The Royal College of Ophthalmologists champions excellence in care. In order to provide the best care for patients, and to generate improvements in care, it is important to be able to measure the quality of clinical services provided. In addition, measuring quality provides quality assurance data for patients, regulators and commissioners. There are many possible ways of measuring service quality including clinical audit, outcome measures and patient surveys.

The College's Quality and Safety Group provides a set of simple self-assessment tools for a number of clinical services: cataract, glaucoma, adnexal, medical retina (including age-related macular degeneration [AMD]), diabetic retinopathy, vitreoretinal surgery, neuro-ophthalmology, children and young adults and adults with learning difficulties. The tools focus on service provision not outcomes and do not attempt to assess every aspect of service but try to focus on a small number of key areas. It is not expected that most clinical services will answer ‘Yes’ to all of the question, and the results should be used in conjunction with other methods of quality assessment to support learning and improvement.

Please send feedback on the form and how you have used it to assess and change your services to [Beth Barnes](mailto:%20beth.barnes@rcophth.ac.uk?subject=Quality%20Standards%20Development%20Feedback), Head of Professional Support [beth.barnes@rcophth.ac.uk](mailto:beth.barnes@rcophth.ac.uk).

Disorders of the retina which are treated non-surgically are very common (age related macular degeneration, diabetic retinopathy, retinal vascular occlusions etc.) and, if mild or long standing, may be dealt with in primary care, primary care ophthalmology, screening services and general ophthalmic services.

Medical retina (MR) disease standards in this document apply to care of the common conditions at the severe or acute end of the spectrum, those requiring invasive procedures and more serious or unusual conditions such as posterior uveitis or unusual retinal vasculopathies, which are more appropriately managed in a dedicated MR service.

1. Consultant leadership.

There is at least one consultant with subspecialist MR training delivering MR care:

YES  NO

There is a nominated lead for MR disease, or for AMD and for diabetic/vascular retinopathy, with this role specified in their job plan / job description:

YES  NO

Evidence / comments:

1. There is a MR/AMD/diabetic retinopathy clinic coordinator or failsafe officer to ensure high risk patients are seen and managed on time:

YES  NO

Evidence / comments:

1. Patients affected by significant or serious MR disorders are seen within a dedicated MR service:

YES  NO

Evidence / comments:

1. Patients with MR disease are routinely supplied with information in an accessible format on their diagnosis, treatment and medication:

YES  NO

List available MR disease leaflets:

Evidence / comments:

1. LogMar visual acuity testing is in routine use (defined as over 75% of the time) for patients**:**

YES  NO

Evidence / comments:

1. Specialist investigations are available:

* Retinal photography YES  NO
* Retinal OCT YES  NO
* Fundus fluorescein angiography YES  NO
* Indocyanine green angiography YES  NO
* Autofluorescence YES  NO
* Wide-field imaging / angiography YES  NO
* Electrodiagnostics (in most units via referral) YES  NO

Evidence / comments:

Imaging, particularly fluorescein angiography, is available:

* Usually without another attendance required (same day) YES  NO
* Frequently enough that treatment is not delayed YES  NO

1. A local rapid referral proforma and pathway for suspected wet AMD for optometrists and general practitioners is available:

YES  NO

Evidence / comments:

1. The Information Technology infrastructure allows networked viewing of all relevant ophthalmic clinical images on workstations in all relevant ophthalmic clinical areas providing the AMD and vascular retinopathy services:

YES  NO

Evidence / comments:

1. Medical retina conditions are managed by appropriately trained clinical staff, or trainees under the supervision of fully trained staff, and appropriate protocols are adhered to:

YES  NO

Where nonmedical staff see MR patients appropriate governance arrangements should be in place including regular in-house training, extended role protocols and recorded competency standards:

YES  NO

Intravitreal injections are undertaken by fully trained clinical staff, or trainees under the supervision of fully trained staff, and appropriate guidelines are adhered to:

YES  NO

Where nonmedical staff undertake intravitreal injections, appropriate governance arrangements should be in place including regular in-house training, extended role protocols and recorded competency standards:

YES  NO

Evidence / comments:

1. Follow up.

The service consistently reviews patients regularly in line with College and NICE Guidelines on AMD and vascular retinopathies and adheres to clinician requested timing of appointments:

YES  NO

The service regularly monitors adherence to clinician requested timing and has no significant “follow up backlog” or delay:

YES  NO

There are no serious incidents of visual harm due to delayed follow up reported in the last 6 months:

YES  NO

Evidence / comments:

1. There is an agreed policy covering do not attend (DNA) patients, cancellations and rescheduling that takes into account visual disability, the needs of vulnerable adults, communication with patients and primary care physicians and also ensures clinician input into decisions on timing of rebooking or discharge:

YES  NO

Evidence / comments:

1. There is easy access to an Eye Clinic Liaison Officer or patient support officer who has close links to social services and relevant third sector organisations (e.g. Macular Society, RNIB) and has received training in psychological/mental health implications, including the Charles Bonnet syndrome, and social aspects of loss of vision in the elderly?

YES  NO

Evidence / comments:

1. There is access to low vision aid (LVA) services within the 18 weeks referral to treatment time:

YES  NO

Evidence / comments:

1. The service has a policy/strategy for providing smoking cessation advice and or signposting to such cessation services relevant patients:

YES  NO

The service has a policy/strategy for providing information or advice on diet and or micronutrient supplementation to relevant AMD patients:

YES  NO

Evidence / comments:

1. Audit. Care and outcomes are audited, using recognised standards, and used for quality assurance and to improve services.

* Adherence to protocols and guidelines including NICE guidelines YES  NO
* Visual acuity loss after intravitreal injections YES  NO
* Visual acuity gain after intravitreal injections YES  NO
* Endophthalmitis rates and other complications of intravitreal injections YES  NO
* Audit data is used for appraisal / performance management of ophthalmologists

YES  NO

Evidence / comments:

# Action Plan

|  |  |  |  |
| --- | --- | --- | --- |
| **Issue identified** | **Action to be taken** | **Who will lead action** | **Date for completion** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |