South East Clinical Senate

Kent, Surrey and Sussex

South East

Clinical

senate

Review of the pre-consultation business case for Ophthalmology Services for East Sussex CCG

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Foreword

The 12 regional clinical senates were established to provide strategic, independent, clinical advice to commissioners and health systems, to help them make the best decisions about health care for the populations they are responsible for. NHS England also strongly recommends a clinical senate review of major service change proposals before they go out to public consultation. In that light, the South East Clinical Senate (Kent, Surrey and Sussex) was asked by the East Sussex System to review the draft pre-consultation business case (PCBC) for the East Sussex Healthcare NHS Trust Ophthalmology Services Transformation, and to provide recommendations.

A multi-disciplinary independent clinical review panel of health and care professionals with a wide range of expertise and experience, including specialist ophthalmology healthcare professionals, was brought together by the Clinical Senate to review the draft PCBC. Following this the Clinical Senate have produced a range of recommendations for how the PCBC could be improved and made more fit for purpose prior to public consultation.

We would like to thank the East Sussex team for taking time to present the proposals to the panel and field their questions. I would particularly also like to thank all the members of the clinical senate panel for giving of their own time to participate in this review.

Finally, a thank you to the support team of the clinical senate for coordinating the review and bringing the report together.

Paul Stevens,
South East Clinical Senate, Kent Surrey Sussex Chair

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1. Introduction and Context of the improving Ophthalmology services in East Sussex proposals

More than 1.5 million people in England have reduced vision. It is estimated that this figure will double by 2050. The population is ageing and one in five people aged over 75 and half of people aged over 90 live with sight loss.[1] Lack of IT connectivity causes difficulties receiving referrals directly from optometrists and sharing information for advice, guidance and shared care. Nevertheless, ophthalmology referrals to hospital eye services rose just over 12% from 2013/14 to 2017/18 and now account for 8.2% of outpatient appointments.[2] More treatments for chronic ophthalmic disease are available that require regular, timely attendance to prevent permanent visual loss, contributing to capacity issues. The processes for the commissioning and provision of eye health services across pathways of care are fragmented, with fragmented solutions for different parts of a pathway of care operating in silos. This results in inconsistency, delays, waste and unwarranted service variations, with governance and quality assurance issues at boundary handovers between steps along the care pathway. To reduce variation in access and outcomes, systems are expected to implement whole pathway transformations and improve performance in Eye Care with support via the National Pathway Improvement Programme.[3]

The East Sussex population has an elderly, multiply comorbid, demographic driving demand for ophthalmic services which include diagnosis, treatment and prevention of conditions that affect the eye and visual system. While there are many clinical conditions that can affect the eye and its surrounding structure in people of all ages, many eye conditions are age-related, making eye health (ophthalmology) services increasingly important as people get older. The prevalence of medical retinal disease (macular degeneration and diabetic retinopathy), glaucoma and cataracts are all significantly higher in the East Sussex population than the England average. East Sussex CCG currently commissions ophthalmology services from the 3 hospital sites in East Sussex Hospitals Trust (ESHT) and through community and primary healthcare providers (optometrists and minor eye conditions services). The changing needs of the population, the changing nature of ophthalmology care and the associated challenges in providing ophthalmology services have made the redesign of ophthalmology a key priority for the East Sussex system.

[1] Key information and statistics on sight loss in the UK https://www.rnib.org.uk/professionals/knowledge-and-research-hub/key-information-and-statistics

[2] Hospital Outpatient Activity 2019-20 https://digital.nhs.uk/data-and-information/publications/statistical/hospital-outpatient-activity/2019-20

[3] NHS England Eye Care Planning Implementation Guidance 2021-22 Summary https://www.rcophth.ac.uk/2021/06/eye-care-planning-and-implementation-guidance

The service at ESHT is consultant-led and provides paediatric and adult ophthalmology at 2 emergency centre hospitals (site 1 - Eastbourne District General Hospital (EDGH) and site 2 - Conquest Hospital Hastings), 1 community hospital (site 3 - Bexhill Hospital) and in some sites in the community. The distribution of services is shown below.

Service/treatments, e.g.:	Site 1	Site 2	Site 3	Community
Outpatients	✓	✓	✓	✓
Screening – Cataract, Maculopathy, Glaucoma	✓	✓	✓	✓
Monitoring/review (in person*)	✓	✓	✓	✓
Diagnostic testing	✓	✓	✓	✓
Pre- / post-operative assessment	✓	✓	✓	✓
Day surgery	✓	✓	✓	✗
Inpatient surgery	✓	✓	✗	✗
Non-elective (emergency)	✓	✓	✗	✗

*Virtual clinics have been developed during the COVID-19 pandemic, and this shift to non face to face activity will continue to be developed where clinically appropriate

During the COVID-19 pandemic provision of outpatient and day care ophthalmology services was temporarily largely transferred to the community hospital site at Bexhill.

The East Sussex Case for Change outlined the key drivers behind the need for the current service to change, providing a basis for local patient and clinician engagement. The case for change highlighted the National Drivers including the NHS Long Term Plan; the recommendations from the Getting It Right First Time (GIRFT) review of ophthalmology;[4] NHS England Transforming elective care services ophthalmology;[5] the Royal College of Ophthalmologists The Way Forward;[6] The College of Optometrists 5-year plan;[7] and the Clinical Council for Eye Health Commissioning

[4] Ophthalmology: GIRFT Programme National Specialty Report https://gettingitrightfirsttime.co.uk/wp-content/uploads/2019/12/OphthalmologyReportGIRFT19P-FINAL.pdf
[5] NHS England Transforming elective care services ophthalmology https://www.england.nhs.uk/wp-content/uploads/2019/01/ophthalmology-elective-care-handbook-v1.1.pdf
[6] The Way Forward. https://www.rcophth.ac.uk/standards-publications-research/the-way-forward/
[7] The College of Optometrists: Our Strategy 2020-2025. https://www.college-optometrists.org/the-college/about-us/strategic-plan.html

(CCEHC) Priorities for Delivering the NHS Long Term Plan for Eye Health.[8] Local drivers included the increasing demands for ophthalmology services; reducing avoidable sight loss and improving the eye health of the population; and longer term clinical, operational and financial sustainability of ophthalmology across East Sussex.

Following pre-consultation engagement, 3 options development and appraisal workshops took place to identify and consider a longlist of possible options for the future provision of ophthalmology services. The options presented for consideration included:

- Option 1: Retaining current services as they are
- Option 2: Provision of services from 2 hospital sites
- Option 3: Provision of services from a single hospital site
- Option 4: Provision of services from a single hospital site with community hospital clinics
- Option 5: Provision of services from a single hospital site with mobile clinics.

