in demand for services due to the ageing population was the top reason, closely followed by the availability of new treatments across a broader range of conditions (86 per cent). Overbooked clinics and a backlog of patients also rated very highly (82 per cent).

Inadequate numbers of staff trained to the correct seniority, regular follow-up for wet AMD patients (monthly or when required), and lack of clinic space were also found to be significant reasons why there are capacity problems - as noted by over 60 per cent of respondents in each case. Commenting on the impact of insufficient clinic space, one respondent said: “we have had to instil eye drops and prepare patients for intravitreal injections in corridors causing confidentiality and patient care issues."

Table nine: Main causes of capacity problems in eye clinics

Causes	Response percentage	Response count
A significant increase in demand for services across a broader range of conditions (for example, due to the NICE approval of treatments for DMO and RVO)	85.7	120
A significant increase in demand for services due to the ageing population	87.9	123
Inappropriate referral	33.6	47
Over treatment such as inappropriate cataract surgery	5.0	7
Overbooked clinics and a backlog of patients	82.1	115
Inadequate numbers of staff trained to the correct seniority	61.4	86
Inadequate funding	47.9	67
Lack of clinic space	68.6	96
Lack of equipment such as visual field and OCT machines	35.7	50
Regular monthly follow-up for wet AMD patients or treatment when it is required	62.1	87
Perverse incentives leading to the prioritisation of patients in whom targets can be achieved	25.0	35
Easy cases being treated by non NHS "Any Qualified Providers" leaving our department to treat complex cases	25.7	36
Patients that do not attend	23.6	33

(Please note: 140 respondents answered this question. Each was asked to indicate which of the above applied to their department, which is why percentages do not total 100.)

Respondents provided additional feedback on why they believe capacity problems exist in ophthalmology and these have been summarised below:

Lack of long term planning in relation to staff recruitment and retention
Many respondents report struggling to meet demand due to staff shortages. Some note that efficiency savings are placing eye clinics under additional pressure to reduce staff costs. Little appears to be done to cover planned and unplanned staff absences and very little thought is given to the sustainability of services despite large numbers of senior staff set to retire in the near future. In the case of vacancies, one respondent said that it took their department so long to recruit a new member of staff, a severe backlog of patients formed putting additional strain on the department. Some

respondents also noted that their trust use short term solutions, such as recruiting expensive locums, to alleviate immediate problems.

Lack of receptiveness to clinical input into decision making processes
Respondents reported that ophthalmology staff rarely have input into eye care decisions made at hospital trust or commissioner level. This means that managers and commissioners allocate resources without understanding the specialty of ophthalmology and what is required to run it effectively.

Inadequate IT systems that do not track patients or allocate appointments effectively
Many eye departments have inadequate IT systems that do not track the number of patients currently attending their clinic nor emerging imbalances between capacity and demand. Respondents also state that IT systems cannot match diagnostic appointments to clinicians due to lack of flexibility in the booking system; and that some Patient Administration Systems struggle to schedule appointments more than one year in advance.

Fragmentation of care due to the expansion of providers
The new health system means that Any Qualified Provider can tender for services. While the full impacts of this are yet to be felt, respondents express concern that this may fragment patient care. Some point out that Independent Sector Treatment Centres (ISTCs) have already caused problems for local hospitals by taking a proportion of their surgical workload without covering other outpatient requirements. Respondents note that it is very difficult to attract senior staff to cover this outpatient demand if there is no surgical aspect to the job.

Other problems related to fragmentation of care include local ophthalmology services being withdrawn or taken over by private sector companies, resulting in higher numbers of complex cases being referred to acute NHS hospitals. Some survey respondents also note that the health reforms are having a detrimental effect on capacity and patient care, as many newly established bodies are still in a state of flux and unable to deal with health issues effectively due to the state of confusion.

Other issues contributing to the capacity problems include:
- Paperwork: where time is spent itemising services for payment at the expense of spending time with patients.
- Inefficient guidelines and practices: such as gathering clinical information on intra-ocular pressure for no apparent reason.
- Inappropriate use of services: such as a patients being seen in the acute (casualty) clinic when there are no regular eye clinic slots.
- Lack of generalists: one respondent noted that due to doctors specialising in various areas of ophthalmology, patients are sometimes booked into

many different eye clinics, when one doctor could have dealt with their numerous eye problems at one appointment.

4.6 Impact of new retina treatments on other ophthalmology services

The introduction of anti-VEGF treatments has prevented a growing number of people losing their sight. This is an enormous breakthrough and warmly welcomed. Previously, people diagnosed with retinal conditions such as wet age-related macular degeneration (wet AMD), diabetic macular oedema (DMO) and retinal vein occlusion (RVO) would have gone blind but now their sight can be saved.

As these retinal conditions develop rapidly and can damage sight in a matter of weeks, it is essential that patients access timely diagnosis and treatment. Worryingly, respondents state that severe capacity problems in retinal clinics are hampering patients' chances of receiving diagnosis and treatment in clinically appropriate timeframes.

Many survey respondents (70 per cent) also note that resources are being taken from other ophthalmology services to prop up anti-VEGF clinics. It appears that hospital management places emphasis on recruiting staff for retinal clinics, which means staffing levels are de-prioritised in other parts of ophthalmology. Some respondents also warn that the focus on retinal treatments mean that people with other chronic eye conditions are slowly going blind while they wait for an appointment.

It is clear that there are inadequate resources to meet current and rising demand across ophthalmology and this must be addressed by hospital managers and commissioners. Increased demand for services must be coupled with increased investment in order to stop needless sight loss.

Table ten: Staff opinion on whether NICE approved anti-VEGF treatments have impacted upon other ophthalmology services

Answer options	Response percentage	Response count
Yes	70.4	121
No	11.0	19
Don't know/not sure	18.6	32

(Please note: 172 respondents answered this question)

4.7 Plans for meeting future demand over the next five to ten years

4.7.1 How eye clinics are planning to meet demand in the near and distant future

When asked about plans for meeting future demand, just over half (54 per cent) of respondents said they would be recruiting more staff. A third said their department would be forecasting future demand based on potential new eye health treatments (32 per cent) and a further third (32 per cent) said they would review demographic changes.

