Elective Care High Impact Interventions: Ophthalmology Specification

May 2018 v2.0

NHS England

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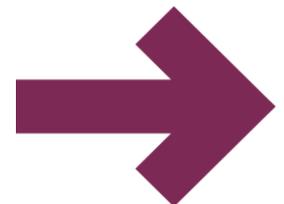
1. Introduction

Despite a reduction in the rate of growth during 2017/18, **there is a rising waiting list and declining performance against the Referral to Treatment (RTT) standard**. The number of patients referred to hospital varies greatly, even after accounting for factors such as deprivation. The Five Year Forward View Next Steps highlights that some **patients are referred to hospital unnecessarily with significant unwarranted variation in referral patterns.** This contributes to the continued increase in patients requiring Hospital Eye Services.

New patients are often prioritised and analysis of waiting times across ophthalmology pathways shows that this can result in delays for patients who require follow up. **For some patients with chronic eye conditions, delays can result in adverse outcomes including visual loss and blindness**. The ageing population means that the number of patients with these conditions will continue to increase. A combination of pathway transformation and failsafe approaches is required to ensure patients are reviewed and treated safely within agreed timeframes.

> *The underpinning principles for the high impact interventions are that patients should be seen by the right person, in the right place, first time; and patients should be seen as quickly as possible in line with their constitutional rights.*

In 2018/19 NHS England regional teams will **support the roll out of interventions and schemes to help CCGs to slow the growth in referrals** while improving clinical quality. Regional teams will work across local systems, with Sustainability and Transformation Partnerships (STPs), Integrated Care Systems (ICSs), Clinical Commissioning Groups (CCGs), trusts responsible for Hospital Eye Services (HES), Getting It Right First Time (GIRFT), RightCare and Local Eye Health Networks to ensure delivery of this **high impact intervention in all localities.**

This specification focusses on **failsafe prioritisation in ophthalmology services**. It describes the **key enablers and the actions** that trusts responsible for Hospital Eye Services, CCGs and STP/ICS leaders should take to **minimise the risk of significant harm** to those patients most at risk of sight loss due to chronic eye conditions. These include failsafe prioritisation, clinical risk and prioritisation audits and eye health capacity reviews.

2. Clinical Case for Change

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Nearly 8 million people are treated each year in Hospital Eye Services. This accounts for 8% of all outpatient appointments across the UK (NHS Digital, 2017). **Demand for ophthalmology services is not being met and continues to grow.**

More than 2 million people have reduced vision in the UK and it is estimated that this figure will double by 2050. (RNIB, 2014) The number of patients with glaucoma alone is expected to increase by 22% in the next ten years.

There are reported high rates of patients not receiving follow up appointments within the clinically-indicated (safe) time and up to 22 patients per month are losing their sight due to health service initiated delay (Foot and MacEwen, 2017). These are often vulnerable patients with chronic conditions requiring long-term routine follow-up, such as glaucoma, age related macular degeneration and diabetic retinopathy.

The predicted rise in the number of patients with these eye conditions (RCOphth, 2017) means that more patients will be at risk of losing their sight, unless action is taken to address current and future capacity issues (Davis et al, 2017). Patients requiring follow up are the most vulnerable group, as they are 8-9 times more likely to have a chronic sight threatening condition (RCOphth, 2016).

There is an ageing population, with 1 in 5 people aged over 75 and half of people aged over ninety living with sight loss (RNIB, 2018). More than 10% of over-65s have some form of visual impairment (RCOphth, 2016).

The total estimated indirect cost of sight loss (2015) is around £5.5 billion (RNIB Sight Loss Data Tool: ONS 2013, Subnational Population Projections for 2015, 2012-based projections release. Office for National Statistics). These indirect costs are £89 annually per person, compared to the annual average spend per person of £29.

Examples of the indirect health implications of sight loss include people with sight loss being twice as likely to have falls (Boyce, 2011). People with sight loss are more likely to suffer from anxiety and depression (Evans et al., 2007) and poor vision commonly precludes meaningful employment for those of working age (Rahi et al., 2009).