These options were assessed against 5 appraisal criteria:

1. Quality and Safety
2. Clinical Sustainability
3. Access and Choice
4. Financial Sustainability
5. Deliverability

Following completion of the process three options were short listed to be taken forward to formal consultation on the future of ophthalmology services in East Sussex:

- Option 2: Ophthalmology Services located at two hospital sites, Eastbourne District General Hospital (EDGH) and Bexhill Hospital, supported by one stop clinics at both and a diagnostic eye hub at Bexhill
- Options 3a and 3b: Ophthalmology services located at one hospital site, supported by one stop clinics and a diagnostic eye hub (Bexhill or EDGH)
- Option 4: Ophthalmology services located at one hospital site, supported by one stop clinics and diagnostic eye hub at the site, and community hospital clinics

Modelling of the 3 options led to the exclusion of options 3a and 3b on the basis of financial affordability and deliverability. Option 2 was the most favourable from an overall modelling perspective, in this option site 1 is EDGH and site 2 is Bexhill Hospital (see below).

[8] Priorities for Delivering the NHS Long Term Plan for Eye Health. Clinical Council for Eye Health Commissioning www.ccehc.org.uk

- Consolidate services to two sites
- All "core" services provided across two sites

(N.B. IP and NEL only possible at acute sites – but not 'core' for model as pathways in place)

Service/treatments, e.g.:	Site 1	Site 2
Outpatients	✓	✓
Screening – Cataract, Maculopathy, Glaucoma	✓	✓
Monitoring/review (in person*)	✓	✓
Diagnostic testing	✓	✓
Pre- / post-operative assessment	✓	✓
Day surgery	✓	✓
Inpatient surgery	✓	✓
Non-elective (emergency)	✓	✓

In considering these options the NHS England South East Clinical Senate has been requested to undertake an independent clinical review of the proposals and the evidence presented; to evaluate the proposals alongside the case for change; to detail recommendations to support commissioners to finalise the PCBC; and to evaluate the proposals in terms of future services being accessible and continuing to meet the needs of the patient population to ensure any inequality issues would be suitably mitigated.

Summary of Feedback

This PCBC describes national and local drivers for change together with a thorough overview of the population demography driving the demand for ophthalmology services. Despite the exigencies of the COVID-19 pandemic the PCBC sought to involve a range of stakeholders in pre-consultation engagement including local people, patients, clinicians and commissioners.

An extensive set of recommendations was produced, centred around the following themes:

The burning platform driving the transformation proposals must be explicitly described. In doing so the proposals for both adult and paediatric ophthalmology pathways must be clearly articulated. During the Senate panel meeting we heard that the fragmentation of services in the current model was affecting patient outcomes and experience, service delivery and creating additional workforce challenges over and above those faced by ophthalmology nationally. This too needs to be clearly articulated in the executive summary of the PCBC.

The proposals include moving adult ophthalmology outpatient and inpatient services from the Hastings site and the rationale for this must be explored together with a description of how emergency ophthalmology on that site will be supported in the preferred option.

There is an opportunity for the PCBC to capitalise on the experience gained from the temporary move of ophthalmology services to the Bexhill site driven by the COVID-19 pandemic. There should be a transparent analysis of this temporary move that makes clear what the impact was on patient outcomes and experiences, health inequalities and service efficiency.

Current demand and future demand in the high-volume areas of ophthalmology is described but this activity and the changes in activity should be mapped to the transformation proposals and to the ophthalmology workforce. A key tenet of the proposals is the reduction in the number of appointments with the hospital eye service in each of the major pathways. Clarity and understanding of how the community service and how community optometrists and orthoptists will contribute to meeting future demands would strengthen this.

Inherent in each of the changes to the high-volume pathways is temporal shortening underpinned by access to one-stop clinics including diagnostics. Provision of this in the current fragmented service is not possible. The PCBC must very clearly explain how this will then be achieved by the transformation proposals and must also describe how this will be sustained in the face of the projected increase in demand for ophthalmology services (over the next 20 years it is estimated that the demand for cataract, glaucoma and medical retina services will rise by 50%, 44% and 20% respectively).

The PCBC would benefit from provision of more data relating to ophthalmology services key performance indicators and how these will be improved by the transformation proposals.

A major patient and public concern will be travel and access to services following implementation of the transformation proposals. How this will be mitigated should be clearly articulated and use of a pictorial representation of current and future service provision together with data evidencing the patient experience of the temporary service change during the COVID-19 pandemic (which we understand was positive).

A more detailed description of the workforce strategy including innovative use of the non-medical ophthalmology workforce, education, training and development of the workforce and the collaboration with key stakeholders, such as Health Education England, would improve understanding and strengthen the case for change.

The PCBC would benefit from more detail concerning innovative use of information technology, virtual consultation and learning from use of information technology during COVID-19, together with examples (local and national) and data to support this. There is also an opportunity to link this to sustainability in healthcare.

A key requirement is that changes in services should demonstrate strong patient and public engagement and be consistent with current patient need and patient choice. This needs to be much more evident and robust in the PCBC.

Conclusion

The draft PCBC demonstrates extensive and detailed work with evidence of patient, public and clinical engagement and involvement. Much of this work and the information presented is generic to wider changes within the East Sussex system and the PCBC would benefit from a greater focus on ophthalmology and provision of data to support the transformation proposals and the case for change. The ambition to create a sustainable model for East Sussex ophthalmology services providing high quality patient outcomes and experience is undoubted but the benefits of proposed changes, for both now and in the future, have to be made clearer and be supported by evidence and modelling. There must also be clear differentiation of adult and paediatric pathways. The risks and the associated mitigations should be described, and further consideration should be made as to how best to present the preferred option for consultation. The Clinical Senate's understanding is that the proposals are in line with the wider ICS plans for ophthalmology services and are also supported by the new South East Region Eye Care Improvement Board.

Clinical senate recommendations are not mandatory but reflect the considered opinion of a group of independently acting clinicians and others after reviewing the material shared with them within the timescales required. It is hoped that the range of recommendations in this report will help to ensure that the proposals going forwards are clear, supported by the evidence provided, address quality and safety requirements, and are shown to improve the quality of care for the population of East Sussex.

2. Review methodology

The panel membership is listed in Appendix D. Great care was taken to ensure that all panel member's declarations of interest and confidentiality agreements were valid.

The initial documentation supplied for this review was, a draft PCBC together with appendices describing ESHT Getting It Right First Time (GIRFT) ophthalmology review summary; the Ophthalmology extended Equality and Health Inequalities Impact Assessment (EHIA); the Public Engagement report; the Transforming Ophthalmology Services in East Sussex Options Appraisal Report; Ophthalmology Patient Pathways Current vs. Proposed; the Quality Impact Assessment (QIA) for the Transformation of ESHT Ophthalmology Services; and the ESHT Transformation Travel Mini project (See Appendix C). The documentation was provided to the clinical senate team on 21st July 2021, who developed key lines of enquiry (KLOE).

