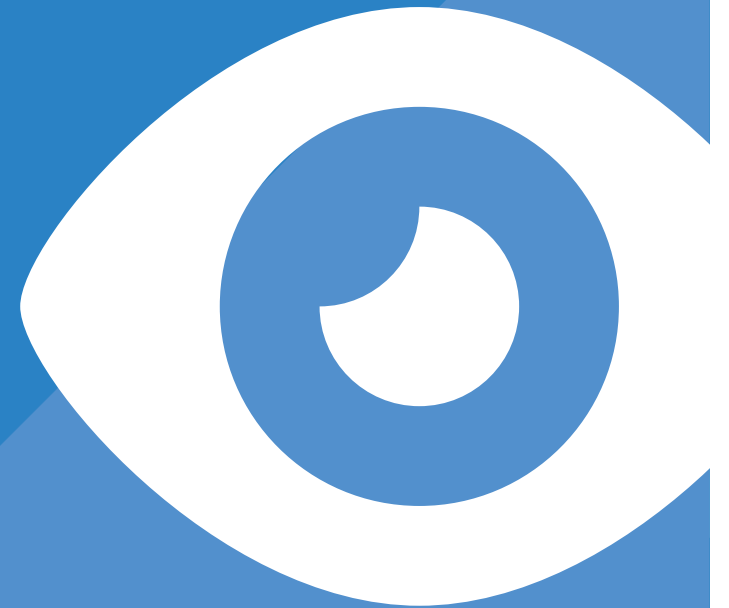




Right person, right place, first time

Transforming elective care services **ophthalmology**



Learning from the Elective Care Development Collaborative



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Introduction

This handbook describes what local health and care systems can do to transform ophthalmology elective care services at pace, why this is necessary and how the impact of this transformation can be measured. Practical guidance for implementing and adopting a range of interventions locally is included to help ensure patients see the **right person, in the right place, first time.**

Interventions and case studies are grouped by theme within this handbook. 'How-to' guides and suggested metrics are included.

The list of interventions is not exhaustive and reflects those tested in the second wave of the Elective Care Development Collaborative, along with further relevant information.

The success of interventions designed to transform local elective care services should be measured by changes in local activity following implementation of the intervention and performance against the Referral to Treatment (RTT) standard. Patient and professional outcome and satisfaction should also be measured ([NHS Improvement, 2018](#)).

The second wave of the Elective Care Development Collaborative included rapid testing in dermatology, diabetes and ophthalmology. This handbook is just one of the resources to be produced following this wave. Further handbooks, case studies, resources and discussion can also be found on the [Elective Care Community of Practice](#) pages.

You can learn about the interventions tested in previous waves (**MSK** and **gastroenterology**) and find all the handbooks and case studies on [our webpages](#).






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1. The national context and challenges facing elective care services in England

The NHS is experiencing significant pressure and unprecedented levels of demand for elective care.

Around 1.7 million patients are referred for elective consultant-led treatment each month. Between 2011/12 and 2016/17, referrals rose annually by an average of 3.7% per year and since 2005/06, total outpatient appointments have nearly doubled from 60.6 million to 118.6 million.

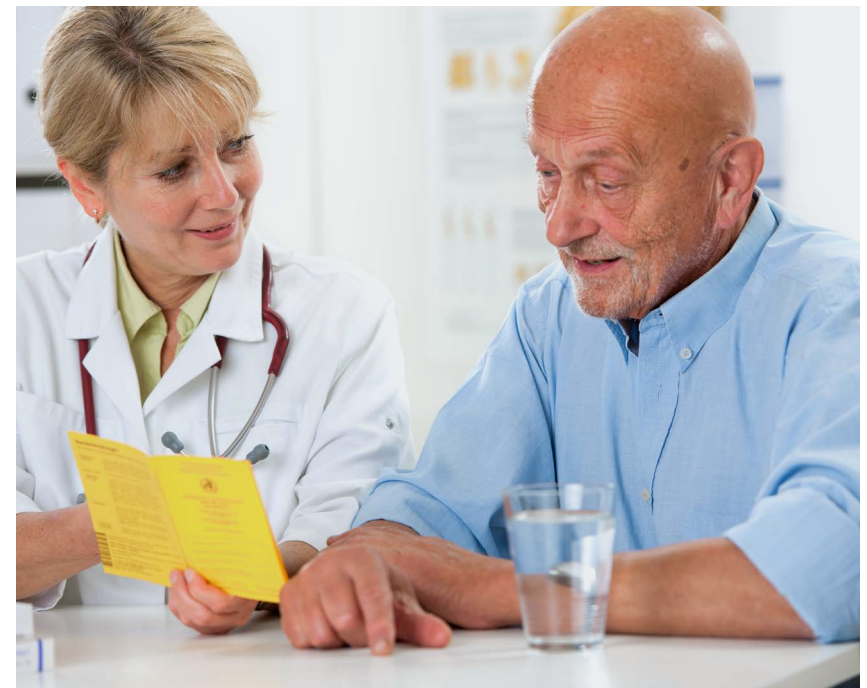
At the end of October 2018 only 87.1% of patients were waiting less than 18 weeks to start treatment (thus not meeting the 92% Constitutional Standard for referral to treatment). 4.2 million patients were waiting to start treatment and of those, 2816 patients were waiting more than 52 weeks.

Timely access to high quality elective care is a key priority under the NHS Constitution.

Two key documents: Next Steps on the Five Year Forward View and the NHS Operational Planning and Contracting Guidance 2017-19, make the redesign of elective care services a must-do for every local system. They call for better demand management that improves patient care while improving efficiency.

The [NHS Long Term Plan](#) clarifies the direction for health and care over the next ten years, including the importance of transforming outpatient services.

The friends and family test results for October 2018 show that overall satisfaction with outpatient services is high, with 94% of 1,401,736 respondents saying that they would recommend the service to a friend or family member; 3% said they would not recommend the service, with the remaining 3% saying 'neither' or 'don't know'. It is important to take steps to ensure that patient satisfaction remains high.






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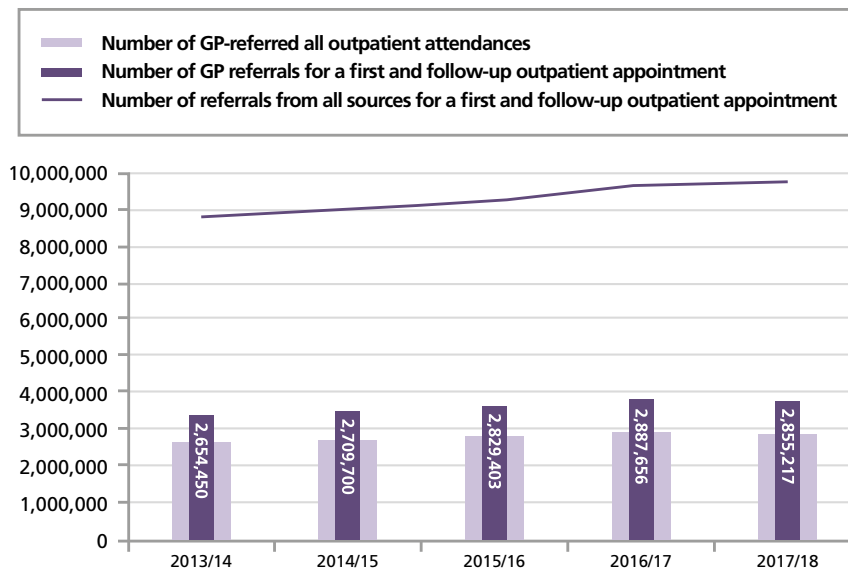
2. The national ophthalmology challenge

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. One in five people aged over 75 and half of people aged over 90 live with sight loss ([Royal National Institute for Blind People, 2018](#)), ([Royal College of Ophthalmologists, 2016](#)). Lack of IT connectivity causes difficulties receiving referrals directly from optometrists and sharing information for advice, guidance and shared care.

Ophthalmology referrals to hospital eye services rose just over 12% from 2013/14 to 2017/18 and now account for just over 8% of outpatient appointments ([NHS Digital, 2017](#)). More treatments for chronic ophthalmic disease are available that require regular, timely attendance to prevent permanent visual loss, contributing to capacity issues.

Opportunities to ensure patients receive assessment, treatment and care in the most appropriate setting, first time include:

- Improving referral processes to remove unwarranted variation. ([Royal College of Ophthalmologists, 2017](#)).
- Improving processes in outpatient clinics, focusing on efficient and safe discharge policies and risk stratification, shared care protocols and booking /rebooking patients for follow up. ([Royal College of Ophthalmologists, 2018](#)) ([Clinical Council for Eye Health Commissioning, 2018](#)).
- Addressing lack of capacity, optimising the skills and expertise available with multidisciplinary working across primary and secondary care ([Royal College of Ophthalmologists, 2017](#)).
- Improving data collection and coding. Ensuring intended dates for treatment and risk of harm can be recorded and the prime referrer can receive feedback.



Source: [National Commissioning Data Repository](#)

- Engaging and empowering patients to self-manage, supporting patients with co-morbidities.

Not all of the above challenges and opportunities could be tackled by the teams during their one hundred days of rapid testing. However, the input from key stakeholders informed the ideas the teams tested. A strategic view of eye health pathways is essential when making any local changes and impact and outcomes across the whole pathway need to be considered.




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3. The Elective Care Development Collaborative

NHS England's Elective Care Transformation Programme supports local health and care systems to work together to:

- Better manage rising demand for elective care services.
- Improve patient experience and access to care.
- Provide more integrated, person-centred care.

As part of this programme, the Elective Care Development Collaborative has been established to support rapid change led by frontline teams. In Wave 2 of the Elective Care Development Collaborative, local health and care systems in Dorset, Stockport, Norfolk and Lincolnshire formed teams to develop, test and spread innovation in delivering elective care services in just 100 days (the 100 Day Challenge). You can find more about the methodology used [here](#).

The teams used an intervention framework to structure their ideas around three strategic themes:

Rethinking referrals



Rethinking referral processes to ensure they are as efficient and effective as possible means that from the first time a patient presents in primary care, patients should always receive the assessment, treatment and care they need from the right person, in the right place, first time.

Shared decision making and self-management support



An all age, whole population approach to personalised care means that:

- People are supported to stay well and are enabled to make informed decisions and choices when their health changes.
- People with long term physical and mental health conditions are supported to build knowledge, skills and confidence to live well.
- People with complex needs are empowered to manage their own condition and the services they use.

This should be considered at every stage of the patient pathway and can be achieved through shared decision making, personalised care and support planning, social prescribing, patient choice, patient activation and personal health budgets.




Transforming outpatients






Transforming outpatients means considering how patient pathways and clinic arrangements (including processes) ensure that patients always receive assessment, treatment and care from the right person, in the right place, first time. This may not be in secondary care. Virtual clinics, technological solutions and treatment closer to home are all possibilities.



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4. Overview of ideas included in this handbook

Theme	Intervention	The opportunity
 Rethinking Referrals	Standardised cataract referral form	The use of standard referral forms means that practitioners should have access to relevant guidance and information when making or receiving referrals. Referral quality should be more consistent and the number of unnecessary referrals should reduce. This should mean patients are seen as quickly as possible and conversion rates for those who are referred should increase.
	Direct referrals from accredited optometrists in to secondary care	When community optometrists are able to make direct referrals to secondary care, patient pathways should be shorter, improving the experience of care. GPs should spend less time processing referrals and more information should be included in referrals. This should make referrals more efficient enabling more decisions to be made in a first consultation.
	Triage of referrals in to secondary care	Triaging referrals into clinics appropriate to the patient's level of risk means that patients should be seen more quickly, by the most appropriate practitioner. Practitioners should see the right patients at the right time and so 'false positive' referrals and patients who do not attend (DNAs) should decrease.
 Shared Decision Making	Patient decision aids	If patients have better quality information about cataract surgery before they are referred in to secondary care, they should be able to make an informed choice about surgery prior to attending an appointment. This should mean that practitioners spend more time seeing the right patients at the right time as unnecessary appointments decrease, reducing the waiting time for surgery.
 Transforming Outpatients	Virtual clinics	If diagnostic information is collected in a community setting and reviewed by the appropriate person virtually (rather than at in-person appointments) patients should be able to access the care they need closer to home. This should mean that practitioners can use their expertise in appropriate care settings which may reduce referral times and the need for follow up appointments in hospital.
	Failsafe policies and processes	Failsafe policies and processes should reduce the likelihood of patients becoming 'lost or delayed follow up' within hospital eye services and mean that they receive appropriate review and treatment at the right time for them. This should lead to fewer patients losing their sight as a result of hospital initiated delays. Practitioners will see the right patients at the right time and backlogs for follow-up appointments within hospital eye services should reduce.




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a. Standard cataract referral form



What is a standard cataract referral form?

Standardised referral forms are structured templates available on primary care IT systems. They support the use of standard referral pathways, ensuring that referrers understand where to direct patients and what information needs to accompany them. They can be used to communicate clear referral criteria for cataracts effectively ([Royal College of Ophthalmologists, 2000](#)). An exemplar cataract care pathway can be found in the latest National Institute for Health and Care Excellence guidance for cataracts ([NICE, 2018](#)).

Why implement standard cataract referral forms?

Anticipated growth in prevalence of cataracts between 2015 and 2035 suggests an increase of 50% in the number of cataract surgeries ([Royal College of Ophthalmologists, 2017](#)). Surgery is the only effective treatment to improve or maintain vision for these patients and the benefits are lifelong ([Royal College of Ophthalmologists and Clinical Council for Eye Health Commissioning, 2018](#)). It is the most commonly performed elective surgical procedure in the UK ([NICE, 2017](#)). Cataract surgery itself is associated with improved vision, quality of life, confidence, mental health and a reduction in disability and falls ([Gillespie et al., 2012](#)).

A standardised referral form can increase referral conversion rates for cataract surgery to more than 80% ([Royal College of Ophthalmologists, 2018](#)). The inclusion of quality of explicit referral criteria ensures that referrers have increased understanding of which cases should be referred. This helps to reduce unwarranted variation in access to cataract surgery and the clinical and administrative information necessary for the referrer. Thus more referrals meet referral criteria and are more likely to be accepted first time. This improves the quality of referrals received, ensuring that time taken reviewing or repeating referrals is reduced for both the referrer and receiving clinician and unnecessary delays for patients are reduced.

We know it works:

A standardised referral form can increase referral conversion rates for cataract surgery to more than 80% ([Royal College of Ophthalmologists, 2018](#)).

Since the start of the one hundred days in Lincolnshire:

- A new referral form which includes a health questionnaire was designed and launched.
- Of the 49 patients referred using the form, 93% were listed for surgery (this compares well to the previous conversion rate of 57%).




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a. Standard cataract referral form



How to achieve success: implementing a standard cataract referral form

The sections below include learning from sites in Wave 2 of the Elective Care Development Collaborative:

Ensure buy-in from everyone who needs to use the forms

- **Engage the right stakeholders from all relevant disciplines early in the process.** This ensures the referral form easily captures the correct information and is relevant to both the local context and to all referrers.

Develop the form




- **Consider who will be making and receiving referrals.** This may include community optometrists, GPs or direct referrals for people already under the care of a hospital eye service for other conditions. ([Royal College of Ophthalmologists and Clinical Council for Eye Health Commissioning, 2018](#)).
- **Ensure the form integrates with relevant local advice and guidance services.** It needs to work with all local pathways and the practitioners using them to avoid any possible duplication.
- **Ensure specific criteria for referral are explicit and included in the referral form.** This will help to guide referrers.
- **Keep the form as simple as possible.** Ask questions that are directly relevant to the surgery and ensure all necessary clinical and administrative information is included. Useful guidance on specific information for cataract referral forms can be found in [The Way Forward – Glaucoma \(Royal College of Ophthalmologists, 2017\)](#).
- **Set up and manage processes for tracking the impact of the form.** Involve the local business intelligence team from the start. Map current cataract pathways and audit referral rates to provide a useful baseline.
- **Develop, test and refine on a small scale to demonstrate early impact** (for example, in one CCG area) before attempting to scale across multiple CCGs or STPs.
- **Ensure clinical sign-off is obtained for the new form.**

People you may wish to involve from the start:

- ophthalmologists
- optometrists
- people with lived experience
- business manager
- commissioners (CCG)
- Local Optical Committee Support Unit (LOCSU)
- administrative team support



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Implement the form

- **Ensure that the success of the form is measured.**
Arrange administrative support in advance to track relevant patient outcomes. Ensure clear guidance is available on how and why to process and track outcomes for the referrals made using the new form. Ensure that feedback from referrers and receiving clinicians is sought, analysed and acted upon. In the early stages of implementation feedback is key to future refinement, so ensure that as much information as possible is captured.
- **Ensure that everyone is aware of and knows how to use the standard referrals form.** Training may be necessary for both clinicians and administrative staff. Training materials can be provided by email to all relevant parties. It may also be beneficial to run training events with key stakeholder groups (e.g. the local optometrist society or specialist nurses in the hospitals).

Provide appropriate information for patients

- Useful guidance is summarised in the [Royal College of Ophthalmologists Commissioning Guide for Adult Cataract Surgery](#).

The following standards and guidance may be useful:

[The Way Forward – Cataract \(Royal College of Ophthalmologists, 2017\)](#)

[Cataract Referral Guidance for Referring Optometrist \(Local Optical Committee Support Unit\)](#)

[Pre and Post-Operative Cataract Community Service Pathway \(Local Optical Committee Support Unit, 2016\)](#)

[Commissioning Guide: Adult Cataract Surgery \(Royal College of Ophthalmologists and Clinical Council for Eye Health, January 2018\)](#)

[WET AMD fast track referral form \(College of Optometrists, 2018\)](#)

[NICE Guideline: NG77](#)

[Sustainable Ophthalmic Pathways: Cataract \(Royal College of Ophthalmologists, 2018\)](#)

Resources required:

- Example referral forms and health questionnaires from elsewhere to adapt to the local context.
- Time for optometrists to fill in new referral forms and questionnaires with patients.




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Metrics to consider for measuring success

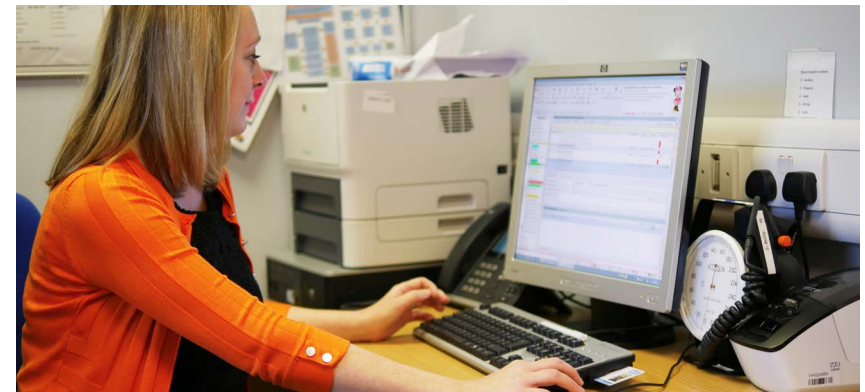
Think about how you are going to provide evidence of the impact you are having. This is not an exhaustive list. However, the following metrics could be used to help demonstrate impact.

Quantitative

- Conversion rate for (cataract) surgery.
- Number of referrals made using the referral form.
- Number of completed surgeries.
- Waiting time.
- Referral to treatment time.
- Time spent completing the referral form.
- Number of referrals made into secondary care.
- Number of referrals rejected by secondary care.
- Number of repeat referrals made.

Qualitative

- Patient feedback on experience of cataract pathway, including waiting time, ease of access, and quality of care received.
- Practitioner feedback on quality of referrals, including quality of information and patient reported outcome measures (PROMs).



Intended benefits:

- Reduction in unwarranted variation in access to cataract surgery.
- Increased capacity for both referring and receiving clinicians.
- Patients less likely to experience unnecessary delays.
- Improvement in patient outcomes.
- Improvement in patient satisfaction.




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a. Standard cataract referral form case study: Lincolnshire



The challenge – why here and why now?

Before the standard cataract referral form was put in place, the conversion rate in Lincolnshire for patients being referred for cataract surgery was estimated at 57%. This level of conversion led to increased waiting times. The percentage of ophthalmology referrals seen within 18 weeks in Lincolnshire East and West Clinical Commissioning Groups (CCGs) fell from approximately 94% in 2016 to approximately 88% in 2017. Patient satisfaction decreased, resulting in a loss of income to some service providers as some patients were travelling out of the county for their cataract surgery. The team wanted to ensure that patients met the criteria for surgery and were knowledgeable about their surgery prior to being referred. They felt that this would improve the patient and clinician experience and optimise time spent in appointments.






The intervention – what did they do and how did they do it?

Consultants supported by nurses, GPs, optometrists, people with lived experience and administrative staff, worked together to design and roll out the referral form. They undertook the following:

- **Established an estimated conversion rate baseline** using existing system-level data and triangulating it with their experience of rejected referrals in surgery.
- **Reviewed a number of cataract referral forms from different trusts and consolidated them to create one** that could be used system wide. Ensured that the form had the minimum data required, but enough information to be meaningful.
- **Chose and edited the health questionnaire** from a pre-existing version to include in the referral form.
- **Agreed which CCG and trust logos would be included** on the forms through discussion with the CCG and the team sponsor.
- **Introduced the referral form to optometrists** at the Lincolnshire Local Optical Committee meeting.
- **Started using the new form** with patients who came through for surgery.
- **Managed referrals and tracked data** through the hospital administrative team.



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a. Standard cataract referral form case study: Lincolnshire



Lessons learned

- In the absence of clean data it was important to be consistent in estimation methods. Coding issues with the data meant that it was not possible to determine if a GP/optometrist referral was for one, two or multiple surgery slots (for one eye, both eyes or both eyes and follow-up appointments). Other geographical areas did not face this challenge as their data architecture was different.
- Using available data (even if it is not perfect) to inform the focus of interventions and understand the impact can help to make the case for scale and sustainability. Testing ideas can also provide an opportunity to identify what data would be most helpful to track.
- Engaging with stakeholders from across the health system, in particular optometrists, helps to move quickly to action and create understanding of impact across the system.
- Offering short-term financial support to offset time spent on testing ideas can help to overcome initial resistance to work in a different way and enable ideas to progress quickly. The team were able to pay for short-term administrative support to manage referrals through the new process. This small investment allowed the team to get the new process up and running within 100 days, which would not have been possible otherwise.
- Setting out a simple and clear process for data collection from the outset is important. Including feedback from patients helps to make sure that there is meaningful data captured.

Headline achievements in 100 days

49 patients were referred and treated through the new process.

Conversion rates of referrals to surgery increased from 57% to 93% for those using the new process.

You can find further information about this work, as well as other case studies on the [Elective Care Community of Practice](#) pages. For more information, please email: england.electivecare@nhs.net




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What are direct referrals from optometrists into secondary care?

Community optometrists are able to refer directly into secondary care without needing to go via the GP to seek additional medical information. Any additional information from the person's health record is added on when the referral is received in secondary care and before the consultation.

Accredited optometrists also have the ability to provide virtual advice and guidance which can help to avoid 'false positives' and increased referrals in to secondary care.

Why implement direct referrals from optometrists?

If community optometrists are able to make direct referrals in to secondary care, the referral process should take less time and GPs will not need to spend time reviewing and processing referrals. Patients should be seen sooner in secondary care and waiting times should reduce.

More information should be included in the referral. There should also be quicker and more accurate monitoring of referrals in to secondary care, with an increase in patients receiving a clinical decision during their first consultation.

Cost savings against the hospital eye service tariff and improved productivity should also be achieved.

We know it works:

National evidence supports this intervention, with 79% of patients in Stockport being managed exclusively in a minor eye conditions service (MECs) over a six month period. Almost 100% of patients were 'very satisfied, or 'satisfied' with the service.

- A prospective study over the course of nine months established that the majority of the 733 direct referrals from accredited community optometrists led to a definitive clinical decision during the first consultation. 86% of these referrals were listed for cataract surgery ([Bowes et al., 2018](#))
- Combined data from six MECS shows only 17% of patients were referred on to secondary care ([Optical Confederation, 2014](#))

Since the start of the one hundred days in Norfolk:

Community optometrists have been allocated NHS.net accounts and General Data Protection Regulation (GDPR) information governance requirements have been met to allow secure communication of patients' details.

Although this intervention was not implemented within the one hundred days, the team in Norfolk made great progress in implementing direct referrals from optometrists to secondary care.




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How to achieve success: implementing direct referrals from optometrists in to secondary care

The sections below include learning from sites in Wave 2 of the Elective Care Development Collaborative:

Meet regularly and involve people and leadership from across the system

- **Hold regular stakeholder meetings.** This enables collaboration across several different organisations, care settings and teams.
- **Involve people with lived experience.** The design of the pathway is particularly important as it directly affects the patient journey.

Agree process for community optometrists to send referrals in to secondary care




- **Involve Local Optical Committee to consult and communicate with optometrists.** This will help ensure the right people are engaged.
- **Map local governance processes.** This ensures that practitioners have clarity on the boundaries/limitations of their roles.
- **Review the impact of processing new referrals on the bookings team's administrative time.**
- **Consider developing a standard referral form and criteria.**
- **Anticipate the possibility of an increase in referrals.** Optometrists may err on the side of caution, so increased referrals should be expected, at least initially.

People you may wish to involve from the start:

- ophthalmologist
- business manager
- GPs
- Local Optical Committee Support Unit (LOCSU)
- Local Optical Committee (LOC)
- community optometrists
- dispensing opticians
- pharmacists
- orthoptists
- ophthalmic nurses
- CCG information governance lead
- CCG transformation lead
- centralised booking team
- IT support across CCG, primary and secondary care, e.g. generating NHS.net accounts.