This intervention complements current key policy documents, guidance and recommendations, building on the work of the Royal College of Ophthalmologists and their three step plan. It is also supported by NICE guidance and reflects the recommendations of the former National Patient Safety Agency, the RNIB and the Clinical Council for Eye Health Commissioning, in their System and Assurance Framework for Eye-health (SAFE).

3. Ophthalmology Failsafe Prioritisation:
Overview and actions necessary

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This high impact intervention incorporates three key actions:

	Owner	Action
Action 1	Trusts responsible for Hospital Eye Services (HES)	**Develop failsafe prioritisation processes and policies** to manage risk of harm to ophthalmology patients.
Action 2	Trusts responsible for HES	**Undertake a clinical risk and prioritisation audit of existing ophthalmology patients**.
Action 3	CCGs/STP/ICS leaders	**Undertake eye health capacity reviews** to understand local demand for eye services and to ensure that capacity matches demand – with appropriate use of resources and risk stratification.

It is essential to combine these three actions to develop new approaches and to fully understand:

✓ **How to minimise the risk of significant harm** to patients by prioritising the review, treatment and care of those at greatest risk of irreversible sight loss

✓ **What the current demand and levels of risk to patients actually are** within the HES

✓ Which challenges exist and **what action needs to be taken** across the local system to **manage capacity effectively**, **deal with demand safely** and **prevent risk of harm to patients in the future.**

While each of these actions could be taken in isolation, they are interdependent and should be carried out together to develop new approaches that prioritise the treatment and care of those patients most at risk of coming to significant harm from delays. Results should be reported at Clinical Quality Review Groups to enable local monitoring of agreed actions by senior commissioners and Trust directors.

Action 1: Develop failsafe prioritisation processes and policies to manage risk of harm to ophthalmology patients

What is failsafe prioritisation?

The failsafe prioritisation model has two distinct but interdependent elements which ensure that **patients with chronic eye conditions receive follow up review and/or treatment from the right person, in the right place, within their specified timeframe.**

These elements are:

- **Prioritisation of patients with chronic eye conditions, based on their risk of significant avoidable harm** (i.e. irreversible sight loss) **from delay to treatment** and their **intended date for follow up**.

- **Implementation of 'closed loop' failsafe processes** that complement existing ophthalmology pathways to identify any actual or possible delays to follow up and identify and complete any actions necessary to ensure a safe outcome for patients.

These processes and back up mechanisms **safeguard against errors that result in patients becoming 'lost to follow up' or their follow up being delayed.** This ensures that patients at the highest risk of significant avoidable harm receive follow up review and/or treatment as scheduled, or at least within 25% of the timeframe for their intended date for follow up. Portfolio of Indicators for Eye Health and Care (VisionUK)

The **Royal College of Ophthalmologists** has published Ophthalmic Service Guidance for safe and efficient processes in ophthalmology outpatients. This guidance relates directly to Actions 1 and 2 in this specification, highlighting the importance of failsafe prioritisation, along with the robust mechanisms necessary to manage non-attendance, cancellations and the rebooking of appointments.

Action 1: Develop failsafe prioritisation processes and policies to manage risk of harm to ophthalmology patients

Why implement failsafe prioritisation?

Failsafe prioritisation aims to **improve patient outcomes and patient safety** by:

- Reducing avoidable vision loss
- Reducing the risk of patients becoming 'lost' or follow up being delayed
- Reducing cancelled appointments and DNAs (where a patient Does Not Attend their appointment)
- Ensuring patients are well informed

'Lost to or delayed follow up' (LTDF) describes any instance where a patient does not have an appointment booked for a follow up visit at the time which was indicated by the clinician at their last review.

This includes scenarios such as:

- Patient not discharged but no review booked or clinically indicated date for review identified, whether or not the timescale planned for review has been breached
- Patient not discharged and a review booked that is beyond the clinically indicated timescale for review. This may be due to:
  - Lack of capacity to book the appointment in agreed timescale
  - Original appointment cancelled by patient and subsequently rebooked
  - Original appointment cancelled by hospital and subsequently rebooked
  - Patient did not attend, so the appointment had to be rebooked.

Action 1: Develop failsafe prioritisation processes and policies to manage risk of harm to ophthalmology patients

What action is necessary?

Trusts should ensure that their Hospital Eye Services **develop and/or review local guidelines**, **policies** and **procedures** to ensure that patients receive follow up review and treatment from the right person, in the right place, **within 25%** of their individual **intended schedule for follow up**. (Portfolio of Indicators for Eye Health and Care (VisionUK))

Standardised processes should be implemented to:

- ✓ **Stratify** all patients **according to their clinical risk of harm** and **specify a date for follow up** based on individual diagnosis and presentation at each patient attendance.

- ✓ **Prioritise patients** for appropriate follow up review and/or treatment **based on their clinical risk of harm** and **intended date for follow up.**

- ✓ **Document and highlight the diagnosis, risk, and intended date for follow up of each patient** so that all staff can identify patients easily and any delays can be acted on.

A failsafe officer should be appointed in each ophthalmology department or site (as appropriate) to ensure the failsafe processes below are implemented and to audit their implementation:

- ✓ **Monitor all chronic ophthalmology patients who have not been discharged,** ensuring each patient has their **intended date for follow up documented** and **appointments are booked**, as appropriate.

- ✓ **Identify, investigate, report** and **escalate all overdue appointments**.

- ✓ **Book, rebook and discharge patients in outpatient clinics**. **Audit, evaluate** and **report** on **DNAs** and **cancellations**.

- ✓ **Identify gaps, inconsistencies, errors** and/or **unwarranted variation in clinical risk stratification** or **prioritisation of follow up,** ensuring pathways are completed, with outcomes recorded and monitored.

A senior clinical lead should have overall responsibility for failsafe prioritisation, ensuring that escalation of lost or delayed follow ups happens appropriately and action is taken to minimise any delay.

Action 1: Develop failsafe prioritisation processes and policies to manage risk of harm to ophthalmology patients

How to achieve success

- ✓ **Agree failsafe prioritisation processes** between all relevant administrative, managerial and clinical staff, ensuring everyone is aware of their own responsibilities.

- ✓ **Each sub-specialty should have a nominated failsafe officer**. Band 4 or 5 is suggested for this role, with a clear line of accountability to the senior clinical lead. Consider how this role is covered across 52 weeks of the year to ensure there are no gaps that could exacerbate delays.

- ✓ The **failsafe officer needs to liaise effectively with administrative staff, senior clinicians and colleagues across primary/secondary care** and may be **part of a wider capacity management remit**. The post holder needs the **authority not only to challenge the prioritisation of patients** within the outpatient system if protocols are not being followed and also to **press for appropriate discharges and community follow-up**, where appropriate.

- ✓ The **resource required will depend on the size of the department and whether the failsafe officer covers more than one sub-specialty/area** (i.e. glaucoma, diabetes, intravitreal injections etc).

- ✓ **Undertake regular audits of adherence to policies and protocols** and **offer training** where necessary, including **for non-clinical staff**, **to understand the nature and progression of eye diseases**.

- ✓ **Ensure that the Patient Administration System (PAS) can record diagnosis, risk, priority status and intended date for follow up**, so all staff can identify high priority patients and any delays can be identified and acted upon.

- ✓ Hold **stratified clinics**, based on clinical diagnosis and risk of avoidable harm, wherever possible.

- ✓ Ensure **systematic and proactive feedback is provided to all GP and optometrist referrers.**

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Action 1: Develop failsafe prioritisation processes and policies to manage risk of harm to ophthalmology patients

How to achieve success

- ✓ **Identify individual risk** and **intended date of follow up for each patient. Treatment plans should be based upon these**.

- ✓ **Ensure patients are aware of their intended date for follow up and the importance of attending**. The RNIB Ask and Tell initiative empowers patients to ask when they should be seen and to tell the eye clinic if their appointment falls beyond this time.

- ✓ For **high risk patients**, where the next follow up appointment is within 6 weeks, **enable patients to book their next review appointment before they leave the hospital.** This reduces the likelihood of DNA, as the patient knows when the appointment is. Discussion can also take place with clinicians if there is a problem booking the appointment within the clinically appropriate timeframe.

- ✓ **Send a reminder by text and/or telephone** for all appointments a few days beforehand to minimise DNAs and optimise the use of clinic time.

- ✓ If a patient does not attend (DNA), **a clinician should review their records to decide whether or not a further appointment is necessary and to confirm the intended timeframe** for this appointment.