Meanwhile 12 per cent said they had no plans in place and one respondent noted that: “Everyone here is feeling the pressure. We cope from day to day. I don't think there are any plans for the expected increase in patients. Change only seems to happen when it has to.”

Table eleven: Plans for meeting future demand over the next five to ten years

Answer options	Response percentage	Response count
Recruiting more staff	54.4	93
Establishing mobile units to provide monitoring and treatment in the community	17.5	30
Anticipating demand based on forecasts of demographic changes	32.2	55
Anticipating demand based on potential new eye health treatments	31.6	54
Don't know	21.1	36
No plans at the moment	11.7	20

(Please note: 171 respondents answered this question. Each was asked to indicate which of the above applied to their department, which is why percentages do not total 100.)

4.7.2 Ways of increasing capacity in ophthalmology clinics

When asked what additional measures are required to meet rising demand over the next five to ten years, respondents overwhelmingly said (76 per cent) increased financial investment. They also repeatedly said that eye care services are never funded correctly.

The need for additional clinic space (74 per cent of respondents) and better IT systems to record clinic activity and inform demand management (62 per cent) also rated highly.

More clinical assessments and evaluation of images undertaken by trained optometrists/nurses (60 per cent of respondents); the recruitment of more consultants or middle grade ophthalmic medical staff (60 per cent); and intravitreal injections delivered by trained technicians/nurses (56 per cent) were also seen as important ways of increasing capacity in ophthalmology clinics.

Table twelve: Initiatives to increase capacity and ensure eye clinics meet demand over the next five to ten years

Initiatives	Response percentage	Response count
Better patient education and prevention strategies	42.9	72
Stronger national and local leadership with input from eye care specialists	53.5	92
Increased financial investment in eye care	76.2	131
Better IT systems to record clinic activity and inform demand management	61.6	106
Better access to equipment such as OCT machines and colour fundus cameras	49.4	85
Increased clinic space and more consulting rooms	74.4	128
More clinical assessments and evaluation of images to be undertaken by trained optometrists/nurses under the supervision of a specialist	59.9	103
More consultants or middle grade ophthalmic medical staff	59.9	103
Non-retinal specialists providing wet AMD treatment	23.8	41
Intravitreal injections delivered by trained technicians/nurses	56.4	97
Introducing innovation and new ways of working into service provision	55.8	96
Follow-up clinics in the community run by optometrists	40.7	70
Electronic transfer of information between community settings and hospitals	39.5	68
Better understanding of patients' needs	32.0	55
Reducing the number of false positives, for example, through filter clinics	36.6	63
This question is not relevant for my department	0.6	1
Don't know/Not sure	0.6	1

(Please note: 172 respondents answered this question. Each was asked to indicate which of the above applied to their department, which is why percentages do not total 100.)

In addition to the views above, respondents provided further ideas on increasing capacity in eye care and these have been summarised below:

A joined up approach to strategic planning is required
Some respondents said that modelling current and future demand with commissioners will help ensure efficient and effective eye care services are put in place. Others said trust management, senior staff in ophthalmology clinics and staff working on the ground should plan current and future needs together. Some respondents noted that there needs to be better communication between medical and non-medical staff in order to plan and deliver services - including a culture where feedback on service improvements can be offered without fear of reprisal.

Patients need to be treated by the right person at the right time and this can be done by exploiting the skill mix within the ophthalmology team:

- **Ophthalmic nurses:** there is strong agreement that nurses should be trained to take on specialist roles such as providing intravitreal injections and running review clinics. They should also be offered appropriate training. Some respondents said that in their department nurses see 70-80 per cent of patients, freeing up clinicians' time in order to deal with complex cases.
- **Optometrists:** hospital based optometrists have a role to play in reducing capacity problems, such as leading review clinics for glaucoma and cataract follow-ups. One respondent said: “optometrists lead glaucoma assessment clinics and have improved the standard of initial assessment in our department.” Respondents also said that more clinical assessments should be conducted by orthoptists as well as nurses and optometrists.
- **Technicians:** making maximum use of non-medical staff also seems to be a favourable option – training technicians to free up nurses’ time is suggested by some. One respondent said that their department has: “trained a photographer to undertake optical coherence tomography.”
- **Eye Clinic Liaison Officers (ECLOs):** respondents and patients alike agree that ECLOs improve the patient experience. ECLOs work closely with medical and nursing staff in the eye clinic and have the time to dedicate to patients following their consultation, helping to ease capacity problems. They help patients understand their condition, its treatment and connect them to further practical and emotional support, helping to integrate health and social care services. Patients regularly tell RNIB that they do not want to be given leaflets as a substitute for high quality

communication and face to face time with a professional and this is what ECLOs offer.

Services should be provided in the right place at the right time
Alongside survey options (ie follow-up clinics in the community run by optometrists and electronic transfer of information between community settings and hospitals), respondents suggest:

- **Using mobile units to reduce the number of hospital visits a patient needs to make:** which is particularly beneficial to those who are less mobile or have to rely on public transport. One respondent said: “We have a large proportion of elderly patients who live in concentrations at long distances from the hospital and we would like to take our service to them." They note that this is particularly helpful for stable patients who can have tests near to home and only attend the hospital when they need treatment.
- **Managing high risk patients:** identify high-risk patients and stratifying them into risk categories was seen as another way of managing demand, alongside the need to run dedicated clinics for specific eye diseases such as glaucoma.
- **Moving patients to a one stop clinic for anti-VEGF treatment:** this was highlighted as a way of tackling capacity problems. It means patients are assessed and treated on the same day rather than on separate occasions.
- **Effective patient pathways:** respondents tell us that patient pathways are not always as efficient and effective as they could be, which causes unnecessary delays. It also means that some patients suffer permanent sight loss while they are being bounced around the healthcare system and not treated on time. Commissioners, clinicians and local eye health networks should review pathways and ensure they are as effective and efficient as possible.
- **Longer acting treatments:** are seen as a way of reducing burden on clinics, patients and their carers. For example, Eylea (aflibercept) currently reduces the burden of treatment in year one for wet AMD patients as they only need bi-monthly monitoring/treatment rather than monthly appointments after their first three injections. Other treatments being approved by NICE include fluocinolone acetonide intravitreal implant and dexamethasone intravitreal implant, both longer acting treatments which will reduce the need for regular monitoring and treatment in patients with conditions such as RVO and DMO. It is hoped that longer acting treatments for wet AMD will eventually come to market.

