Ophthalmology

Ophthalmology: Support document for commissioners through CCGs, STPs and regional reconfigurations

The ROYAL COLLEGE of OPHTHALMOLOGISTS

What are the potential patient safety risks in the commissioning of ophthalmology activity and how can they be alleviated?

Ophthalmology, as a specialty, recognises the need for changing and modernising the delivery of care as demand has increased incrementally year on year. It is a high volume specialty (over 8% of all outpatients seen and 7% of all surgical activity) and relates to a variety of very different disease management requirements – from conditions that will not need any follow up through, for example, high volume cataract surgical pathways to those that require regular assessment and treatment appointments for several years, or even for life. This, in itself, is a challenge. The risk of unnecessary loss of vision due to failure to manage essential follow up outpatient appointments effectively is well recognised.

The combination of an increasing prevalence of ophthalmic disease in an aging population, new treatment availability and NICE guidelines has increased demand for ophthalmology services without a matching increase in ophthalmic workforce or infrastructure support. The lack of capacity is exacerbated by the 18 week RTT, which can act as a perverse incentive to prioritise new over follow up patients. There is compelling evidence, from sources including the NPSA, the National Reporting and Learning System (NRLS), CQC inspections, patient and charity groups, and The Royal College of Ophthalmologists British Ophthalmological Surveillance Unit survey, that hundreds of patients have suffered irreversible loss of vision due to delay in ophthalmology outpatient follow up attendances from 2003 onwards, with ongoing evidence of about 200 such cases still occurring annually in the UK.

The recent changes in outpatient tariff payments have the potential to compound this situation by putting further pressures on providers to reduce or delay clinically appropriate follow up appointments and even creating the potential that recommended chronic disease pathways become financially unviable, endangering patient safety. Currently there is a lack of established provision to undertake the required care in a community or primary care setting. The use of inventive and supportive local contract variations could potentially alleviate this risk, whilst work and training continue to increase community and secondary care capacity. In particular, it is important to:

- Identify the particular patient groups at risk who require ongoing follow up for chronic disease monitoring and management and ensure agreement about safe new to follow up ratios for these specific conditions
- Have a clear understanding of the local issues and data around the extent and nature of the delays that affect follow up appointments and actively monitor and report on these – this will help to drive change if managed appropriately
- Consider agreement on KPIs/Commissioning for Quality and Innovation (CQUINs) to limit the delays (e.g. limit delays to be no more than a 25% time delay from the time determined by the clinician based on clinical judgement or disease specific guidance

- Explore incentives/KPIs/CQUINs to promote models of care within both primary and secondary which maximize current capacity using nationally recommended pathways eg the development of virtual clinics, development of protocols, connectivity
- Agree access and 'Did Not Attend' (DNA) policies between commissioners and providers that reflect clinical risk (e.g. clear policies for the number of DNA and cancellations and thresholds for discharge. Enforce a requirement for the records of all DNAs and cancellation patients to be reviewed by clinicians for risk based decision on outcome with clear pathways for communicating these decisions to primary care clinicians). Resist 'standard' DNA letters
- Develop an active management plan of activity in ophthalmology to work across the primary /secondary care interface and between secondary care providers in the region, to identify suitable patients and networked pathways for management in different secondary care and community locations and the training needs and infrastructure to deliver this
- Commissioners should identify where the new tariffs do not adequately cover costs for safe chronic disease outpatient care and consider local contract variation to decrease patient risk whilst ensuring incentives for effective and efficient care

What is the evidence base for commissioning outpatient activity?

The use of new to follow up ratios across ***all*** ophthalmic care is a crude way of commissioning outpatient activity. In many conditions regular long term monitoring with or without outpatient procedures (eg intravitreal injections/ laser treatment) are part of nationally recommended treatment pathways and this is particularly true for chronic retinal disease and glaucoma. Most notably these include National Institute for Clinical Excellence (NICE) approved interventions for the management of age related macular degeneration, diabetic macular oedema (DMO) and retinal vein occlusion (RVO) and NICE guidance for the management glaucoma.

These high-risk outpatient-based active treatment pathways, which reflect chronic patient management, should be considered separately to routine outpatient care, and commissioning guidance is available from the College. Expected new to follow up ratios for these particular patient groups would be approximately 1:16 in high risk glaucoma and 1:12 in age related macular degeneration and diabetic eye disease.