- ✓ **Do not reschedule appointments without clinician input**, to ensure that the clinical risk and target date for follow up for the individual are considered.

- ✓ It is good practice to have significant consultant input into decisions to book a review visit, to **reduce unnecessarily frequent re-attendances and to increase safe discharge rates**. Do not give patients a follow up appointment without a clear, documented, clinical reason.

The Ophthalmic Service Guidance for safe and efficient processes in ophthalmology outpatients contains further detail and useful information.

Action 2: Undertake a clinical risk and prioritisation audit of existing ophthalmology patients

What is a clinical risk and prioritisation audit and why do one?

A clinical risk and prioritisation audit of existing ophthalmology patients should examine data and patient records to **establish and record how many patients are awaiting follow up**, **delays to follow up (highlighting any hospital-initiated deferrals)** and any **LTDF patients**. (RCOphth Three Step Plan, 2016).

It is both an **administrative and a clinical process**, with several stages (Davis et al, 2017). An administrative review alone will enable services to begin to understand current need and the size of their backlog. Clinical review of records is necessary for informed decisions to be made and actions to be taken to address any backlog or delays.

One of the main causes of avoidable sight loss in patients within Hospital Eye Services is delayed follow up appointments. (Foot and MacEwen, 2017). Hospital Eye Services have not previously been required to report or monitor delays for follow up appointments, (RCOphth Three Step Plan, 2016), therefore the scale of any backlog is not immediately evident.

A clinical risk and prioritisation audit **enables the identification of those patients at most risk of serious irreversible harm** so that appropriate plans can be put in place to review and treat them. (RCOphth Three Step Plan, 2016)

In response to the NPSA Glaucoma Safety Alert in 2009, Moorfields Eye Hospital effectively and efficiently reviewed the records of all ophthalmology patients without a follow up appointment booked (145,234 episodes). 54.8% (70,562) of these episodes were closed following administrative review alone. A further 34.8% (50, 519) of these patients were discharged following clinical review of the paper records.

Davis, A. et al., 2017. A review of 145234 ophthalmic episodes lost to follow up. *Eye,* 31, pp. 422-429

Action 2: Undertake a clinical risk and prioritisation audit of existing ophthalmology patients

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What actions are necessary?

Trusts should ensure that their Hospital Eye Services undertake a clinical risk and prioritisation audit of existing ophthalmology patients in line with the recommendations of the NPSA Rapid Response Report, 2009 and the RCOphth Three Step Plan to identify and record:

✓ The number of patients awaiting follow up

✓ Any patients with delays to follow up (highlighting any hospital-initiated deferrals or cancellations)

✓ Any patients 'lost to follow up'

✓ DNA rates.

The risk and prioritisation audit should align with the processes, policies and protocols developed and implemented to ensure failsafe prioritisation.

✓ Serious Incident (SI) reporting protocols and management procedures should be followed whenever a patient stratified as high risk is identified as LTDF (RCOphth, 2018) or is not seen within 25% of their intended schedule for follow up. (Portfolio of Indicators for Eye Health and Care, VisionUK, 2018)

Action 2: Undertake a clinical risk and prioritisation audit of existing ophthalmology patients

NHS England

How to achieve success

There are several possible stages to this process:

✓ **Administrative review of all patients** to identify those without a follow up appointment booked
  ↳ **Discharge** of those patients known to have died or who have received a discharge letter but not been discharged from the system.

✓ **Administrative review of a significant sample of patients with follow up appointments currently booked** to identify whether their follow up is overdue
  ↳ **Prioritisation and rebooking** patients where appropriate.

✓ **Clinical review of electronic records** of remaining patients
  ↳ **Discharge** of those patients where there is sufficient information to make this decision.

✓ **Clinical review of paper records** of remaining patients
  ↳ **Discharge or transfer or care** to appropriate community services, where clinically indicated.

✓ **Prioritisation and rebooking** of remaining patients to ensure follow up appointments take place.

Adapted from: Davis, A. et al., 2017. A review of 145234 ophthalmic episodes lost to follow up. *Eye,* 31, pp. 422-42

✓ If an audit identifies a backlog of high risk patients, trusts should consider evening or weekend clinics or securing external provision to help clear this backlog.

Action 3: Undertake local eye health capacity reviews

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What is an eye health capacity review and why undertake one?

An eye health capacity review enables local areas to understand current levels of activity and use of eye services and to ensure that capacity matches demand (RCOphth Three Step Plan, 2016). It aims to improve equity of access to ophthalmology services.

Such reviews can identify opportunities to improve provision and develop Hospital Eye Services, primary eye care and community ophthalmology services to help manage demand, using clinical risk stratification to ensure that patients see the right person, in the right place, first time.

Objectives:

✓ Determine and review current capacity locally (including private providers)

✓ Determine drivers of future demand and estimate impact on capacity requirements

✓ Determine the most appropriate local model for delivery across primary care, community and secondary ophthalmology services, optimising skills and capacity within the system.

✓ Ensure that ophthalmology pathways and referral processes are standardised and understood locally, with patients directed to the right person, in the right place, first time.

Action 3: Undertake local eye health capacity reviews

How to achieve success

- ✓ Work across local systems, involving Local Eye Health Networks, provider organisations, consultant ophthalmologists and clinicians from all relevant trusts, Local Optical Committee(s), public health and all other relevant stakeholders to understand the current and possible challenges and opportunities.

- ✓ Ensure risk stratification across the whole pathway is integral to commissioning processes (CCEHC System and Assurance Framework for Eye-Health, 2018)

- ✓ Determine and review appropriateness and quality of current referral activity and capacity locally (including private providers).

- ✓ Determine drivers of future demand and estimate their impact on capacity requirements.

- ✓ Determine the most appropriate local model for delivery of ophthalmology services across primary care and community and secondary ophthalmology services, optimising skills and capacity within the system. (CCEHC System and Assurance Framework for Eye-Health, 2018)

- ✓ Ensure clear strategies are in place to reduce unnecessary new attendances, such as targeted continuing professional development for community practitioners, advice and guidance on pathways, efficient discharge policies and reliable, high quality feedback to referrers.

- ✓ Consultant time and expertise should be maximised with the backing of an effective multi-disciplinary team made up of medical and non-medical eye healthcare professionals (RCOphth Three Step Plan, 2016).

- ✓ Consideration should be given to post-operative discharge of low risk cataract patients to help release capacity, with the commissioning of community optometrists to deliver post-operative follow up care and reporting of visual acuity outcome data. (The Way Forward, RCOphth, 2017) (Monitor, 2015)

- ✓ Use the evidence gathered on delayed or cancelled follow up appointments as part of the clinical risk and prioritisation audit and the reasons behind these as the starting point for a local needs assessment plan. (NPSA, 2009).

Action 3: Undertake local eye health capacity reviews

NHS England

Key resources for action 3:

[CCEHC: System and Assurance Framework for Eye Health (SAFE)](#)

The SAFE (2018), developed by the Clinical Council for Eye Health Commissioning (CCEHC) provides local organisations in STPs (and ICSs) with a means for taking forwards the capacity reviews through a systems-based approach to service planning and provision, to manage patient flows across their whole pathway within a service system.

This includes:

[SAFE: Overview](#)

[SAFE: Cataract](#)

[SAFE: Glaucoma](#)

[SAFE: Age Related Macular Degeneration](#)

[SAFE: Implementation of NICE Guidelines](#) (This presents the key NICE recommendations and their relative priority for implementation.)

[SAFE: Quality Indicators for Commissioning](#) (These indicators serve to provide quality assurance of the commissioning process).

[CCEHC Primary Eye Care Framework for First Contact Care](#)

[CCEHC Community Ophthalmology Framework](#)

[CCEHC Low vision, habilitation and rehabilitation framework](#)

CCEHC Frameworks (for services for Primary Care for First Contact; Community Ophthalmology; and low vision, habilitation, and rehabilitation) provide the basis for how pathways of care within a service system are organised, delivered and monitored, based on the clinical risk stratification of a patient's condition and the skills and competence of the health care practitioner.