Clearly the ideas in this section are not comprehensive and simply aim to facilitate discussion between commissioners, hospital trust managers and ophthalmology staff. Bodies such as the Royal College of Ophthalmologists,

the College of Optometrists, the National Clinical Council for Eye Health Commissioning and UK Vision Strategy offer more comprehensive guidance, information and advice on introducing innovation into ophthalmology services.

4.7.3 Shifting services into the community and unlicensed treatments

Some respondents suggest that moving services into the community and using an unlicensed anti-VEGF treatment (Avastin) to treat certain retinal condition will save the NHS money and ease capacity problems in ophthalmology departments. These options are sometimes presented as straightforward choices which are of clear benefit to patients and the healthcare system, however, associated costs and safety implications are often not recognised. RNIB believes that an in-depth analysis of these complex areas is required to truly assess whether they are cost-effective, safe alternatives to current practice.

We therefore call for commissioners, service providers and professional bodies to investigate whether moving certain eye care services into the community will improve patient outcomes and offer a viable alternative to acute hospital care.

We also call on Health Ministers and the Department of Health to instruct the Medicines and Healthcare products Regulatory Agency (MHRA) to examine the evidence on the safety of Avastin for use in the eye. This should include the risk of eye infection and inflammation. If Avastin is found to be safe and is recommended by NICE for use in the NHS; then a national body must be identified to take responsibility for risk management and pharmacovigilance to monitor its ongoing safety when used in the eye.

5. Assessing need and commissioning eye care services

The Health and Social Care Act 2012 brought many changes to the NHS in England.

As of 1 April 2013, Clinical Commissioning Groups (CCGs) and local authorities are jointly responsible for producing Joint Strategic Needs Assessments (JSNAs) to assess the current and future health and wellbeing needs of their local populations. CCGs are also responsible for commissioning local health services, including planned hospital care, and must use their JSNA when making commissioning decisions.

To assess how well this is working in practice, RNIB conducted two pieces of research to examine the new commissioning process in England and the findings are summarised here.

5.1 Which JSNAs reference eye health and sight loss?

RNIB undertook online research to examine each local authority JSNA and ranked them according to the information they contain on the needs of blind and partially sighted people and those at risk of developing sight threatening conditions.

Our rankings use the following traffic light system:

- **Green:** means the JSNA contains a section on sight loss and may make links between sight loss and other determinants of health.
- **Amber:** means the JSNA contains a section on sensory impairment but either (a) makes no specific reference to sight loss and eye health or (b) offers data on the number of people registered with sight loss but provides no supporting information on what these figures mean.
- **Red:** means the JSNA contains no information on sight loss or sensory impairment.

Our research reveals that only 36 per cent of JSNAs in England contain a section on sight loss and eye health. Worse still, 16 per cent ranked 'amber' and 48 per cent 'red' (ie they contain little or no information on sight loss and eye health). These are poor statistics considering the importance of these documents - JSNAs are used to make commissioning decisions and hold local authorities to account for the public health outcomes they achieve.

The following table provides a regional breakdown of our research findings and JSNA rankings. It clearly shows that some regions of the country are de-prioritising the eye health needs of their local populations by failing to

reference sight loss and eye health in their assessments. The West Midlands is particularly bad with 93 per cent of JSNAs containing little or no information on sight loss. This is closely followed by the North West, where 82 per cent of assessments make little reference to sight loss and eye health. Fortunately the picture is better in the South East and East Midlands where 69 per cent and 60 per cent of JSNAs respectively contain a section on sight loss. Full results, broken down by each local authority, are provided in appendix three of this report.

Table thirteen: Ranking of all JSNA's in England broken down by region

Region	Percentage of JSNAs ranked red	Percentage of JSNAs ranked amber	Percentage of JSNAs ranked green
South West	46	27	27
London	56	10	34
North West	59	23	18
North East	33	17	50
West Midlands	72	21	7
Yorkshire and Humber	53	20	27
East Midlands	30	10	60
East of England	45	10	45
South East	26	5	69

5.2 What evidence do CCGs use when commissioning eye health services?

The final part of our research involved sending Freedom of Information (FOI) requests to all 211 CCGs in England - the questions contained in the FOI are listed in appendix two of this report. The research aimed to investigate the evidence CCGs use to assess current and future eye health needs of their local populations.

Findings reveal that only 64 per cent of commissioning groups are using JSNAs when making commissioning decisions, despite Department of Health guidance stating that they should refer to these assessments and local authority public health advice when making decisions. Our research also reveals that out of the 64 per cent of CCGs using JSNAs, only 45 per cent actually include information on sight loss and eye health. This is the case with CCGs such as NHS Birmingham South and Central CCG and NHS Knowsley CCG.

Worryingly, some respondents (3 per cent) believe they are not responsible for assessing the eye health needs of their population. Instead, they state that NHS England is charged with this activity.

Table fourteen: Sources used by CCGs to make commissioning decisions about eye care

Freedom of Information request questions	CCG response
Does the CCG refer to the local JSNAs and local authority public health advice when making commissioning decisions?	**64** per cent said yes (135 CCGs) **30.3** per cent said no (64 CCGs) **2.8** per cent believe they are not responsible for assessing local eye health needs (6 CCGs) **2.8** per cent did not respond (6 CCGs)
Is there a named lead with responsibility for eye care services in the CCG?	**68.7** per cent said yes (145 CCGs) **25.6** per cent said no (54 CCGs) **2.8** per cent believe they are not responsible for assessing local eye health needs (6 CCGs) **2.8** per cent did not respond (6 CCGs)
Does the CCG receive regular reports on eye care performance and eye health issues?	**60.7** per cent said yes (128 CCGs) **33.6** per cent said no (71 CCGs) **2.8** per cent believe they are not responsible for assessing local eye health needs (6 CCGs) **2.8** per cent did not respond (6 CCGs)
Does the CCG access independent feedback and advice from patients?	**71.6** per cent said yes (151 CCGs) **22.7** per cent said no (48 CCGs) **2.8** per cent believe they are not responsible for assessing local eye health needs (6 CCGs) **2.8** per cent did not respond (6 CCGs)

(Please note: we received responses from 205 out of 211 CCGs. The full findings, broken down by CCG, are listed in appendix three of this report.)

In addition to JSNAs, some CCGs are undertaking their own in-depth analysis of the prevalence and incidence of eye conditions in their area as well as examining current and future need. This is to be applauded as it supplements the information contained in the local authority assessment and means that the eye health needs of their local populations are thoroughly assessed. This is the case with NHS South Devon and Torbay CCG. Meanwhile some CCGs rely solely on their local JSNA, which is disastrous when there is no reference to sight loss and eye health in that assessment - how can appropriate eye health services be commissioned if the needs of the population have not been adequately assessed?

Between these two extremes, our findings show that CCGs are using a variety of sources to make commissioning decisions, which differ both in quality and quantity. Evidence used, for example, includes NICE guidance and costing templates, the NHS Atlas of Variation, Medisoft data from providers, meetings with professionals and the Local Optical Committee, UK Vision Strategy commissioning guidance and patient feedback. Such inconsistent use of evidence can only lead to a postcode lottery approach to decision making and variation in service provision.

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Appendix one: questionnaire sent to ophthalmology clinics across England

Question one: please indicate your role in your department:

□ ophthalmologist
□ orthoptist
□ hospital based optometrist
□ community based optometrist
□ nurse
□ technical staff
□ clerical staff
□ other (please specify)

_____

Question two: which of the following best describes the capacity in your ophthalmology department?

□ there is enough capacity to adequately meet current and expected future demand
□ there is enough capacity to meet current demand but not any increase in future demand
□ there is not enough capacity to meet current demand and there will not be enough to meet future demand
□ lack of capacity is a significant problem and we undertake extra clinics in the evenings and at weekends in order to meet current demand
□ other (please specify)

_____

Question three: how does your department ensure it meets current and future demand?

(please tick all relevant boxes):

□ modelling current need in order to ensure services meet demand
□ modelling current and future need in order to ensure services meet and will continue to meet demand
□ ensuring there is adequate staff numbers to cover planned and unplanned absences
□ preparing ahead of time for the introduction of new NICE treatments
□ other (please specify)

_____

Please use the free text box below to provide further comments:

Question four: if your department is experiencing capacity problems, what are the causes?
(please tick all relevant boxes):

- □ a significant increase in demand for services across a broader range of conditions (for example, due to the NICE approval of treatments for DMO and RVO)
- □ a significant increase in demand for services due to the ageing population
- □ inappropriate referral
- □ over treatment such as inappropriate cataract surgery
- □ overbooked clinics and a backlog of patients
- □ inadequate numbers of staff trained to the correct seniority
- □ inadequate funding
- □ lack of clinic space
- □ lack of equipment such as visual field and OCT machines
- □ regular monthly follow-up for wet AMD patients or treatment when it is required
- □ perverse incentives leading to the prioritisation of patients in whom targets can be achieved
- □ easy cases being treated by non NHS "Any Qualified Providers" leaving our department to treat complex cases
- □ patients that do not attend (DNA)
- □ other (please specify)

_____

Please use the free text box below to provide further comments:

Question five, part one: if your department is experiencing capacity problems, what impact is this having on patient care?
(please tick all relevant boxes):

- □ appointments are rescheduled or cancelled
- □ patients are not diagnosed within clinically appropriate timescales
- □ patients are not treated within clinically appropriate timescales
- □ patients are not monitored within clinically appropriate timescales (for example in the case of wet AMD patients)
- □ there are longer waits to see the doctor/professional at each appointment
- □ patients are turned away and asked to return at a later date for their appointment
- □ patients have to return for treatment on another day as there is no capacity to undertake tests and treat the patient on the same day
- □ other (please specify)

_____

Please use the free text box below to provide further comments:

Question five, part two: are patients losing sight due to delayed diagnosis caused by capacity problems?
(please tick the relevant box):
□ often
□ sometimes
□ rarely
□ never

Question five, part three: are patients losing sight due to delays in treatment and monitoring caused by capacity problems?
(please tick the relevant box):
□ often
□ sometimes
□ rarely
□ never

Question six: has the NICE approval of anti-VEGF treatments for wet AMD, RVO and DMO impacted upon other ophthalmology services?
□ yes
□ no
□ not sure
Please use the free text box below to provide further comments: for example, has the treatment of wet AMD, RVO and DMO drawn resources away from other services such as cataract surgery or glaucoma treatment? What impact has this had on patient care?

Question seven: if relevant, what would increase capacity and ensure your department can meet demand over the next five to ten years?
(please tick all relevant boxes):
□ better patient education and prevention strategies
□ stronger national and local leadership with input from eye care specialists
□ increased financial investment in eye care
□ better IT systems to record clinic activity and inform demand management
□ better access to equipment such as OCT machines and colour fundus cameras
□ increased clinic space and more consulting rooms

- □ more clinical assessments and evaluation of images to be undertaken by trained optometrists/nurses under the supervision of a specialist
- □ more consultants or middle grade ophthalmic medical staff
- □ non-retinal specialists providing wet AMD treatment
- □ intravitreal injections delivered by trained technicians/nurses
- □ introducing innovation and new ways of working into service provision
- □ follow-up clinics in the community run by optometrists
- □ electronic transfer of information between community settings and hospitals
- □ better understanding of patients' needs
- □ reducing the number of false positives, for example, through filter clinics
- □ other (please specify)

_____

Please use the free text box below to provide further comments:

Question eight: what are your plans for meeting future demand over the next five to ten years?
(please tick all relevant boxes):

- □ recruiting more staff
- □ establishing mobile units to provide monitoring and treatment in the community
- □ anticipating demand based on forecasts of demographic changes
- □ anticipating demand based on potential new eye health treatments
- □ other (please specify)

_____

Please use the free text box below to provide further comments:

Question nine: if there is anything else you would like to share with us relating capacity problems, please add your comments in the free text box below.

We would also be very grateful for examples of best practice, such as case studies relating to innovation or new ways of working that have successfully helped your department manage demand for services.