The PCBC, impact assessments, additional resources and KLOEs were shared with the Clinical Senate review panel on 27th July 2021.

A half-day panel meeting was held on 11th August 2021. Members of the East Sussex Clinical Commissioning Group (CCG) and the East Sussex Healthcare Trust (ESHT) (see Appendix E) presented a summary of the proposed ophthalmology transformation and options and took detailed questions from the panel. The second half of the panel meeting was for the clinical senate review panel alone to consider their response and recommendations. The full agenda for the panel is shown in Appendix D.

The notes from the meeting and comments made were synthesised into a first draft, which was circulated to the panel for comment. The final draft was then prepared for submission to the East Sussex CCG and ESHT for matters of accuracy on 27th August 2021, and for review, comment then sign off by the clinical senate council.

3. General recommendations

R1. The pre-consultation business case (PCBC) describes and considers options for the future configuration of ophthalmology services. The strategic context and national drivers for change are articulated in the PCBC but the Senate would recommend being explicit that the national and regional/local transformation of ophthalmic services, together with the demands inherent in meeting future standards and the negative aspects of a fragmented service and workforce, make doing nothing an untenable option. The burning platform should be clearly articulated.

R1.1 The scope of the review and the PCBC state that the focus is on the paediatric and adult ophthalmology pathways relating to patients who use services at ESHT and the surrounding areas. During panel it was stated that inpatient paediatrics would remain unchanged. The plans for paediatric ophthalmology pathways need to be clearly articulated in the PCBC with supporting capacity and activity modelling.

R 1.2 The rationale for moving adult ophthalmology (nearly 30% of all activity) from Hastings should also be prominently highlighted in the executive summary.

R1.3 The Senate panel heard that the current service is fragmented and that an adequate service cannot be delivered whilst continuing on 3 sites. Why that is and why it is not possible to support 3 sites with increased staffing and equipment resource and changes to the estate needs to be clearly articulated. For example, why it is not possible to provide the quality of care and improve patient experience and the inability to provide adequate supervision for both ophthalmology trainees and non-medical staff.

R1.4 The panel heard that during the COVID-19 pandemic ophthalmology services across ESHT had been successfully moved to and operated from Bexhill Hospital and that this success formed part of the rationale for the preferred Option. Greater detail concerning what worked well, what didn't and what impacts there were on patient outcomes and experience, health inequalities and service efficiency would considerably strengthen the PCBC. Separate impact assessments for adult and paediatric ophthalmology should be undertaken if indicated.

R1.5 Is there any transferrable learning from transformational changes made in other services in East Sussex that could strengthen the PCBC? There may also be transferrable learning from other systems that have already 'transformed' their ophthalmology services.

R1.6 It would be helpful for the executive summary to detail the key clinical problems faced by the service as it is now and how these will be mitigated and improved by the service transformation.

R1.7 The Royal College of Ophthalmologists The Way Forward executive summary[9] suggests that proposed service changes should at least meet or exceed key clinical standards; be fully costed; detail clear protocols and pathways; address training and education needs; provide data from audit and quality improvement to support the case; and detail how communication and innovative use of information technology will be employed. The PCBC narrative touches on each of these areas but lacks data in support. For example, audit and quality improvement data in each of the high-volume areas, performance against standards, compliance with NICE guidance etc.

R1.8 There is a considerable amount of narrative in the PCBC that is generic to East Sussex health needs and not specific to the ophthalmology transformation proposals. It would be helpful to replace this with ophthalmology evidence and data that supports the proposed changes. For example, the panel heard that ESHT submits data to the National Ophthalmology database and therefore is able to benchmark itself and compare quality outcomes with providers across the country. Highlighting key positives about the service together with negatives that will be improved by transformation would strengthen the PCBC.

R1.9 The PCBC details that the service transformation proposals affect both adult and paediatric ophthalmology but without great detail surrounding paediatric ophthalmology. However, during the presentation the panel heard that the paediatric ophthalmology model works well and would not be changed. Specifically, the paediatric inpatient service currently provided from Hastings would continue, including the screening for retinopathy of prematurity services. The narrative should reflect this and would help give the public confidence that key adjacencies with paediatric services would not be lost.

R1.10 The panel heard that paediatric ophthalmology outpatient services would be introduced at Bexhill in the proposed new model. There is no detail concerning this in the PCBC narrative as it currently is and the rationale and service would need clear explanation, particularly as we understand there are no other paediatric services currently on the Bexhill site.

R1.11 The panel heard that a key part of both the current and proposed clinical model is the provision of Primary Care Clinics and that there would be expansion in capacity of these clinics through the proposed changes. The panel found the term confusing, and it does not appear in the PCBC narrative which details one-stop clinics and urgent ophthalmology clinics. We recommend clarification of the clinic structure and function in the PCBC mapped to current and future activity and workforce. You might consider avoiding the term 'primary care clinic' as that suggests either primary care involvement or location within primary care.

[9] https://www.rcophth.ac.uk/wp-content/uploads/2015/10/RCOphth-The-Way-Forward-Executive-Summary-300117.pdf

R1.12 The PCBC details how demand will increase in the elderly, multiply comorbid population including those with a diagnosis of dementia. The Senate recommend articulating clearly the pathway for complex patients requiring general anaesthetic for ophthalmology treatment from the localities surrounding Hastings following implementation of the transformation proposals.

R1.13 The panel heard that there were major difficulties configuring the estate for ophthalmology on the Hastings site and that the position of the Conquest Hospital in Hastings was such that moving services to the Bexhill site would not disadvantage patients. This needs to be evidenced in a way that those not familiar with the sites can understand. Visual footprints of the hospitals, showing where services are and where they will be in the future and how the changes will support the process for patient care, including provision of rooms/cubicles would be very helpful.

R1.14 The PCBC makes reference to old and outdated ophthalmology equipment and during panel it was made clear that this equipment is highly expensive, requires dedicated space and is not easily transportable. Although more could be made of this as a driver for change the panel also gained the impression that charitable donation of equipment was dependent on it being located at Bexhill. If that is true, then it should be transparently stated but equally access for the East Sussex population to a single diagnostics hub would clearly favour Bexhill as a site and more could be made of this as a key driver.

R1.15 The patient pathways clearly detail how the high-volume pathways will be timelier following implementation of changes but lack detail concerning other quality outcomes. For example, the PCBC details that the rates of sight loss and avoidable sight loss are currently higher in East Sussex than across the region and nationally. It would be helpful to detail how the transformation will improve this, particularly for areas of high deprivation.

