The ROYAL COLLEGE of OPHTHALMOLOGISTS

Ophthalmic Service Guidance

Ophthalmology outpatients – safe and efficient processes

February 2018

18 Stephenson Way, London, NW1 2HD T. 020 7935 0702
contact@rcophth.ac.uk rcophth.ac.uk @RCOphth

Contents

Date of review: February 2021

1 Summary

Ophthalmology is the second busiest outpatient specialty and demand is outstripping capacity, with the risk of delays, particularly to follow up patients which can result in permanent loss of vision. It is crucial to ensure robust processes to ensure effective safe use of resources to deliver outpatient care. This document outlines some key principles and aims to support national programmes involved in reconfiguration of ophthalmology services for improvement such as the National Elective Care Transformation programme, Getting it Right First Time and Right Care.

2 General Principles

Every eye clinic should have a clear written policy or protocol on booking, rebooking, postponing and discharging patients in outpatient clinics. This should be agreed between, and then adhered to by all relevant administrative, managerial and clinical staff. Training may be required.

Clinical staff leave must be booked well in advance without short notice, except in exceptional circumstances.

Audits of adherence to the policy or protocol should be regularly undertaken.

There needs to be an audit trail of all decisions made to book and rebook patients which can be investigated in the event of incidents, complaints or concerns.

Non-clinical admin staff need training to understand the nature and progression of eye diseases.

There should be a reminder by text and/or telephone for all appointments a few days beforehand to minimise DNAs.

Patients should be given clear information about contact details and be able to easily get through to the right person to alter or query their appointment.

Patients should be informed about why they are being asked to return, the risks of not keeping timely appointments for their condition, and the main principles of the policy including the likely outcomes of DNAs and patient-initiated cancellations.

Ideally, patients should receive all investigations, the results and the clinical opinion within one visit rather than having to attend multiple times for these. An example would be to preop outpatients, and do the biometry and preop assessments for cataract surgery at a one-stop visit, or to ensure visual field tests are performed on the day of the glaucoma visit.

3 Access into the service

Primary care professionals (GPs, optometrists) should have access to an electronic advice and guidance service and access to urgent clinical advice by phone or fax/email with robust monitoring and reply; the first tier can be a trained AHP (nurse, optometrist) but a consultant opinion must be available, urgently if required.

4 Managing patients once in the service

Review vs discharge decisions

There should be clear clinical guidelines for individual subspecialties and common conditions on the frequency of follow up and discharge criteria, taking into account national guidance (especially NICE and College) and an assessment of clinical risk for the individual patient.

No patient should be given a review appointment without a clear clinical reason – 'checking up' on self-limiting, untreatable or fully treated conditions, or giving test results that will not result in a clinical action should be discouraged. Reasons for the need for review and timing of the requested appointment should be clear in all cases in the records.

There should be a range of review options available depending on clinical risk, optimising use of the full multidisciplinary team, including non-medical clinical staff-led clinics, virtual clinics, telephone reviews, and use of community and primary care settings as appropriate. Consideration should be given to mechanisms whereby patients can be contacted by phone or letter regarding results of tests, rather than requiring another routine appointment.

Methods of risk stratification should be developed and patients directed to the correct clinic.

Give the patients information and control. Patients with minor symptomatic conditions should be treated and given the opportunity to rebook through a specific channel if they do not improve, rather than given a further appointment.

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.

Audits of decisions to book follow ups or discharge vs protocols should be regularly undertaken.

Non-attendance or cancellations

There should be robust mechanisms for managing DNAs and cancellations and, if patients repeatedly do not attend (DNA) or cancel, they should not be continually rebooked without contact with the patient and the GP/primary care professional.

The notes of all patients who DNA, who cancel or who are cancelled or postponed, should be reviewed by a senior clinician and a further appointment organised, or decision to discharge made, based on individual circumstances rather than a blanket rule. The patient should be written to about this decision as well as the referring clinician and/or GP. These tasks should never be left solely to non-clinical staff.

Mechanisms for varying these processes for vulnerable adults and children are required, including managing safeguarding issues.

Closing clinics and outcomes for patients

Clinics should not be closed until decisions have been made on all the patient outcomes by the clinicians and received and actioned by the receptionists.

Clinic receptionists should be present throughout the whole time the clinic runs.

When patients' outcomes have been decided, these should either be immediately actioned before the patient leaves, which is best practice or, if there partial booking system, there should be active electronic management of the review list database. Boxes of paper outcome forms which have not yet been actioned are unsafe.

High risk diseases

For certain conditions with increased risk, particularly DR (R3, DMO), wet AMD, RVO, cancer and glaucoma, there should be:

- A failsafe officer to identify and manage safe timings and ensure follow up delays are avoided but where they occur they do not result in patient harm.
- Use of an ECLO to support patients to understand their condition and the importance of attendance and compliance with treatment.
- Ideally a mechanism for assessing and flagging clinical risk (low vs high risk) for each attendance which is visible on PAS system.
- A mechanism to identify any follow up delays, to report and manage for individual cases and for the service. This needs to be assessed at least weekly with the ability to flex clinic capacity to deal with issues.
- A target or standard on adhering to clinician requested follow up timings should be agreed and audits or reporting undertaken against this.
- Ideally clear electronic identification of the diagnosis or diagnostic code for the purposes of identifying high risk patient populations within the service.
- For existing significant backlogs, the service needs to be able to identify the affected patients with high risk disease, and undertake a risk adjusted virtual examination of the cases using admin, managerial and clinical staff as appropriate to prioritise patients and handle via discharge, transfer to community or low risk clinics, telephone review, rebook or bring in for urgent clinical assessment.
- There should be clear escalation rules for individual patients and for services on follow up delays to senior management and the consultant in charge of the care.

Authors: Melanie Hingorani, RCOphth Chair of Professional Standards

Carrie MacEwen, Clinical Lead for Ophthalmology Getting It Right First Time

With thanks to Alison Davis and Lydia Chang, Ophthalmology Getting It Right First Time, Parul Desai, Chair Clinical Council Eye Health Commissioning (CCEHC)