Question ten: this survey is anonymous; however, it would be helpful to know which area of England you are working in. If you are happy to

respond to this question, please tick the relevant geographical area below:

- □ East Midlands
- □ East of England
- □ London
- □ North West
- □ South West
- □ South East
- □ North East
- □ West Midlands
- □ Yorkshire and the Humber

Appendix two: Freedom of Information request sent to all CCGs in England

Freedom of Information (FOI) request

Re: Commissioning eye care services to meet current and future demand

As part of Royal National Institute of Blind People's work to prevent avoidable sight loss, we would like to know how Commissioners assess and procure services to meet the eye health needs of their local populations.

To assist with this work, we are sending this FOI request to all Clinical Commissioning Groups across England.

Meeting current and future demand

1. **What evidence does your CCG use to assess the eye health needs of your local population? Please list your sources.**

2. **What processes are in place for assessing the current and future eye health needs of your local population?**

   Please provide copies of any meeting minutes or documents which reference the work you are doing to assess current and future demand.

Seeking advice to inform commissioning decisions

3. **Is there a named lead with responsibility for eye care services in your CCG? (please tick relevant box)**
   - □ yes
   - □ no

4. **Does your CCG receive regular reports on eye care performance and eye health issues (please tick relevant box)?**
   - □ yes
   - □ no

5. **Does your CCG access independent feedback and advice from the following experts when making commissioning decisions about eye health services? Please tick relevant boxes:**

	Yes	No
ophthalmologists	□	□

optometrists	□	□
patients with a sight condition	□	□
social care professionals	□	□
public health professionals	□	□

Appendix three: the commissioning process

The following table lists which CCGs use their local JSNA to assess the eye health needs of the populations they service. It also shows which of the corresponding JSNAs actually reference sight loss and eye health.

JSNAs have been ranked according to the level of information they include using the following traffic light system:

- **Green:** means the JSNA contains a section on sight loss and may make links between sight loss and other determinants of health.
- **Amber:** means the JSNA contains a section on sensory impairment but either (a) makes no specific reference to sight loss or (b) offers data on the number of people registered with sight loss but provides no supporting information on what the figures mean.
- **Red:** means the JSNA contains no information on sight loss or sensory impairment.

	CCG	Does it use the JSNA in its commissioning decisions?	Local authorities related to CCG	What ranking does the JSNA have?
1.	NHS Airedale, Wharfedale and Craven CCG	Yes	Bradford North Yorkshire	Amber Green
2.	NHS Ashford CCG	Yes	Kent	Red
3.	NHS Aylesbury Vale CCG	Yes	Buckinghamshire	Amber
4.	NHS Barking & Dagenham CCG	Yes	Barking and Dagenham	Green
5.	NHS Barnet CCG	Yes	Barnet	Green
6.	NHS Barnsley CCG	Yes	Barnsley	Amber
7.	NHS Basildon and Brentwood CCG	No	Essex	Amber
8.	NHS Bassetlaw CCG	No	Nottinghamshire	Amber
9.	NHS Bath and North East Somerset CCG	Yes	Bath and North East Somerset	Amber
10.	NHS Bedfordshire	Yes	Bedford Central Bedford	Green Green

	CCG	Does it use the JSNA in its commissioning decisions?	Local authorities related to CCG	What ranking does the JSNA have?
	CCG			
11.	NHS Bexley CCG	No	Bexley	Amber
12.	NHS Birmingham CrossCity CCG	Yes	Birmingham	Red
13.	NHS Birmingham South and Central CCG	Yes	Birmingham	Red
14.	NHS Blackburn with Darwen CCG	Did not respond	Blackburn with Darwen	Red
15.	NHS Blackpool CCG	No	Blackpool	Amber
16.	NHS Bolton CCG	Yes	Bolton	Red
17.	NHS Bracknell and Ascot CCG	Yes	Bracnell Forrest	Green
18.	NHS Bradford City CCG	Yes	Bradford	Amber
19.	NHS Bradford Districts CCG	Yes	Bradford	Amber
20.	NHS Brent CCG	Yes	Brent	Red
21.	NHS Brighton & Hove CCG	Yes	Brighton and Hove	Green
22.	NHS Bristol CCG	No	Bristol	Green
23.	NHS Bromley CCG	Yes	Bromley	Amber
24.	NHS Bury CCG	No	Bury	Green
25.	NHS Calderdale CCG	Yes	Calderdale	Red
26.	NHS Cambridgeshire and Peterborough CCG	Yes	Cambridgeshire Peterborough	Green Green
27.	NHS Camden CCG	Yes	Camden	Red

	CCG	Does it use the JSNA in its commissioning decisions?	Local authorities related to CCG	What ranking does the JSNA have?
28.	NHS Cannock Chase CCG	Yes	Staffordshire	Red
29.	NHS Canterbury and Coastal CCG	Yes	Kent	Red
30.	NHS Castle Point, Rayleigh and Rochford CCG	Yes	Essex	Amber
31.	NHS Central London (Westminster) CCG	Yes	Westminster	Red
32.	NHS Central Manchester CCG	No	Manchester	Red
33.	NHS Chiltern CCG	Yes	Buckinghamshire	Amber
34.	NHS Chorley and South Ribble CCG	Yes	Lancashire	Green
35.	NHS City and Hackney CCG	Yes	Hackney	Green
36.	NHS Coastal West Sussex CCG	Yes	West Sussex	Red
37.	NHS Corby CCG	Yes	Northamptonshire	Red
38.	NHS Coventry and Rugby CCG	Yes	Coventry Warwickshire	Red Green
39.	NHS Crawley CCG	No	West Sussex	Red
40.	NHS Croydon CCG	Did not respond	Croydon	Red
41.	NHS Cumbria CCG	No	Cumbria	Amber
42.	NHS Darlington CCG	No	Darlington	Red
43.	NHS Dartford,	Yes	Kent	Red

	CCG	Does it use the JSNA in its commissioning decisions?	Local authorities related to CCG	What ranking does the JSNA have?
	Gravesham and Swanley CCG			
44.	NHS Doncaster CCG	Yes	Doncaster	Red
45.	NHS Dorset CCG	Yes	Dorset	Red
46.	NHS Dudley CCG	Yes	Dudley	Red
47.	NHS Durham Dales, Easington and Sedgefield CCG	No	County Durham	Red
48.	NHS Ealing CCG	Yes	Ealing	Green
49.	NHS East and North Hertfordshire CCG	Yes	Hertfordshire	Red
50.	NHS East Lancashire CCG	No	Lancashire	Green
51.	NHS East Leicestershire and Rutland CCG	Yes	Leicestershire Rutland	Geen Amber
52.	NHS East Riding of Yorkshire CCG	Yes	East Riding	Amber
53.	NHS East Staffordshire CCG	Yes	Staffordshire	Red
54.	NHS East Surrey CCG	No	Surrey	Green
55.	NHS Eastbourne, Hailsham and Seaford CCG	Yes	East Sussex	Green
56.	NHS Eastern Cheshire CCG	Yes	Cheshire East	Red
57.	NHS Enfield CCG	No	Enfield	Red