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Work with hospital and CCG IT teams to enable critical access to IT and email systems

- **Build relationships and set goals and timescales as early in the process of development as possible.** Setting up new e-Referral processes that require shared access across care settings can be particularly challenging. However, working with information governance lead can help to address any emerging issues.
- **Ensure patient information can be shared electronically, ensuring connectivity with e-Referral Service wherever practicable and possible.** Optical practices are not connected to N3 secure network (used by local NHS organisations) or the e-Referral Service unless specifically funded locally by the CCGs.
- **Set up NHS.net email addresses for accredited community optometrists.**
- **Enable access to electronic patient record systems used within GP practices for secondary care.**
- **Draft data-sharing agreement between GPs and the hospital.** This should allow the hospital to access GP data via SystemOne/EMIS when a referral has not come from the GP.

Assess the capacity and qualifications of local optometrists to perform required pre-referral tests

- **Understand which optometrists have qualifications and equipment necessary to conduct NICE recommended pre-referral tests for glaucoma.**

- **Set up a triage process for non-accredited optometrists to divert unrefined, suspect glaucoma referrals to appropriate practitioners for review.** It is important that optometrists are funded appropriately for their time.
- **Glaucoma repeat measures will need to be funded by CCGs.** Subsequent tests are not included in the NHS sight test fee.

The following standards and guidance may be useful:

[NICE Guideline CG81](#)

[Helping NHS providers improve productivity in elective care \(Monitor, 2015\)](#)

[Primary Eye Care Framework for First Contact Care \(Clinical Council for Eye Health Commissioning, 2016\)](#)

[Minor Eye Conditions Service Pathway \(Local Optical Committee Support Unit, 2016\)](#)

[Pre- and Post-Operative Cataract Community Service Pathway \(Local Optical Committee Support Unit, 2016\)](#)

[Glaucoma in Adults: QS7 \(NICE, 2017\)](#)

[Guidance for Professional Practice \(College of Optometrists, 2017\)](#)

[Commissioning Guide: Adult Cataract Surgery \(Royal College of Ophthalmologists, 2018\)](#)




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Metrics to consider for measuring success

Think about how you are going to provide evidence of the impact you are having. This is not an exhaustive list. However, the following metrics could be used to help demonstrate impact.

Quantitative

- Improvement in data quality.
- Clinical outcomes (eye health).
- Number of referrals in to secondary care.
- Waiting time.
- Referral to treatment time.
- Number of direct referrals from optometrists in to secondary care.
- GP time spent working on referrals.
- Number of 'false positive' referrals.
- Number of referrals from non-accredited to accredited optometrists and results of these, e.g. referred onto secondary care/managed within the community.
- Number of referrals in to secondary care with clinical decision made during first consultation.
- Costs.
- Patient outcomes.
- Number of visits.

Resources required:

- NHS.net email accounts for community optometrists.
- Access to primary care clinical record systems for secondary care practitioners, e.g. Egton Medical Information Systems (EMIS) and SystemOne.

Qualitative

- Patient feedback on referral experience, including waiting times and number of appointments required.
- Practitioner feedback: GP feedback on amount of time spent processing referrals. Consultant feedback on quality of information presented upon referral.

Intended benefits:

- **For patients:** reduced waiting times and increased satisfaction.
- **For practitioners:** reduced time spent reviewing, revising and resending referrals.
- **For the system:** improved productivity and cost savings due to majority of patients receiving clinical decision during their first consultation.




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The challenge – why here and why now?

Between September 2016 and 2017 Norfolk CCG, Norwich CCG and South Norfolk CCG did not meet the 92% target for ophthalmology referrals seen within 18 weeks. This idea has been under consideration in central Norfolk for a number of years but has faced the challenges of IT, information governance (IG), resource and change to process. The 100 Day Challenge, combined with the national 'paper switch-off' initiative, has provided an added impetus to drive the idea forward.

The intervention – what did they do and how did they do it?

The team had consistent representation from community optometrists, GPs, specialist nurses, the operations team at the acute trust, consultant ophthalmologists and the CCG. They met regularly throughout the challenge and kept clear records of their milestones and accountability for actions.

- **Developed the necessary processes for receiving referrals** by engaging and working with the hospital outpatient bookings team.
- **Ensured local optometrists were fully compliant** with General Data Protection Regulation (GDPR) by working with the Local Optical Committee Support Unit business manager ahead of national deadline.
- **Resolved information sharing issues** by working closely with outpatients' booking teams and IT. The IT team gave additional hours to the challenge outside their typical remit in order to develop work-around solutions to technological challenges.
- **Approved and implemented a new contract with community optometrists to enable them to directly refer glaucoma patients to accredited optometrists**, who could then do NICE recommended pre-referral eye tests and decide whether to refer in to secondary care.
- **Communicated changes** in referral pathways to optometrists via the Local Optical Committee.
- At the end of the 100 days, the only remaining barrier to implementing the project was **enabling patient histories and medication to be appended to the referral** without the need to refer via the GP.