R1.16 The PCBC refers to some services in the community but without detailing what activity is undertaken. We understand that community-based ophthalmology services are being developed as part of the wider ICS strategy. It would be helpful to understand what is proposed to take place in the community together with the service transformation and how this will benefit both patients and the service, particularly given the projected increase in demand for services.

R1.17 The PCBC does not give a full understanding of how the service performs against key performance metrics and how these might be improved by transformation. Suggested examples include visual acuity outcomes in addition to the sight loss data; data from the national cataract audit (surgical complications, cataract volumes per surgeon, infection rates); injection rates and infection rates in the medical retina service; and compliance with the NICE glaucoma guidance.[10]

R1.18 The panel heard that the proposed transformational changes were consistent with the wider ICS plans for ophthalmology, further detail in the PCBC narrative would strengthen the case.

R1.19 The eye care planning implementation guidance has led to the recent establishment of a South East Region Eye Care Improvement Board. The Clinical Senate recommends enlisting their support and help with the transformation proposals (the senior responsible officer and clinical leads from both ophthalmology and primary care optometry can be contacted via england.southeasteyecare@nhs.net).

R1.20 In the pictorial description of options 3 and 4 which are both single hospital site options (figure 16, page 56 and figure 18 page 58 of the PCBC) there is a yellow tick against inpatient surgery indicating only a partial service. This is mis-leading because there is a full service for inpatient surgery on one site in option 2, the 2 site option.

4. Population health/inequalities. Improved health outcomes and associated activity projections

R2. The health needs of the population and the demography driving the prevalence and incidence of ophthalmic disease have been clearly identified and described in the PCBC. The East Sussex population has an elderly demographic, with the highest percentage of over 65s in the Rother locality, there are also pockets of deprivation, most notably in Hastings. The narrative in the PCBC should articulate how the proposed changes will benefit these populations with the greatest health needs. The Senate recommends that the narrative should consider the trade-offs between moving services from the Hastings site and access to those services considering the demography and deprivation in the different population areas.[11]

[10] Glaucoma: diagnosis and management. NICE Clinical Guideline NG81
https://www.nice.org.uk/guidance/ng81/resources

[11] Chief Medical Officer's annual report 2021: health in coastal communities
https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2021-health-in-coastal-communities

R2.1 The narrative concerning population health details the associated comorbidity of an elderly population but does not link this to the increasing complexity of the ophthalmic treatment of patients with multiple long term conditions and the potential increased demand for inpatient treatment as opposed to day case surgery. This is also of relevance with the removal of inpatient care from the Hastings site.

R2.2 The Senate recommends making clearer how the equity of access to hospital eye care will be addressed, specifically in the context of use of community optometrists to provide services closer to home and use of virtual consultation. Reference should be made to work currently being undertaken that focuses on health inequalities and models of care described for example in digital solutions to support optometrists to refer easily and efficiently into secondary eye care services.[12]

4.1 Catchment areas and populations in relation to the presented options: Travel

R3. The PCBC and its related appendix the ESHT Transformation Travel Mini project provide a detailed analysis of the impact of the proposed move of services to Bexhill, together with a series of example scenarios. Feedback from the pre-engagement work was that people reported difficulties accessing and attending appointments, including problems with public transport, mobility issues, not having access to a car and struggling to afford public transport or taxis. The PCBC suggests that an action plan is being developed and much more detail should be included within the PCBC narrative.

R3.1 Visual demonstration with maps and figures showing the position of Conquest Hospital relative to Hastings town centre and the relationships between both Conquest Hospital and Bexhill Hospital with railway and bus services together with an analysis that demonstrates the real difference for those that will now be accessing services at Bexhill may mitigate the transport and access impact.

R3.2 During panel the Senate understood that the temporary move of ophthalmological services across to Bexhill driven by the COVID-19 pandemic is still largely extant (albeit orthoptists and optometrists are supporting the Hastings site). There is an opportunity to provide data concerning access to these services at Bexhill, including patient feedback, to strengthen the case for permanent change.

R3.3 Page 36 of the PCBC provides some data from Friends and Family testing but only covers the periods 2018/19 and 2019/20 what do the data demonstrate subsequently whilst ophthalmology services have been provided from Bexhill?

[12] NHSX Improve referrals to eye care services. https://www.nhsx.nhs.uk/key-tools-and-info/digital-playbooks/eye-care-digital-playbook/improve-referrals-to-eye-care-services/

R3.4 The PCBC details that the transformation proposals will dramatically reduce multiple appointments and reduce the need for access to hospital eye care. This is key, both for those more remote from the service but also those with significant difficulties with vision and/or mobility problems. More detail with data and modelling of exactly what this translates to in terms of requirement to access face to face hospital eye care in the different high-volume areas (medical retina, glaucoma and cataract) would be very helpful here.

R3.5 Are there any plans to work with local transport providers such as Stagecoach and voluntary organisations to improve the transport services to Bexhill Hospital?

R3.6 Exactly who and which conditions will be able to benefit from local follow up and virtual consultation? What impact has patient initiated follow up (PIFU) had? (see R4.8)

R3.7 What learning can be taken away from the enforced move of services to Bexhill during the COVID-19 pandemic (link to R1.3 and R3.2)?

R3.8 Is there any learning to be had from other areas of the country where access to hospital eye care services is poor? For example, NHS Grampian's Eye Health Network (see reference 12).

5. Clinical Model, Activity modelling and Workforce Strategy

R4. Within the PCBC the current services and future proposed services are described, together with the current activity. Workforce challenges are described, but only in terms of national workforce shortages and recruitment challenges. The PCBC makes reference repeatedly to development of the workforce, diversification, recruitment and workforce planning and that these will all be improved by the transformation proposals. However, there is no detail to support the statements. The PCBC would be considerably strengthened by description of the current workforce and how this maps to current activity; description of the future proposed workforce and how this maps to future activity; and exactly how it is planned to use the non-medical ophthalmology workforce to meet the future increased demand for services. For example, the panel heard that ESHT have used non-medical injecting staff for medical retina treatments for some years but there are no data relating to this in the PCBC. Where hard data and/or modelling is not available it would be helpful to include examples from where diversification and innovative use of non-medical ophthalmology staff already exists (Ref. 12).

R4.1 Although ESHT does not provide an eye hospital service on its 2 acute sites description of the provision of emergency eye care should be articulated with reference to the Royal College of Ophthalmologists emergency eye care guidance in The Way Forward.[13]

R4.2 Building on the description recommended in R4.1 the PCBC should also articulate how the level and quality of emergency eye care service will not be lessened when adult ophthalmology moves from the Conquest site. Assurance that patients on the Conquest site requiring urgent review by an ophthalmologist will not be disadvantaged would strengthen the proposals.