	CCG	Does it use the JSNA in its commissioning decisions?	Local authorities related to CCG	What ranking does the JSNA have?
58.	NHS Erewash CCG	Yes	Derbyshire	Red
59.	NHS Fareham and Gosport CCG	Yes	Hampshire	Green
60.	NHS Fylde & Wyre CCG	Yes	Lancashire	Green
61.	NHS Gateshead CCG	No	Gateshead	Green
62.	NHS Gloucestershire CCG	Yes	Gloucestershire	Green
63.	NHS Great Yarmouth & Waveney CCG	Yes	Norfolk Suffolk	Red Red
64.	NHS Greater Huddersfield CCG	Yes	Kirklees	Red
65.	NHS Greater Preston CCG	Yes	Lancashire	Green
66.	NHS Greenwich CCG	No	Greenwich	Green
67.	NHS Guildford and Waverley CCG	Yes	Surrey	Green
68.	NHS Halton CCG	No	Halton	Red
69.	NHS Hambleton, Richmondshire and Whitby CCG	Yes	North Yorkshire	Green
70.	NHS Hammersmith and Fulham CCG	Yes	Hammersmith and Fulham	Red
71.	NHS Hardwick CCG	Yes	Derbyshire	Red
72.	NHS Haringey CCG	Yes	Haringey	Red

	CCG	Does it use the JSNA in its commissioning decisions?	Local authorities related to CCG	What ranking does the JSNA have?
73.	NHS Harrogate and Rural District CCG	No	North Yorkshire	Green
74.	NHS Harrow CCG	Yes	Harrow	Red
75.	NHS Hartlepool and Stockton-on-Tees CCG	No	Hartlepool Stockton-on-Tees	Green Green
76.	NHS Hastings & Rother CCG	Yes	East Sussex	Green
77.	NHS Havering CCG	Yes	Havering	Amber
78.	NHS Herefordshire CCG	Yes	Herefordshire	Red
79.	NHS Herts Valleys CCG	Yes	Hertfordshire	Red
80.	NHS Heywood, Middleton & Rochdale CCG	No	Rochdale	Red
81.	NHS High Weald Lewes Havens CCG	No	East Sussex	Green
82.	NHS Hillingdon CCG	Yes	Hillingdon	Green
83.	NHS Horsham and Mid Sussex CCG	No	West Sussex	Red
84.	NHS Hounslow CCG	Yes	Hounslow	Red
85.	NHS Hull CCG	Yes	Kingston Upon Hull	Red
86.	NHS Ipswich and East Suffolk CCG	Yes	Suffolk	Red
87.	NHS Isle of Wight CCG	Yes	Isle of Wight	Red
88.	NHS Islington CCG	Yes	Islington	Red
89.	NHS Kernow	No	Cornwall	Amber

	CCG	Does it use the JSNA in its commissioning decisions?	Local authorities related to CCG	What ranking does the JSNA have?
	CCG			
90.	NHS Kingston CCG	Yes	Kingston-Upon-Thames	Red
91.	NHS Knowsley CCG	Yes	Knowsley	Red
92.	NHS Lambeth CCG	Yes	Lambeth	Red
93.	NHS Lancashire North CCG	No	Lancashire	Green
94.	NHS Leeds North CCG	Yes	Leeds	Red
95.	NHS Leeds South and East CCG	Yes	Leeds	Red
96.	NHS Leeds West CCG	Yes	Leeds	Red
97.	NHS Leicester City CCG	Yes	Leicester	Green
98.	NHS Lewisham CCG	No	Lewisham	Red
99.	NHS Lincolnshire East CCG	No	Lincolnshire	Red
100.	NHS South Lincolnshire CCG	No	Lincolnshire	Red
101.	NHS South West Lincolnshire CCG	No	Lincolnshire	Red
102.	NHS Lincolnshire West CCG	No	Lincolnshire	Red
103.	NHS Liverpool CCG	No	Liverpool	Red
104.	NHS Luton CCG	Yes	Luton	Red
105.	NHS Mansfield & Ashfield CCG	No	Nottinghamshire	Green
106.	NHS Medway CCG	Yes	Medway	Red

	CCG	Does it use the JSNA in its commissioning decisions?	Local authorities related to CCG	What ranking does the JSNA have?
107.	NHS Merton CCG	Yes	Merton	Green
108.	NHS Mid Essex CCG	Yes	Essex	Amber
109.	NHS Milton Keynes CCG	Yes	Milton Keynes	Green
110.	NHS Nene CCG	Yes	Northamptonshire	Red
111.	NHS Newark & Sherwood CCG	No	Nottinghamshire	Green
112.	NHS Newbury and District CCG	Yes	West Berkshire	Green
113.	NHS Newcastle North and East CCG	No	Newcastle Upon Tyne	Green
114.	NHS Newcastle West CCG	No	Newcastle Upon Tyne	Green
115.	NHS Newham CCG	Yes	Newham	Green
116.	NHS North & West Reading CCG	Yes	Reading	Green
117.	NHS North Derbyshire CCG	Yes	Derbyshire	Red
118.	NHS North Durham CCG	No	Durham	Red
119.	NHS North East Essex CCG	Yes	Essex	Amber
120.	NHS North East Hampshire and Farnham CCG	Yes	Hampshire Surrey	Green Green
121.	NHS North East Lincolnshire CCG	No	North East Lincolnshire	Red
122.	NHS North Hampshire CCG	Yes	Hampshire	Green
123.	NHS North Kirklees CCG	Yes	Kirklees	Red
124.	NHS North Lincolnshire	No	North Lincolnshire	Red