In comparison, many high volume ophthalmic conditions require no or minimal follow up and these should also be noted and their n:fu ratios identified.

What are the possibilities for new ways of working in delivering ophthalmology outpatient activity?

There are many examples of new and innovative ways of delivering patient care. These involve ways to:

- decrease the number of false positive referrals into secondary care
- optimise secondary care efficiency and value
- deliver care in different settings through shared or community care and virtual clinics.

Commissioners and providers from all disciplines in the ophthalmic sector (optometry, medical, nursing, orthoptic, ophthalmic technicians) should work together with the NHS England Local Eye Health Networks to maximise potential and ensure good clinical governance of such innovative pathways. Examples, and how they can be commissioned and developed can be found in:

- RCOphth The Way Forward publications
- Commissioning Frameworks produced by the Clinical Council for Eye Health Commissioning (CCEHC)
- RCOphth Commissioning Guidance for Glaucoma and Cataract
- College of Optometrists and the Local Optical Committee Support Unit (LOCSU)

How to assess quality, safety and cost effectiveness of secondary and surgical ophthalmic care

The RCOphth has developed simple self-assessment Quality Standard tools for secondary care for all the major ophthalmic subspecialties, children/young people and groups of vulnerable patients, which are recommended to be reassessed at least annually. These provide a rapid assessment of quality and safety in units and networks of secondary ophthalmic services and can be used by providers and commissioners for assurance and to drive quality improvement.

The College has also produced a draft Model Ophthalmic Hospital tool which can be used for assessment and more benchmarks for inclusion will emerge as the GIRFT project progresses.

Glossary

AMD – age-related macular degeneration, deterioration or breakdown of the eye's macula due to increasing age.

RVO - retinal vein occlusion, a blockage of the retinal veins causing poor blood supply and swelling (oedema) in the retina.

CCEHC – Clinical Council for Eye Health Commissioning, set up to provide national clinical leadership for eye health. It brings together leading patient and professional bodies involved in eye health (includes The Royal College of Ophthalmologists and the College of Optometrists). For a full list of members: http://www.college-optometrists.org/en/utilities/document-summary.cfm?docid=8AFDDCBB-9BAA-44EF-8CC2504ED0CE2B4D

CQC - The ***Care Quality Commission*** monitors, inspects and regulates hospitals, care and social care services. www.cqc.org.uk

CQUINs - Commissioning for Quality and Innovation. These are payments intended to encourage care providers to share and continually improve the delivery of care. Commissioning for Quality and Innovation

DNA - Did not attend – The patient did not attend an appointment and no explanation was given in advance of the appointment. DNAs can be the result of many causes, including visually impaired people receiving notification of appointments in inappropriate forms.

KPI - *Key Performance Indicator,* a measurable value that demonstrates how effectively an organisation is achieving key objectives.

LOCSU – local optic support unit, supports Local Optical Committees (LOCs), community optometrists and opticians across England to work with local commissioners in developing local community based eye health services.

NICE - The National Institute for Health and Care Excellence provides national guidance and advice to improve health and social care. https://www.nice.org.uk/about

NICE Technology Appraisals - assess the clinical and cost-effectiveness of health technologies, such as new pharmaceutical and biopharmaceutical products, to ensure that all NHS patients have access to the most clinically- and cost-effective treatments available.

NRLS - The National Reporting and Learning System is a central database of patient safety incident reports. https://report.nrls.nhs.uk/nrlsreporting/

NSPA - National Patient Safety Agency. in **June 2012** the key functions and expertise for patient safety developed by the NPSA transferred to the NHS Commissioning Board Special Health Authority.

RTT – Referral to treatment. The NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment. https://www.england.nhs.uk/resources/rtt/