[RCOphth Commissioning Standards for Ophthalmology](#)

[Commissioning Guide: Glaucoma – Full Report](#)

[LOCSU Commissioning Guidance](#)

[NICE guidance for cataract in adults NG77](#)

[NICE guidance for glaucoma NG81](#)

[NICE guidance for AMD NG82](#)

[NICE QS for glaucoma](#)

[Eye Health Network for London: Achieving Better Outcomes](#) is a good practice example of the review of pathways, capacity and service redesign, with recommendations linked to national policy and local need.

The [Portfolio of Indicators for Eye Health and Care (Vision UK)](#) presents key evidence-based indicators relevant to eye health, services and care for regular monitoring of their quality and outcomes.

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4. Implementation overview

2018/19

Actions necessary:

- NHSE central team to co-ordinate a baseline audit against the Hospital Eye Services actions.
- Local GIRFT Teams to use results from the baseline audit, data from GIRFT deep dives and local intelligence to help inform the prioritisation of Hospital Eye Services for support with implementation of:
  - **Action 1:** Hospital Eye Services to develop failsafe prioritisation processes and policies to manage risk of harm to ophthalmology patients.
  - **Action 2:** Hospital Eye Services to undertake a clinical risk and prioritisation audit of existing ophthalmology patients.
- The prioritisation of Hospital Eye Services for phased local roll out of these actions will take into account the data review and the ongoing *phased 'go live'* of GIRFT Implementation Hubs around the country. The local prioritisation will be confirmed at the seven local implementation workshops for GIRFT/NHSE colleagues.
- GIRFT regional colleagues will monitor uptake of these actions and feed back on progress to NHSE regional colleagues who are responsible for reporting via the NHSE assurance process.
- CCG/STP/ICS leaders to ensure a plan is developed across the appropriate footprint during Q1 with details of how the following will be delivered:
  - **Action 3:** CCG/STP/ICS leaders to undertake local eye health capacity reviews to understand local demand for eye services and to ensure that capacity matches demand – with appropriate use of resources and risk stratification.
- NHS England regional teams will assure these local ophthalmology transformation plans.

2019/20 onwards

Actions necessary:

CCGs/STPs/ICSs are expected to ensure that:

- Clinical risk stratification, prioritisation and failsafe processes are embedded and being used effectively.
- IT processes and systems are being used appropriately across Hospital Eye Services and community ophthalmology services to flag patients at risk of harm, manage their care appropriately and feed back to referrers.

The Elective Care Transformation Programme will be working in partnership with other national programmes to help local systems implement this intervention:

- GIRFT to incorporate the HII specification and recommendations as part of their work, ensuring essential and efficient clinic management processes are embedded.
- NHS Digital to develop an Information standard to support system changes.

5. Ophthalmology Failsafe Prioritisation
Key Outcome Measure

The key outcome measure below is extracted from The Portfolio of Indicators for Eye Health and Care (Vision UK), which presents key evidence-based indicators relevant to eye health, services and care for regular monitoring of their quality and outcomes.

Portfolio Indicator - 11	Minimum Standard	Achievable standard	Reporting frequency	Data source Data collection	Evidence/ policy base	Purpose/ application	Domain and Population Group	Indicator Definition
Percentage of hospital appointments that occur within 25% of their intended follow up period, including rescheduling of hospital initiated cancellations and non-attendance.	85%	95%	Quarterly	**Data source:** Local trust or service provider **Data collection:** Local Hospital Eye Service departmental audit and review.	• NPSA alert for glaucoma (2009) • Unchanged from portfolio of indicators (2015)	• Would monitor delays in continuity of management and losses to follow up, arising from capacity issues (clinical and administrative) – especially for chronic diseases (Glaucoma, AMD, Diabetic Eye Disease) • This could be included in service/pathway contract specifications for review through clinical audit • An in-depth review is triggered for all appointments falling outside the standard • Applicable in devolved nations with nation-specific amendments	Safety Effectiveness Experience All ages	Booking interval applied to any changes to planned appointments i.e. if planned follow up interval cannot be accommodated, or for re-booking DNA (did not attend). Trust or Patient cancellation

In order to be able to record the above metric, the 'Earliest Clinically Appropriate Date' field on the PAS system should be completed with the target date for follow up for each patient that is determined by their clinician. The diagnosis code field should also be completed so that the risk can be documented. Both these fields can be found in the outpatients data set (as defined in the NHS Data Dictionary).