R4.3 The PCBC describes how the medical retina pathway will be considerably shortened through the introduction of one stop diagnostics, decision and urgent treatment. The Way Forward Age-Related Macular Degeneration and Diabetic Retinopathy details the referral and flow through the hospital system with early triage and focused treatment delivery, describing fast track referrals and rapid access for immediate assessment and imaging.[14] How will the future East Sussex service compare with best practice? What is the reduction in requirement for face to face access to hospital eye care?

R4.4 The PCBC describes how the glaucoma pathway will be significantly streamlined following the transformation implementation both in terms of avoiding unnecessary appointments through referral refinement and reduction in time to treatment. The Way Forward Glaucoma describes referral refinement models, treatment response clinics, consultant efficient models, face to face clinics with stratification based on clinical risk, virtual clinics and shared care and decentralisation.[15] Inherent is these models is the use of non-medical Health Care Professionals in the delivery of the pathway. How will the future East Sussex service compare with best practice? What is the reduction in requirement for face to face access to hospital eye care? How much of the service can be provided by community optometrists?

R4.5 The PCBC also describes streamlining the cataract pathway with an associated significant reduction in time from referral to surgery, utilising a one stop clinic for assessment and decision making followed by surgery at the next visit. What proportion of ESHT cataract operations currently require anaesthetic input? Given the East Sussex demography and the projected increased demand for cataract surgery in the multiply comorbid elderly the numbers requiring anaesthetic input can only increase. What will the impact be on the population in the localities served by the Hastings site and how will this be mitigated?

[13] The Way Forward Emergency Eye Care. Royal College of Ophthalmologists. January 2017 RCOphth-The-Way-Forward-Emergency-Eye-Care-300117.pdf
[14] The Way Forward Age-Related Macular Degeneration and Diabetic Retinopathy. Royal College of Ophthalmologists. January 2017 RCOphth-The-Way-Forward-AMD-300117.pdf
[15] The Way Forward Glaucoma. Royal College of Ophthalmologists. January 2017 RCOphth-The-Way-Forward-Glaucoma-300117.pdf

R4.6 The diagnostic hub is central to the transformation proposals and also to delivery of the high-volume ophthalmology services. Data and modelling of future demand and capacity of the diagnostic hub and its relationship to one-stop clinics would improve the understanding of what the proposals are aiming to achieve. It would also be helpful to articulate the contribution to training and development of the workforce for the future.

R4.7 The PCBC details that there will be more one stop clinics and discharges because of increased opportunities for senior supervision and training leading to less requirement for access to hospital eye care. The panel heard that discharge decisions will also be made, and are currently being made, by non-medical ophthalmology staff and this is consistent with national guidance provided eye safety is paramount. What data are available to model the expected impact of increased one stop clinics and increased discharges in terms of mitigating increased demand? What audit data do you have to assure patients and the public that this can be safely achieved?

R4.8 The PCBC details the five opportunities for transformation in the NHS England ophthalmology roadmap including implementing patient-initiated follow-up (PIFU) care where appropriate. The panel heard that ESHT have adopted PIFU already, expected benefits include the safe reduction of unnecessary ophthalmology hospital outpatient appointments and reduced duplication of care. Inclusion of audit data capturing the impact of PIFU implementation would be extremely helpful. If data are not available locally then data from other Trusts who have already adopted and evidenced the value of PIFU would strengthen the case.

R5. The National shortages in ophthalmology workforce mean that training and development are key factors for both the success of the transformation proposals and for recruitment and retention of staff. The PCBC details the ESHT GIRFT ophthalmology review recommendations and suggests that implementation of the transformation proposals should enable achievement of the GIRFT recommendations. A key theme here is development of the non-medical ophthalmology workforce using the Ophthalmic Common Clinical Competency Framework (OCCCF).[16] The PCBC should detail how the transformation proposals will help achieve this and how the workforce will contribute to delivery of service in the high volume-areas of practice.

R5.1 The panel recommends articulating how East Sussex have worked with Health Education England and other training institutes in developing their OCCCF and why the changes the transformation proposals bring about are central to delivery of this.

[16] Ophthalmic Common Clinical Competency Framework. NHS HEE June 2019. https://www.hee.nhs.uk/our-work/advanced-clinical-practice/ophthalmology-common-clinical-competency-framework-curriculum

R5.2 The PCBC states that the proposed clinical model of care will provide high quality clinical training for junior doctors and other health professionals, develop non-consultant roles such as Highly Trained Optometrists, Orthoptists, Ophthalmic Nurses and Non-medical injectors and increase sub-speciality training, staff development, and career progression. These objectives are commendable and would be significantly enhanced through the inclusion of a roadmap to achievement. Again, we suggest using the OCCCF here. We recommend mapping these to the workforce shortages described in the PCBC.

R5.3 The panel heard about the immense value obtained from an Eye Clinic Liaison Officer (ECLO) and how ECLOs are integral to meeting the needs of patients in the hospital eye service. We recommend including a description of the role in the PCBC and how the transformation proposals would positively impact development of an ECLO service. If there are no local data indicating the value of the service it would be helpful to include data from other areas of the country.[17,18]

R5.4 Any move of services will entail re-location of staff. A full assessment of the impact, risks and proposed mitigation should be included within the narrative.

6. Level of patient, public and clinical engagement

R6. It is clear from the PCBC and related appendices that considerable work has taken place in engagement with all key stakeholders. Support for the clinical model is evident but it would be helpful to have clear statements to that effect from each of the staff groups within ophthalmology, from other specialities potentially affected by the proposals such as paediatrics, neurology and emergency care, from the Trust executive and from the South East Region Eye Care Improvement Board.

R6.1 Appendix 3 (Public Engagement Report) provides rich information concerning public engagement, we would recommend including the graph on page 6 of the appendix within the PCBC to give a clear message that a significant number of either current users, past users or carers and family members of users of the service contributed.

[17] Eye Clinic Liaison Officers. https://www.rcophth.ac.uk/2019/03/eye-clinic-liaison-officers-eclos-are-vital-to-supporting-patients-with-sight-loss/
[18] Eye Clinic Liaison Officer Impact Report 2019. https://www.kab.org.uk/get-support/services/eye-clinic-liaison-officers/

R6.2 In the pre-engagement work do the patient and user views and opinions include those who would normally be seldom heard including those with hearing difficulties, learning disabilities, those who either have no access to or choose not to use IT and those with poor health seeking behaviours? Have you reached those users of the service who will be most affected by the service changes?