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Lessons learned

- Enabling community optometrists to refer glaucoma cases to accredited optometrists is a valuable part of redesigning the referral pathway for all eye conditions. By setting up a contract to enable this referral between optometrists, the team anticipated that this would ultimately reduce referrals directly into the hospital eye service.
- Bringing the senior leadership of both the CCG and the acute trust together helps to unblock barriers in relation to pushing forward contracts and electronic access, as well as giving teams a sense of permission to pursue their ideas.
- Working with a team across organisational and professional boundaries helps ideas to move forwards, particularly those that involve action from across the trust.

What did people say?

"This is something that the trust has been trying to do for 10 years and have been able to rapidly progress as part of the 100 days."
Commissioner, Norfolk.

Headline achievements in 100 days:

- Information governance had been met – enabling secure communications of patient details from optometrists to secondary care.
- Community optometrists set up nhs.net accounts so they could refer directly through secure channels.
- Within the 100 Day Challenge, the team were able to make significant progress on an idea that had been considered as 'too hard' logistically for a number of years. They commented: "Where there is a good idea, it is worth keeping on rather than giving up when it looks 'too hard'".

You can find further information about this work, as well as other case studies on the [Elective Care Community of Practice](#) pages. For more information, please email: england.electivecare@nhs.net




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What is triage of glaucoma referrals into secondary care?

Triage is a process by which referrals in to secondary care are assessed and directed into appropriate clinics in either secondary care or the community ([Royal National Institute of Blind People, 2015](#)).

This could be into different grades of clinic led by different specialists, e.g. consultants, junior doctors or specialist nurses.

In relation to glaucoma, this is sometimes known as Glaucoma Referral Filtering Schemes (GRFS), encompassing referral refinement (GRRS) for the diagnosis of ocular hypertension (OHT) ([Local Optical Committee Support Unit,](#)

[2017](#)) ([Royal College of Ophthalmologists, 2017](#)). There is a hierarchy of GRFS in accordance with NICE Guidance: repeat measures, enhanced case finding and referral refinement.

Why implement triage of glaucoma referrals in to secondary care?

Glaucoma is the second most common cause of certified sight loss in the UK and the number of people with glaucoma is expected to rise by 22% by 2025 ([Royal College of Ophthalmologists, 2016](#)). Currently, there is a backlog of appointments in hospital eye services. If referrals from GPs for glaucoma are correctly triaged into clinics according to patient risk level:

- **Patients** should spend less time on waiting lists, be seen by the most appropriate clinician and have reduced anxiety caused by a 'false positive' referral ([NICE 2014](#)). Those with the highest level of need should be seen by a consultant more quickly, thus reducing clinical risk.
- **Practitioners** involved in the triage should be able to use their skills and expertise to diagnose and treat patients at the appropriate level of risk and need, thus making them more likely to spend time seeing the right patients at the right time.
- There should be a reduction in waiting times for referrals into secondary care ([Baker et al., 2016](#)). The system should also see fewer 'false positive' referrals as well as DNAs ([RNIB, 2015](#)).

We know it works:

- An evaluation of an optometry led Ophthalmic Diagnostic and Treatment Centre for glaucoma in Wales showed a reduction in waiting time between appointments from 208 days to 111 days ([RNIB, 2015](#)).

Since the start of the one hundred days in Norfolk:

- Referral waiting times reduced from 20 weeks to 13 weeks
- Consultant and nurses designed four new clinic pathways. Through triaging patients into these pathways, the team was able to gain oversight of demand for each cohort before going live.




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How to achieve success: implementing triage of glaucoma referrals into secondary care

The sections below include learning from sites in Wave 2 of the Elective Care Development Collaborative:

Involve clinicians from across the system and people with lived experience in the design of triage and new clinics

- **Involve consultants and nurses in designing new risk stratified pathways and clinics.** Improvements are most effectively implemented when they are clinically led and involve people from across the system coming together with a shared focus. Involving people with lived experience is particularly important and valuable when redefining patient pathways.
- **Engage with the centralised booking team around process reconfiguration.**
- **Gain feedback from primary care on the triage process and new pathways.**

Plan how to assess demand for new clinics in advance of going 'live' with triage

- **Baseline current service usage.** Collecting indicative data relating to number of patients who would be referred to new clinics once live is helpful to identify areas for improvement and invaluable in making the case for scale and sustainability. It can also help achieve clinical commitment to an intervention.
- **Set up a process for data collection for service review and evaluation.** Work with the business intelligence team to ensure there is ongoing data collection for service review and evaluation. Complete outline business case using data collected.

People you may wish to involve from the start:

- consultant
- glaucoma specialist nurse
- ophthalmology manager
- IT team (hospital)
- business Intelligence team (hospital and CCG)
- hospital optometrists
- orthoptists
- GPs
- field technicians




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Design clinic models that are appropriate for your local area and practitioners' capacity

- Consider your local skill mix. For example, use specialist nurses, junior doctors and optometrists to set up face-to-face clinics with stratification based on clinic risk.
- Other models that national guidance suggests include: treatment response clinics, face-to-face healthcare professional clinics, intensive joint clinics with consultant and multidisciplinary team members and virtual clinics ([Royal College of Ophthalmologists, 2017](#)).
- **Identify space for the clinics.** Allocate rooms for staff in clinical area.