References

1. Surveillance of sight loss due to delay in ophthalmic treatment or review: frequency, cause and outcome. barny.foot@rcophth.ac.uk Authors: B Foot and C MacEwen http://www.nature.com/eye/journal/vaop/ncurrent/full/eye20171a.html
2. The Way Forward was commissioned by the RCOphth to identify current methods of working and schemes devised by ophthalmology departments in the UK to help meet the increasing demand in ophthalmic services. The information aims to offer a helpful resource for members who are seeking to develop their services to meet capacity needs https://www.rcophth.ac.uk/standards-publications-research/the-way-forward/
3. "Preventing delay to follow-up for patients with glaucoma". NRLS 0959 Rapid Response Report, NPSA; 11 June 2009. http://www.nrls.npsa.nhs.uk/alerts/?entryid45=61908
4. Cambridge University Hospital NHS Foundation Trust CQC report 2015. http://www.cqc.org.uk/sites/default/files/new_reports/AAAD0110.pdf
5. Saving money, losing sight. RNIB 2013. http://www.rnib.org.uk/sites/default/files/Saving%20money%20losing%20sight%20Campaign%20report_0.pdf
6. AMD services survey report. Macular Society and The Royal College of Ophthalmologists 2013. https://www.rcophth.ac.uk/2014/01/survey-results-show-under-resourced-eye-clinics-put-patients-sight-at-risk/report?
7. NICE Technology Appraisals for Aflibercept – TA294: Age Related Macular Degeneration. NICE 2013 https://www.nice.org.uk/guidance/ta294,
8. TA305: Macular oedema from CRVO. NICE 2014 https://www.nice.org.uk/Guidance/ta305,
9. TA346: Diabetic Macular Oedema. NICE 2015 https://www.nice.org.uk/guidance/ta346?unlid=297709785201692720104O,
10. TA409: Macular oedema from BRVO - NICE 2016 https://www.nice.org.uk/guidance/ta409,
11. Glaucoma; diagnosis and management CG 85. NICE 2009. https://www.nice.org.uk/guidance/cg85.

12. Glaucoma commission guide. The Royal College of Ophthalmologists 2016. https://www.rcophth.ac.uk/wp-content/uploads/2016/06/Glaucoma-Commissioning-Guide-Recommendations-June-2016-Final.pdf
13. Commissioning better eye care. Age related macular degeneration. The Royal College of Ophthalmologists and College of Optometrists, 2013, https://www.rcophth.ac.uk/wp-content/uploads/2014/12/AMD-guidance-25-11-13-2013_PROF_262.pdf
14. New to follow up (N:F) ratios in ophthalmology outpatient services. The Royal College of Ophthalmologists 2011. https://www.rcophth.ac.uk/wp-content/uploads/2014/12/2011_PROF_114_New-to-follow-up-ratios-in-ophthalmology-outpatient-services.pdf
15. Ophthalmology common clinical competency framework. The Royal College of Ophthalmologists 2016. (https://www.rcophth.ac.uk/2016/01/competency-framework/
16. Community ophthalmology framework. Clinical Council for Eye Health Commissioning. http://www.college-optometrists.org/en/utilities/document-summary.cfm?docid=04657CE1-1824-4058-B8C6ADC4E40A9A76
17. Primary eye care framework. Clinical Council for Eye Health Commissioning. 2016. http://www.college-optometrists.org/en/utilities/document-summary.cfm?docid=8A93D228-AC28-4E6E-98AF94C62C0F8442
18. https://www.nice.org.uk/sharedlearning/reducing-avoidable-sight-loss-from-glaucoma-through-a-reduction-in-delays-to-glaucoma-patient-follow-up-appointments-and-patients-lost-to-follow-up

The Royal College of Ophthalmologists

The aims of The Royal College of Ophthalmologists (RCOphth) are to advance the science and practice of ophthalmology which we do by supporting excellence in the training and continuing professional development of ophthalmologists. The RCOphth collaborates with a wide range of organisations to deliver services, events and information which influences national eye health policy, benefits patients with vision impairment and supports our members.

View our statement on 'Making Vision and Eye Health a National Priority' which outlines the significant public health gains and reduction of the financial and resource burden on the wider community and social care systems.

View our 'Three Step Plan' on reducing risk for eye patients and improving timely care.

Ophthalmology: Support document for commissioners through CCGs, STPs and regional reconfigurations

Appendix 1

Referral refinement

More than 50% of referrals from the diabetic retinal screening service are considered false positives (low risk maculopathy). Automatic grading has been shown to be effective and has promise to reduce workload. Services using OCT screening reduce referrals and patients can be followed up in the community

Virtual Clinics

Virtual review of glaucoma and age related macular degeneration patients is becoming increasingly common. Patients may be seen solely by technicians or non-medical HCPs and the information gathered through examination and imaging is viewed remotely by the ophthalmologist who does not routinely see the patient. https://www.rcophth.ac.uk/standards-publications-research/the-way-forward/

Discharge policies

Acute and emergency departments should have clear discharge and onward referral for patients. This includes telephone review and clear patient information regarding self-management and indications for review.