	CCG	Does it use the JSNA in its commissioning decisions?	Local authorities related to CCG	What ranking does the JSNA have?
	CCG			
125.	NHS North Manchester CCG	No	Manchester	Red
126.	NHS North Norfolk CCG	Did not respond	Norfolk	Red
127.	NHS North Somerset CCG	Yes	North Somerset	Green
128.	NHS North Staffordshire CCG	No	Staffordshire	Red
129.	NHS North Tyneside CCG	No	North Tyneside	Amber
130.	NHS North West Surrey CCG	Yes	Surrey	Green
131.	NHS North, East, West Devon CCG	No	Devon Plymouth	Green Red
132.	NHS Northumberland CCG	No	Northumberland	Green
133.	NHS Norwich CCG	Yes	Norfolk	Red
134.	NHS Nottingham City CCG	Did not respond	Nottingham City Nottinghamshire	Green Green
135.	NHS Nottingham North & East CCG	No	Nottingham City Nottinghamshire	Green Green
136.	NHS Nottingham West CCG	No	Nottinghamshire	Green
137.	NHS Oldham CCG	No	Oldham	Red
138.	NHS Oxfordshire CCG	Yes	Oxfordshire	Red
139.	NHS Portsmouth	Yes	Portsmouth	Green

	CCG	Does it use the JSNA in its commissioning decisions?	Local authorities related to CCG	What ranking does the JSNA have?
	CCG			
140.	NHS Redbridge CCG	Yes	Redbridge	Red
141.	NHS Redditch and Bromsgrove CCG	Yes	Worcestershire	Amber
142.	NHS Richmond CCG	Yes	Richmond-Upon-Thames	Red
143.	NHS Rotherham CCG	Did not respond	Rotherham	Green
144.	NHS Rushcliffe CCG	No	Nottinghamshire	Green
145.	NHS Salford CCG	No	Salford	Red
146.	NHS Sandwell and West Birmingham CCG	No	Sandwell Birmingham	Red Red
147.	NHS Scarborough and Ryedale CCG	No	North Yorkshire	Green
148.	NHS Sheffield CCG	No	Sheffield	Green
149.	NHS Shropshire CCG	Yes	Shropshire	Red
150.	NHS Slough CCG	Yes	Slough	Green
151.	NHS Solihull CCG	No	Solihull	Amber
152.	NHS Somerset CCG	Yes	Somerset	Amber
153.	NHS South Cheshire CCG	Yes	Cheshire East	Red
154.	NHS South Devon and Torbay CCG	Yes	Devon Torbay	Green Amber
155.	NHS South East Staffs and Seisdon and	No	Staffordshire	Red

	CCG	Does it use the JSNA in its commissioning decisions?	Local authorities related to CCG	What ranking does the JSNA have?
	Peninsular CCG			
156.	NHS South Eastern Hampshire CCG	Yes	Hampshire	Green
157.	NHS South Gloucestershire CCG	No	South Gloucestershire	Green
158.	NHS South Kent Coast CCG	Yes	Kent	Red
159.	NHS South Manchester CCG	No	Manchester	Red
160.	NHS South Norfolk CCG	Yes	Norfolk	Red
161.	NHS South Reading CCG	Yes	Reading	Green
162.	NHS South Sefton CCG	Yes	Sefton	Amber
163.	NHS South Tees CCG	No	Middlesbrough Redcar and Cleveland	Green Red
164.	NHS South Tyneside CCG	No	South Tyneside	Amber
165.	NHS South Warwickshire CCG	Yes	Warwickshire	Amber
166.	NHS South Worcestershire CCG	Yes	Worcestershire	Amber
167.	NHS Southampton CCG	No	Southampton	Green
168.	NHS Southend CCG	Yes	Southend-on-sea	Red
169.	NHS Southern Derbyshire CCG	Yes	Derby City Derbyshire	Green Red
170.	NHS Southport and Formby	Yes	Sefton	Amber

	CCG	Does it use the JSNA in its commissioning decisions?	Local authorities related to CCG	What ranking does the JSNA have?
	CCG			
171.	NHS Southwark CCG	No	Southwark	Green
172.	NHS St Helens CCG	No	St Helens	Red
173.	NHS Stafford and Surrounds CCG	Yes	Staffordshire	Red
174.	NHS Stockport CCG	Yes	Stockport	Amber
175.	NHS Stoke on Trent CCG	Yes	Stoke-on-Trent	Amber
176.	NHS Sunderland CCG	No	Sunderland	Red
177.	NHS Surrey Downs CCG	Yes	Surrey	Green
178.	NHS Surrey Heath CCG	Yes	Surrey	Green
179.	NHS Sutton CCG	Yes	Sutton Merton	Green Green
180.	NHS Swale CCG	Yes	Kent	Red
181.	NHS Swindon CCG	Yes	Swindon	Red
182.	NHS Tameside and Glossop CCG	Yes	Tameside	Green
183.	NHS Telford & Wrekin CCG	Yes	Telford and Wrekin	Red
184.	NHS Thanet CCG	Yes	Kent	Red
185.	NHS Thurrock CCG	No	Thurrock	Green
186.	NHS Tower Hamlets CCG	Yes	Tower Hamlets	Green
187.	NHS Trafford CCG	No	Trafford	Red
188.	NHS Vale of	Yes	City of York	Green

	CCG	Does it use the JSNA in its commissioning decisions?	Local authorities related to CCG	What ranking does the JSNA have?
	York CCG		North Yorkshire	Green
189.	NHS Vale Royal CCG	Yes	Cheshire West	Red
190.	NHS Wakefield CCG	No	Wakefield	Green
191.	NHS Walsall CCG	No	Walsall	Red
192.	NHS Waltham Forest CCG	Yes	Waltham Forest	Red
193.	NHS Wandsworth CCG	No	Wandsworth Merton	Red Green
194.	NHS Warrington CCG	No	Warrington	Red
195.	NHS Warwickshire North CCG	Yes	Warwickshire	Green
196.	NHS West Cheshire CCG	Yes	Cheshire West	Red
197.	NHS West Essex CCG	Yes	Essex	Amber
198.	NHS West Hampshire CCG	Yes	Hampshire Dorset	Green Red
199.	NHS West Kent CCG	No	Kent	Red
200.	NHS West Lancashire CCG	No	Lancashire	Green
201.	NHS West Leicestershire CCG	No	Leicestershire	Green
202.	NHS West London (K&C & QPP) CCG	Yes	Kensington and Chelsea Westminster	Red Red
203.	NHS West Norfolk CCG	Yes	Norfolk	Red
204.	NHS West Suffolk CCG	No	Suffolk	Red