R6.3 Better use of the excellent primary care support and engagement could be made with the narrative, highlighting the total end to end pathway focus. The narrative could also be strengthened particularly with reference to broadening the team engagement.

7. COVID-19, Digital and Communication

R7. The COVID-19 pandemic drove a temporary move of ophthalmology services to Bexhill Hospital. Given that the proposed transformation of services includes both a diagnostic hub centralised at Bexhill and a move of ophthalmology services from Hastings to Bexhill we would recommend including in the PCBC a comparison of outcomes data pre- and post-move of services and feedback from patients from the various East Sussex localities concerning access to services. The panel heard that the 'Did Not Attend' rate was also significantly lower; these data would also help strengthen the rationale for change.

R7.1 The PCBC would benefit from data supporting the positive aspects of the temporary reconfiguration of services driven by COVID-19. The PCBC (page 81) states that there was improved clinical stratification, enabling patients to be seen more quickly by the most appropriate healthcare professional for their particular pathway and condition and improved availability of senior clinicians. However, there are no data offered in support of this statement.

R7.2 The Equality and Health Inequalities Impact Assessment (EHIA) highlighted that COVID-19 exacerbated health inequalities during the COVID-19 pandemic. What is the learning from this that can improve the transformation proposals?

R8. The PCBC case for change recognises that benefit can be gained from use of modern digital technology and the panel heard that East Sussex have begun to pilot the Electronic Eyecare Referral System (EERS). Data from this pilot would help demonstrate how this supports service transformation and if data are not yet available capturing the experience of others would be helpful.

R8.1 The PCBC also states digital technology presents opportunities that support service transformation; enable greater availability of virtual clinics; more Advice and Guidance from consultants to community optometrists and GPs supporting patients to receive their care from the most appropriate healthcare professional; and improved systems to ensure patients are safe and receiving the care and treatment they require. Telehealth solutions of the future will improve access to a range of eye care services, particularly for those living in rural and remote areas and these tools could provide a more efficient delivery of healthcare services, freeing up clinical resources and allowing doctors to spend more time with patients. The PCBC could be strengthened by including some examples from the eye care digital playbook. [19]

R8.2 Communication is the Achilles heel of any service and during development of the transformation proposals the East Sussex team have garnered rich feedback concerning where communication with patients, carers and other health professionals could be strengthened. The PCBC would be strengthened by inclusion of an action plan detailing both how communication will be strengthened but also how the transformation of services contributes to the improvements.

R8.3 How will digital innovation contribute to improved communication with patients/carers and other health professionals and to reduction in requirement to access face to face hospital eye service appointments?

8. Sustainability

R9. The PCBC (page 16) recognises the requirement to reduce carbon emissions but should grasp the opportunity to demonstrate how the transformation of services will achieve this.

R9.1 Central to the case for transformation is the reduction in requirement for face to face access to the hospital eye service and the associated reduction in transport journeys. This could be quantified and translated into kg carbon dioxide equivalent reductions. Reducing from 3 sites to 2 sites will also potentially reduce workforce carbon emission travel impact.

[19] Eye care digital playbook. https://www.nhsx.nhs.uk/key-tools-and-info/digital-playbooks/eye-care-digital-playbook/

R9.2 Cataract surgery is one of the most commonly performed surgical procedures. However, its contribution to harming the environment is significant, considering that a single procedure is equivalent to the energy consumed by the average person during a week. The literature suggests that the average solid waste per phacoemulsification ranges between 0.19 kg and 4.27 kg, and greenhouse gases range from 41 kg carbon dioxide equivalents (CO2e) to 130 kg CO2e per phacoemulsification.[20] The transformation of ophthalmology services would benefit from assessment of the impact on carbon dioxide emissions.

R9.3 The proposed transformation of ophthalmology services will require changes to the estate and again there is an opportunity to briefly refer to environmentally friendly strategies to achieving these in the PCBC.

9. The options appraisal process

R10. In the description of the current services the Senate recommends highlighting the quality aspects of that service and areas of good practice with assurances that the new model of care will retain these whilst improving and developing the remainder of the service.

R10.1 Emphasise that the development of the option for consultation is driven by patient need and patient choice with patient participation in the development process.

R10.2 It is not the role of clinical senate to make recommendations on option appraisal process issues. However, the current PCBC narrative focuses predominantly on option 2, consolidating services to EDGH and Bexhill with the move of nearly 30 percent of activity from the Hastings site. The PCBC describes how the long list of 5 options, which included retaining services on all 3 sites, was reduced effectively to either a one hospital site option or a 2-hospital site option. Table 15 on page 51 of the PCBC details stakeholders in attendance at the Options Development and Appraisal workshops and conveys the impression that very few people were involved in the actual process of coming to the preferred options to be assessed against the 5 appraisal criteria. We recommend that the narrative in this important section of the PCBC clarifies the exact process to assure both the inclusivity and objectivity in the option appraisal and scoring process.

[20] Goel H, Wemyss TA, Harris T, Steinbach I, Stancliffe R, Cassels-Brown A, Thomas PBM, Thiel CL. Improving productivity, costs and environmental impact in International Eye Health Services: using the 'Eyefficiency' cataract surgical services auditing tool to assess the value of cataract surgical services. BMJ Open Ophthalmol. 2021 May 20;6(1):e000642. doi: 10.1136/bmjophth-2020-000642. PMID: 34104796; PMCID: PMC8141432 Improving productivity, costs and environmental impact in International Eye Health Services: using the 'Eyefficiency' cataract surgical services auditing tool to assess the value of cataract surgical services (bmj.com)

R10.3 The impression gained is that the choice of option 2 over options 3a and 3b was driven by financial sustainability and deliverability. We recommend detailing the improvement in quality of services hidden in the deliverability to ensure better understanding and support.

R10.4 It appears unlikely that there will be any impact on neighbouring Trusts but if that is the case it would be helpful to state this explicitly.

R10.5 The PCBC details that following pre-consultation engagement, three options development and appraisal workshops were independently chaired and facilitated by Opinion Research Services (ORS). It would be helpful to include the ORS credentials in the PCBC narrative to improve confidence in the process.