6. Case Study:

Southend University Hospital Trust - Audit of ophthalmology follow up patients and implementation of failsafe prioritisation processes

The challenge or opportunity	The intervention

• Identify the number of patients awaiting follow up appointments
• Reduce the Ophthalmology waiting list
• Improve clinical quality
• Ensure that high risk patients are appropriately prioritised
	✓ A two stage review had been carried out in the ophthalmology department to monitor and prioritise clinical risk in ophthalmology patients:
	    • Administrative review - Identifying patients who can be discharged without clinical review and identifying whether booked follow ups are overdue
	    • Clinical review - Identifying low risk patients who could be discharged and high risk patients who still need follow up appointments.
	✓ Initial exercise of clinical review of waiting list involved procuring extra clinical capacity but reduced number of patients from approximately 18,000 to approximately 6,000. Teaching sessions were helpful in mitigating against junior doctors 'over-referring' patients for follow up. Southend hospital delivered the training and set criteria for follow ups which also helped to reduce the waiting list .
	✓ As a result of recommendations from Moorfields, the Trust had senior clinicians directly oversee clinics as well as seeing patients in order that they had better ownership over the referral and follow up practices.
	✓ The development of the pathway was led by the trust clinical lead, alongside fellow clinicians, which helped to get clinical buy-in when it was implemented
	✓ Service lead clinicians meet routinely with admin team to review referrals and ensure patients are triaged to the right provider.
	✓ The Trust is developing nurse-led injection clinics to ensure that doctors only see patients that they need to see.
	✓ No patient now leaves clinic without an appointment booked

6. Case Study:

Southend University Hospital Trust - Audit of ophthalmology follow up patients and implementation of failsafe prioritisation processes

The intervention (continued…)

✓ The aim and focus of the weekly review is to ensure prioritisation of appointments is correct aimed along the following lines:

Stratification
- Casualty – urgent care needed
- AMD patients – needing treatments (injections) due within specific timeframes
- Glaucoma – high risk patients (unstable)
- Glaucoma – high risk patients (stable)

Prioritisation
- Urgent Follow-up - 1-3 weeks
- Follow-up - 4-6 weeks
- Urgent New referrals
- Routine New referrals

✓ The reviews focus on getting clinical input into prioritising as indicated above and it helps with moving doctors away from their normal schedules to specific areas of need as required.

✓ The hospital's patient records system (PAS) forms the main source of patient information for the reviews. An excel spreadsheet is used to stratify and prioritise as above and then further broken down by sub-speciality before patients are assigned to doctors and appointments are arranged to reduce the number of outstanding patient appointments.

✓ A partial booking system is created using information from the outcome forms and once validated via the weekly reviews, actual appointments dates are created and sent to patients for their follow up appointments. This system allows for prioritisation to be carried out before appointments are confirmed.

6. Case Study:

NHS England

Southend University Hospital Trust - Audit of ophthalmology follow up patients and implementation of failsafe prioritisation processes

Outcome and Impact	Lessons Learned
• Visibility of the backlog for follow ups was enabled. • Whilst there was additional cost to the initial clinical review of approximately £10 per patient, all other interventions were completed as part of business as usual and without additional implementation or ongoing costs. They helped to reduced the waiting list from approximately 18,000 to 6,000. • Through the outsourcing of follow up appointments and extra resource for 'super Saturday' clinics, the service has now reduced the number of overdue follow up appointments to just over 4000.	• Securing funding to outsource earlier on in the period of staff shortages would help in reducing the backlog faster. • Introducing the weekly monitoring process earlier would give focus and clarity to patient care and give assurance to stakeholders on having clinical input in managing patient referrals. • Booking of laser treatments has previously cost valuable appointment time. Allocating points (relating to time required) to each type of laser treatment has allowed a more targeted appointment time allocation which has reduced wastage on appointment times. • Conversion rates that have increased due to staff shortage (18+ weeks outstanding etc.) can be better managed by reports on a more granular level to indicate the level of backlog by sub-specialty. A new review process targeting outstanding lists for each sub-speciality will enable the clinical lead to focus on the more critical areas and allocate resources accordingly. • Using hard copy outcome forms alone as done historically often caused discrepancies and errors. This has now been rectified as they are now scanned and uploaded onto the electronic system to allow verification of recommended follow-up dates. • The partial booking system created acts as an enabler for the effective management of prioritised bookings.