	CCG	Does it use the JSNA in its commissioning decisions?	Local authorities related to CCG	What ranking does the JSNA have?
205.	NHS Wigan Borough CCG	Yes	Wigan	Amber
206.	NHS Wiltshire CCG	Yes	Wiltshire	Green
207.	NHS Windsor, Ascot and Maidenhead CCG	Yes	Windsor and Maidenhead	Green
208.	NHS Wirral CCG	Yes	Wirral	Green
209.	NHS Wokingham CCG	Yes	Wokingham	Green
210.	NHS Wolverhampton CCG	No	Wolverhampton	Red
211.	NHS Wyre Forest CCG	Yes	Worcester	Amber

Appendix four: Resources for assessing need, commissioning services and strategic planning

1. Resources for assessing the eye care needs of the local population

RNIB calls on public health professionals to make eye care a priority by:

i. Including a specific section on sight loss in the JSNA, setting out predicted numbers of people currently living with sight loss and future predictions.
ii. Making links between sight loss and other health priorities in the JSNA, for example, diabetes, falls and smoking.
iii. Mapping what local provisions and support are already available for blind and partially sighted people and identifying where there are potential gaps.
iv. Mapping what local services are in place to prevent avoidable sight loss and identifying and addressing potential gaps. This includes understanding any issues relating to capacity within ophthalmology.
v. Involving blind and partially sighted people and the voluntary sector in the development of JSNAs.
vi. Monitoring progress against the Public Health Outcomes Framework sight loss indicator and taking action to reduce avoidable sight loss.
vii. Ensuring multi-disciplinary falls strategies set out plans for preventing falls in people with sight loss and supporting those who experience a fall.
viii. Ensuring local diabetic eye screening programmes achieve 100 per cent rates of invitation to screening, and meet and maintain rates of 80 per cent and above take-up. Programmes should also monitor rates of exclusion and address any problems if the level is unusually high.
ix. Ensuring smoking cessation programmes include messages about the link between sight loss and AMD.

RNIB has produced a number of resources to support councillors, health and wellbeing boards and public health professionals in understanding the local needs of blind and partially sighted people and those at risk of losing their sight:

Sight loss data tool: provides local data and information related to sight loss for blind and partially sighted people.
www.rnib.org.uk/aboutus/Research/statistics/Pages/sight-loss-data-tool.aspx

UK Vision Strategy JSNA guidance for local authorities: helps users develop a JSNA which includes good information on sight loss and eye health.

www.commissioningforeyecare.org.uk/commhome.asp?section=175&sectionTitle=Health+and+Wellbeing+Boards

Public health indicator and measuring sight loss factsheet: facilitates understanding around the use of the sight loss indicator and measuring sight loss.
www.rnib.org.uk/getinvolved/campaign/yoursight/Documents/PHI_info_JSNA.doc (Word, 176KB)

Diabetic Screening factsheet: sets out what can be done to support diabetic screening services.
www.rnib.org.uk/getinvolved/campaign/yoursight/Documents/Diabetes_JSNA.doc (Word, 177KB)

Falls factsheet: provides information on assessing and addressing sight loss in order to prevent falls.
www.rnib.org.uk/getinvolved/campaign/yoursight/Documents/Falls_JSNA.doc (Word, 176KB)

2. Resources to assist with the commissioning of eye care services

The following list has been compiled to provide resources to help commissioners plan and deliver effective eye care services:

- **Effective eye care commissioning** (UK Vision Strategy)
  www.vision2020uk.org.uk/ukvisionstrategy/commhome.asp?section=153&sectionTitle=Effective+eye+care+commissioning
- **Commissioning for value** (Right Care)
  www.rightcare.nhs.uk/index.php/commissioning-for-value/
- **NHS Atlas of Variation** (NHS Right Care)
  www.rightcare.nhs.uk/index.php/nhs-atlas/
- **NHS eye care data** (NHS Health and Social Care Information Centre)
  www.hscic.gov.uk/primary-care
- **Hospital Episode Statistics Data** (NHS Health & Social Care Information Centre)
  www.hscic.gov.uk/hospital-care
- **NICE Quality Standards** (NICE website)
  www.nice.org.uk/guidance/qualitystandards/qualitystandards.jsp

3. Questions for strategic planning

RNIB recommends that commissioners, hospital trust managers and ophthalmology staff (at all levels) should meet urgently to discuss the

capacity problems in ophthalmology. Questions to facilitate this discussion are listed below:

i. What is capacity like in your eye clinic right now and how can any problems be addressed?
ii. What are the department's short, medium and long-term goals? Are there sufficient resources to meet those goals?
iii. How many patients is your department managing and how might this number grow over the next five to ten years?
iv. What developments are coming up in the next five to ten years, including new treatments and interventions, and how will the department cope with the rise in demand for these treatments/ interventions?
v. Are there sufficient numbers of staff, with the appropriate skills, in place to meet current demand? Is skill mix being maximised with care being delivered by the most appropriate person? Is there an action plan for the long term recruitment and retention of staff?
vi. Are patients moved through the clinic as effectively and efficiently as possible? Where are the bottlenecks and how can they be addressed?
vii. Is there efficient clinic space to meet current and future demand?
viii. Does the department have appropriate equipment in place both in terms of quantity and quality? What additional equipment will be required over the next five to ten years (taking into account any known technological advances)?
ix. Are there appropriate IT systems and processes in place to record and audit clinic activity? For example, do these systems record patient appointments that are cancelled or delayed and do they enable clinicians to assess each patient's clinical priority in order to reschedule their appointment in clinically appropriate timeframes?
x. What plans does the hospital have to engage with clinical commissioning groups, the local Public Health Director, the chair of the local Health and Wellbeing Board, Local Eye Health Networks, the local Healthwatch, patients and patient representatives and the voluntary sector?
xi. How will the hospital communicate resourcing requirements to public health professionals and commissioners?
xii. How does the department monitor and review its performance? What plans are there for doing this in the future?