Appendix A. Key Lines of Enquiry (KLOEs)

East Sussex: - Ophthalmology - Clinical Senate Review Final Key Lines of Enquiry (KLOE)
General KLOEs
Has the Case for Change, and the health needs of the population been clearly identified? Do the proposals deliver improved and high-quality patient outcomes?
Are projections for changes in demand realistic? Taking account of: • Factors increasing demand (population ageing, population growth and increasing incidence of acute and chronic conditions) • Factors reducing demand (prevention, better long-term care, demand management, more proactive primary/community based care.
Have clinical standards been identified and are they sufficiently comprehensive as the framework for delivering high quality care and added value. How will the new proposed model ensure that ESHT will consistently meet the range of performance indicators and national guidance (improved patient outcomes from the available resources)?
How do the current proposals to transform ophthalmology services, providing one stop clinics and diagnostic eye hubs align with the longer-term strategic plans to consolidate services as part of the Sussex-wide Ophthalmology Transformation programme?
What is the potential impact on travel times (ambulance, patient transport, public transport for visitors) and how have you mitigated any adverse impacts? What are the must do times and can you achieve them for all the population, >90% of the population, >80% of the population?
Is there a coherent and realistic workforce strategy that takes account of the national shortages of consultant ophthalmologists particularly in glaucoma and age-related macular degeneration e.g. consultant led technician delivered virtual clinics?
How do the proposed new pathways of care maximise the role of the optometrist particularly for the provision of local extended primary eye care services?
Describe your plans to develop the role of the health care professional (HCP) in response to the GiRFT recommendation to optimise training and development for the MDT.

Are there any major inconsistencies in the proposed reconfiguration of services with the NHS Long Term Plan/GiRFT recommendations, 21/22 Planning Guidance.
What approaches have been taken to ensure that the future clinical models for ophthalmology take full account of sustainable healthcare requirements for the future?
Has the relevant system learning from COVID-19 been taken into account as part of the plans?
Has the breadth and depth of clinical engagement been sufficient?
Has there been meaningful patient and public involvement in coming to the options being proposed? How has the involvement to date sought to be inclusive of seldom heard, minority and deprived population groups?
B. Ophthalmology Service specific KLOEs
General comments on the proposed patient pathways, are they clear and sound? • Cataract • Glaucoma. • Medical Retina (encompassing macular degeneration and diabetic eye disease). • Oculoplastics • Neuro Ophthalmology • Primary Care Clinics (PCC) • Paediatric Ophthalmics/Orthoptics (outreach and vision screening remain as is).
With an increasingly ageing population it can be expected that there will be a significant increase in demand within the system and across Sussex for ophthalmic services. How confident are you in your demand projections for intervention for cataract, glaucoma and medical retinal services?
Within the proposed clinical models and patient pathways how do you propose to make best possible use of modern digital technology, e.g. PIFU and EERS in order to improve access to services, manage demand and improve pathways, including enhanced services for cataract and glaucoma? Is there a clear articulation of the risks and mitigations associated with 'digital poverty' in deprived localities and the impact that this may have on the delivery of the proposed revised models of care?

Is there a clear articulation of how new patient pathways might pursue the opportunities for changes in service delivery as described in the NHSE Ophthalmology road map: • Integrated eye care pathways across primary, secondary and community care • Risk stratification and failsafe processes to reduce the risk of patient harm • Remote consultations for all appointments where possible and safe to do so • Virtual diagnostic clinics for all appointments where possible and safe to do so • Patient-initiated follow-up (PIFU) care where appropriate?
Describe how you have increased community capability to facilitate integrated cross care pathway services. How does this now translate to developing sustainable integrated pathways between the community and secondary care?
How do you propose to include a Minor Eye Conditions Service (MECS) model for patients with common, minor eye ailments that might otherwise be referred to the hospital or result in an unnecessary A&E attendance?
The PCBC states that the provision of emergency ophthalmology services are not within the scope of the proposed changes. However, what are the risks to service delivery and implementation of revised clinical models through the exclusion of rapid specialist opinion, diagnosis and treatment for those people presenting to both A&Es with sight threatening emergencies.
Does the current activity and capacity modelling demonstrate that planned capacity will be sufficient to ensure there is no delay in the patient pathways?
It is not clear from the described models how the proposals eliminate loss to follow up of those with potentially sight threatening conditions. How have you mitigated against this?
There is only limited reference to the proposals to develop paediatric pathways, other than for lazy eye. Additional clarity is required with a clear reference to individual paediatric pathways with supporting capacity and activity modelling. Describe the key proposed paediatric models inclusive of proposed disposition of services within each of the proposed options.
Have clinical standards been identified, and are they sufficiently comprehensive as the framework for delivering high quality care and added value (improved patient outcomes from the available resources)?

Option appraisal process - describe how you minimised the risk of unconscious bias as options were shortlisted?
KLOEs relating to the shortlisted options - (Option 2, 3a, 3b and 4)
Option 2: Ophthalmology services located at two hospital sites, Eastbourne District General Hospital (EDGH) and Bexhill Hospital, supported by one stop clinics at both and a diagnostic eye hub at Bexhill. **Option 3a: Ophthalmology services located at one hospital site, Bexhill Hospital, supported by one stop clinics and a diagnostic eye hub at Bexhill** **Option 3b: Ophthalmology services located at one hospital site, Eastbourne District General Hospital, supported by one stop clinics and a diagnostic eye hub at EDGH** **Option 4: Ophthalmology services located at one hospital site, supported by one stop clinics and a diagnostic eye hub at the site, and community hospital clinics**
Are there option-specific issues that need highlighting in relation to: • Impact on quality of care and clinical outcomes • Equitable access for the population • Clinical co-dependencies between services • Impact on specific major inpatient clinical services • Workforce implications • Capacity (Beds, theatres, critical care) • Patient flow?
Is the impact on neighbouring hospitals clearly described and quantified for the clinical model within either option presented, and are there any associated issues of concern that may be option specific that are not described in the PCBC?

Appendix B. Glossary

A&E	Accident and Emergency
AMD	Age-related Macular Degeneration
BAME	Black, Asian and Minority Ethnic
BSL	British Sign Language
BX	Bexhill Hospital
CCEHC	Clinical Council for Eye Health Commissioning
CCG	Clinical Commissioning Group
CQ	Conquest Hospital
CUES	COVID-19 Urgent Eyecare Service
DMO	Diabetic Macular Oedema
DR	Diabetic Retinopathy
ECTP	Elective Care Transformation Programme
ECAD	Earliest Clinically Appropriate Date
EDGH	Eastbourne District General Hospital
EERS	Electronic Eyecare Referral System
EHIA	Equality and Health Inequalities Impact Assessment
EPR	Electronic Patient Record
ESHT	East Sussex Healthcare NHS Trust
GIRFT	Getting It Right First Time
GOS	General Ophthalmic Service
GP	General Practice and/or General Practitioner
HCP	Healthcare Professional
HES	Hospital Eye Services
HLOP	Healthy Living Optical Practice
HOSC	Health Overview Scrutiny Committee
ICS	Integrated Care System
IP	Inpatients
ITU	Intensive Care Unit
JSNA	Joint Strategic Needs Assessment
LOC	Local Optical Committee
LOCSU	Local Optical Committee Support Unit
LTP	Long-Term Plan
MDT	Multi-disciplinary Team
MECS	Minor Eye Conditions Service
NEL	Non-elective
NHSE/I	NHS England and Improvement
NICE	National Institute for Health and Care Excellence
OCT	Optical Coherence Tomography
OP	Outpatients
ORS	Opinion Research Services