6. Case Study:

Risk stratification: Manchester Eye Hospital

The challenge or opportunity

- Increasing demand for ophthalmology services
- High risk patients need frequent outpatient review.

The intervention

- Developed team with visual scientist and lead optometrist working with consultant ophthalmologist.
- Engaged with LOC and commissioners.
- Training of optometrists in HES in glaucoma assessment and management and nurses in patient education.
- Stratification of patients as low, medium and high risk:
  - Low risk GEC virtual clinics
  - Interim GEC virtual clinics for backlog and those already waiting a long time
  - Optometric led Glaucoma Clinic for medium risk
  - Consultant clinics for high risk/complex.

Outcome and Impact

- Triage of new referrals to reduce first appointments and ensure patients are seen by appropriate clinician.
- Impact – more appropriate use of clinician time.

Lessons Learned

- Key successes – training and accreditation of roles and stakeholder engagement.

6. Case Study:

Clinical prioritisation of follow up: Betsi Cadwaladr University Health Board

The challenge or opportunity

- Hospital Eye Services (HES) in Wales have a backlog of patients with chronic eye conditions needing ophthalmologist supervision of care.
- Delays in initial assessment and follow-up for some conditions may lead to irreversible sight loss.
- Regular ongoing review is required to ensure the outcome of improved sight and reduced risk of avoidable blindness is achieved.
- Eye referral and subsequent first appointment is included within RTT, however the subsequent pathway (follow up appointments) is not currently subject to a target or prioritised or recorded and reported on waiting lists.
- This raised concerns with stakeholders who have looked at outcome measures and made proposals for ophthalmic follow up patients.

The intervention

- Introduced new Patient Target Date (PTD) for all appointments and monthly reporting on percentage of patients waiting longer than the target date.
- Patients have a maximum waiting time following referral and clinically indicated intervals for ongoing review.
- 95% of priority 1 patient seen by their target date or within 25% of their target waiting period.
- PTD sequenced in priority order within their sub-category. Anyone missing their PTD will be seen in priority sequence.

Considerations:

- The three categories agreed in the Ophthalmology Specialist Advisory Group paper on clinical prioritisation are:
  - P1: Risk of irreversible harm or significant patient adverse outcome if PTD is missed
  - P2: Risk of reversible harm or adverse outcome if PTD is missed
  - P3: No risk of significant harm.

Outcome and Impact

- A decrease in the number patients with high risk conditions in the backlog.
- Potential increase in waiting times for patients with conditions that did not threaten irreversible sight loss.

Lessons Learned

- Until the waiting list is reduced, specific waiting time standards based on clinical need to define the risk if the Patient Target Date is missed.

7. Further resources

- RCOphth Three Step Plan, 2016
- The Way Forward, RCOphth, 2017
- RCOphth Ophthalmic Service Guidance for safe and efficient processes in ophthalmology outpatients, 2018
- Portfolio of Indicators for Eye Health and Care (Vision UK)
- NPSA, 2009
- Eye Health Network for London: Achieving Better Outcomes
- CCEHC – System and Assurance Framework for Eye Health (SAFE), 2018
- CCEHC Primary Eye Care Framework for First Contact Care
- CCEHC Community Ophthalmology Framework
- CCEHC Low vision, habilitation and rehabilitation framework
- Commissioning Guide: Glaucoma – Full Report
- LOCSU Commissioning Guide
- Davis, A. et al., 2017. *'A review of 145234 ophthalmic episodes lost to follow up.'* Eye, 31, pp. 422-42
- Foot B, MacEwen CJ. Surveillance of Sight Loss due to delay in ophthalmic treatment or review: frequency, cause and outcome. EYE 2017;31:771-775

In summer 2018, as part of the series of **Elective Care Specialty Handbooks,** NHS England will be publishing an Ophthalmology handbook, illustrating where local healthcare systems have redesigned and improved elective care pathways.

The Elective Care Transformation Programme are launching the Elective Care Community of Practice in spring 2018. For more information, please email: england.electivecare@nhs.net.