Appendix 2

What are the important principles when commissioning networks of ophthalmic care across traditional boundaries – from CCG to STP?

- Involve *all* stakeholders in commissioning and establishing a network, working in partnership with a range of stakeholders, including service users and carers, community optometry services and Local Optical Committees, general practitioners, health and wellbeing boards, the hospital eye service, community pharmacy services, established local networks, social care, rehabilitation officers for the visually impaired, voluntary organisations, and adjacent clinical commissioning groups. Ideally joint ongoing and regular meetings on safety and operational issues should occur following establishment of any network
- Consideration and planning are required to ensure that key clinical stakeholders and patient representatives can be included in stakeholder meetings, including provision of dedicated resourced time for lead clinicians, and scheduling meetings so that cancellation of clinical care is required without appropriate notice
- Commissioners should be mindful of ensuring access and suitability for vulnerable or hard to reach groups, including those with special needs. Vulnerable individuals, such as people in long term care and people with learning difficulties, are at increased risk of sight loss. Care should be suitable for, and make appropriate adjustments for, the requirement of groups with special needs such as the visually impaired and those with dementia
- Organisations should use nationally recommended guidance to assess their current performance in *all* sites and care setting against evidence-based measures of best practice, and identify priorities for improvement; in particular, for ophthalmology this includes Royal College of Ophthalmologists and College of Optometrists guidance and quality standards, NICE guidance for ophthalmic conditions, CQC requirements
- All providers should use evidence based guidelines, locally adapted from national guidance where available, and agreed by all parties. There should be specific protocols governing ophthalmic care which has been traditionally “medical” being delivered by appropriately trained allied health professionals
- Named clinical governance leads or contacts should be identified for all providers /settings and one overall person should be the nominated lead with overall responsibility to lead and oversee clinical governance. There should be similar expectations for clinical governance engagement and performance, adapted to be appropriate for each provider and settings
- For incidents (particularly those with moderate or severe harm), Serious Incidents and Never Events there should be across the network clear reporting structures, clear methods for joint investigation where appropriate and methods for sharing lessons learnt to network staff. The same is required for complaints and claims structures
- There should be clear methods for routinely sharing patient and clinical information to ensure all relevant documentation is available at each clinical encounter, including clinical notes and results of specialist investigations, to create seamless pathways and joined up comprehensive care; ideally this will be via secure electronic systems with role based access, but may involve paper-based systems. Paperwork shared across providers should be agreed, simple and clear
- There should be clear and agreed out of hours, urgent and emergency care for all patients and patients must be informed, including in writing, of the routes and contact numbers no matter

which site or provider they are currently being cared for. Emergency care should be supported with appropriate contracts and agreements and not assumed to be provided without agreement by the larger hospital units nor should individual units withdraw unilaterally from previous emergency provision without discussion and agreement

- Arrangements for experience, training, accreditation and CPD need to be agreed so that allied health professionals can access and maintain the requisite training for providing ophthalmic care, and these should follow the recommendations of national guidance including NICE, and Royal College of Ophthalmologists, the College of Optometrists and the joint College Competency Frameworks. Staff should have documented sign off against the requirements of these documents which should be reviewed for all staff at least annually. There should be a clear performance management structure so that staff who are not performing appropriately can be proactively identified, managed and supported.
- KPIs should be realistic, meaningful and cover not only efficiency and cost effectiveness across the whole network but also patient experience and key areas of quality and safety pertinent to ophthalmology such as delays to recommended safe timings of follow up, clinical audit for key clinical outcomes, assessment to adherence for national ophthalmic guidance, false positive and false negative rates, rates of inappropriate referrals etc. Commissioners should ensure that patient focused mechanisms are in place to track appointments, which is of particular importance where integrated services straddle the hospital-community interface. Commissioners should also ensure that patients with clinical priority or at high risk are clearly identifiable and if their appointment is cancelled, missed or delayed that measures are in place to ensure that their appointment takes place within an appropriate time frame. There should be clear measures for patient experience and satisfaction for the network and all sites, and learning and actions arising from these disseminated and implemented across the network
- For all agreements and contracts, there should be appropriate and transparent arrangements, declarations and management of conflicts of interest. There should be agreed time points and systems for re-assessment and reconsideration of arrangements. Systems and arrangements which have been implemented elsewhere should be assessed and should not be implemented without change and learning where there is evidence of failure or poor performance elsewhere