OTWG	Ophthalmology Transformation Working Group
PCBC	Pre-consultation Business Case
PCN	Primary Care Network
PHE	Public Health England
PIFU	Patient Initiated Follow-Up
POD	Point of Delivery
PPG	Patient Participation Group
QIA	Quality Impact Assessment
RCOphth	Royal College of Ophthalmologists
RNIB	Royal National Institute of Blind People
RVO	Retinal Vein Occlusion
SAFE	Systems and Assurance Framework for Eye Health
SAS	Staff Associate Specialists
STP	Sustainability and Transformation Plan
WAMD	Wet age-related Macular Degeneration

Appendix C. Documentation provided by the East Sussex Team

Document Number	Document Name
1	East Sussex Healthcare NHS Trust Ophthalmology Services Transformation DRAFT Pre consultation Business Case V0.16.
2	Appendix 1 – Summary of ESHT Ophthalmology GIRFT Review and Visit, March 2018.
3	Appendix 2 - Equality and Health Inequalities Impact Assessment (EHIA) extended.
4	Appendix 3 – Public Engagement report v2.2
5	Appendix 4 - Transforming Acute Ophthalmology Services in East Sussex Options Development and Appraisal - Report of Findings.
6	Appendix 5 – Ophthalmology Pathways V1.1 25/06/2021.
7	Appendix 6 - Comprehensive Quality Impact Assessment Tool
8	Appendix 7 – Travel Analysis
9	Appendix 8 – Draft Consultation Document

Appendix D. South East Clinical Senate (KSS) Council Review Group membership, declarations of interest and agenda

1. South East Clinical Senate (KSS) Council Review Group Membership

Name	Roles
Paul Stevens	Kent Surrey Sussex Clinical Senate Chair
May Bullen	Patient and Public Partner
Andrew Lotery	Professor of Ophthalmology, Southampton University Hospitals Trust
Gill Manning	Patient and Public Partner (Observer)
Sarah Markham	Patient and Public Partner (Observer)
Jonathan Purday	Consultant in Critical Care, Ophthalmic Anaesthetist, East Kent Hospitals University Foundation Trust
Greg Richardson	Head Orthoptist, Royal Berkshire NHS Foundation Trust
Rebecca Rogers	GP, Surrey Heartlands Clinical Commissioning Group
Sambath Tiroumel	Consultant Ophthalmic Surgeon, Hampshire Hospitals Foundation Trust
Janet Waters	Patient and Public Partner
Helen Bell	Programme Manager, South East Clinical Senates'
Pat Haye	Assistant Director, Clinical Programmes and Delivery, NHS England and Improvement, South East
Emily Steward	Senate Manager, South East Clinical Senates'

2. Declarations of Interest

Name	Personal pecuniary interest	Personal family interest	Non-personal pecuniary interest	Personal non-pecuniary interest
Paul Stevens	None	None	None	None
May Bullen	None	None	None	None
Andrew Lotery	None	None	None	None
Gill Manning	None	None	None	None
Sarah Markham	None	None	None	None
Jonathan Purday	None	None	None	None
Greg Richardson	None	None	None	None
Rebecca Rogers	None	None	None	None
Sambath Tiroumel	None	None	None	None
Janet Waters	None	None	None	None
Helen Bell	None	None	None	None
Pat Haye	None	None	None	None
Emily Steward	None	None	None	None

3. South East Clinical Senate (KSS) Review Group Agenda 11th August 2021

South East Clinical Senate Expert Review Panel – 11th August 2021:
Review of the proposals to re design ophthalmology services in East Sussex.

*(Please note: Clinical Senate Panel **only** Pre meet 12.30-13.00pm)*
Via TEAMs link

Click here to join the meeting

Item	Time	Item	Lead
1.	12.15	**Registration/Join TEAMS (*Clinical Senates panel only*)**	
2.	12.30	**South East Clinical Senate Expert Review Panel *only* pre-meet.**	**PS**
	13.00	***Sussex Transformation Partnership team to join the meeting***	
3.	13.00	**Welcome, Introduction, context and approach to the review.**	**PS**
4.	13.05	**Presentation from the Sussex Transformation team**, summarising the strategic context, Case for Change, purpose of the proposed reconfiguration, criteria used for options shortlisting and brief overview of options. **1. Clinical model presentation** Review of the proposed clinical models and pathways: **a.** Cataract, Glaucoma, Medical Retina (encompassing macular degeneration and diabetic eye disease), Oculoplastic, Neuro Ophthalmology, Primary Care Clinics (PCC) and Paediatric Ophthalmics/Orthoptics **2. Options Presentation** Review of each of the shortlisted options for service reconfiguration including any option specific issues in relation to delivery of the proposed clinical models and pathways	**Sussex Team**
7.	14.00	**Panel Q&A** **Key Lines of Enquiry**	**PS**
8.	15.20	**Sussex Team to leave the meeting - Comfort break**	
9.	15.30	**Panel Discussion:** Key findings, evidence base and emerging themes for recommenda	**PS**
10.	16.50	**Summing up, next steps**	**PS**
11.	17.00	**Meeting close**	

Appendix E. East Sussex Panel membership

Name	Roles
Jessica Britton	Executive Managing Director, East Sussex CCG
Sharon Ball	Service Manager, East Sussex Healthcare NHS Trust
Nikki Brooker	Planned Care Officer, East Sussex CCG
Fiona Crotty	Head Orthoptist, East Sussex Healthcare NHS Trust
Mike Farrer	Strategy, Innovation & Planning Team, East Sussex Healthcare NHS Trust
Victoria Hill	Senior Planned Care Manager, East Sussex CCG
Suneeta Kochhar	GP Principal and Clinical Director, East Sussex CCG
Jane Lodge	Associate Director of Public Involvement, East Sussex CCG
Helen Peregrine	Head Optometrist, East Sussex Healthcare NHS Trust
Kashif Qureshi	Ophthalmology Clinical Lead, East Sussex Healthcare NHS Trust
Victoria Spencer-Hughes	Consultant in Public Health, East Sussex
Fiona Streeter	Associate Director of Commissioning and Partnerships, East Sussex CCG
Harriet Vogt	Community Ambassador
Kevin Wilcox	Head of Planned Care and Cancer, East Sussex and Brighton and Hove CCGs
Tracey Woolridge	Assistant Head of Planned Care and Cancer, East Sussex CCG