Specify criteria for signposting referrals and develop a discharge flowchart for staff involved in the clinics to refer to

- **Allocate consultants to conduct triage.** Direct involvement of the ophthalmologist in reviewing and triaging referrals can help ensure that patients are triaged to the appropriate clinic.
- **Configure IT systems to electronically manage the new referral pathways.**

Anticipate training needs of practitioners involved in new clinics

- **Train new staff to run clinics.** Additional training should be offered where non-ophthalmologists are involved in receiving triaged referrals (e.g. for specialist nurses or junior doctors).

The following standards and guidance may be useful:

[Primary Eye Care Framework for First Contact Care \(Clinical Council for Eye Health Commissioning, 2016\)](#)

[Glaucoma in Adults: QS7 \(NICE, 2017\)](#)

[Expanding Community Eye Care for Glaucoma: A Pilot Ophthalmic Diagnostic and Treatment Centre \(Royal National Institute of Blind People, 2015\)](#)

[Ophthalmology outpatients – safe and efficient processes \(Royal College of Ophthalmologists, 2018\)](#)

[The Way Forward – Glaucoma \(Royal College of Ophthalmologists, 2017\)](#)

Resources required:

- Reconfigured IT system to electronically manage new referral pathways.
- Consultant and specialist nurse time to design pathways and triage.
- Rooms for clinics within hospital.




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Metrics to consider for measuring success

Think about how you are going to provide evidence of the impact you are having. This is not an exhaustive list. However, the following metrics could be used to help demonstrate impact.

Quantitative

- Waiting times.
- Number of referrals in to secondary care.
- Reduction in additional referrals (local definition required, but could use number of additional referrals as a proxy).
- Referral to treatment time.
- Number of follow-up appointments.
- Number of outpatient attendances.
- DNA rate.
- Number of referrals to each triage stream/grade.
- Number of surgical interventions.
- Number of blind registrations.
- Clinical outcomes.
- Costs

Qualitative

- Patient feedback on the referral experience, including waiting times and satisfaction with care level received.
- Practitioner feedback on suitability of patients they are seeing.

Intended benefits:

- **For patients:** less time should be spent on waiting list and they should be seen by the most appropriate clinician. This should mean reduced anxiety caused by a 'false positive' referral (NICE 2014). Those with the highest level of need should be seen by a consultant more quickly, thus reducing clinical risk.
- **For practitioners:** use their skills and expertise to diagnose and treat patients at the appropriate level of risk and need during triage, thus making them more likely to spend time seeing the right patients at the right time.
- **For the system:** there should be a reduction in waiting times for referrals in to secondary care (Baker et al., 2016). The system should also see fewer 'false positive' referrals as well as DNAs.




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The challenge – why here and why now?

Patients with glaucoma make up the largest number of referrals in to secondary care for ophthalmology in Norfolk, with patients waiting up to 20 weeks as opposed to the trust's quality goal of six weeks. Patients on the waiting list could be subject to further deterioration of vision while waiting. Reducing the waiting time improves the quality of service and the patient's experience.

The intervention – what did they do and how did they do it?

Consultant ophthalmologists reviewed referrals and worked with a specialist nurse practitioner and ophthalmology operations manager to design new pathways and clinics with input from optometrists and administration support:

- **Reviewed glaucoma referrals** received from GPs in the hospital eye service to identify the most effective new pathways.
- **Designed four new pathways:** low-risk glaucoma (seen by specialist nurse practitioner), medium-risk glaucoma (seen by junior doctor), high-risk glaucoma (seen by consultant) and narrow angles patients (seen by consultant). Staff appropriate for the risk level are allocated to patients but the service remains consultant-led.
- **Trained specialist nurse practitioners** to deliver the new clinics.
- **Asked consultants to 'soft' triage patients** for a period of time before the new clinics went live, in order to establish the demand and therefore the required frequency of each clinic.
- **Configured IT systems** to electronically manage the new referral pathways.




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Lessons learned

- Ensuring that initiatives are clinically led helps to secure buy-in among consultants and specialist nurses for any changes to clinics.
- Inviting ophthalmologists to directly triage referrals (rather than others in the consultant team receiving/accepting these) can have unexpected benefits. The team found that this helped with the accuracy of referral pathways and had the knock-on effect (even before the 'live' clinics were established) of changing referral patterns, which meant that patients would get to see the right specialist first time. The team also found that consultants were more prepared for appointments because they had seen the patient's details at the point of referral.
- Taking time to measure demand for new clinics by conducting a period of 'soft triage' (triage before the new clinics are in place) makes sure that the new clinics are data driven. This also has the unexpected consequence of starting to drive down waiting times due to more patients being seen by the right person first time.
- Involving a person with lived experience in redefining pathways is important. In this case, it helped to ensure that appropriate information was produced for each of the new pathways, including information about the waiting times in each. This helped patients make informed decisions about their treatment.




Headline achievements in 100 days

- Referral waiting times reduced from 20 weeks to 13 weeks, with triage being a contributing factor (see lessons learned).
- Once the new clinics for triaged patients go live the team anticipate that waiting times will continue to come down towards their goal of six weeks.

You can find further information about this work, as well as other case studies on the Elective Care Community of Practice pages. For more information, please email: england.electivecare@nhs.net



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What are patient decision aids?

Patient decision aids are tools that support people to make informed decisions about their treatment options ([NHS England, 2018](#)).

In ophthalmology they can be used as a means of providing information about options such as cataract surgery, outlining both the potential benefits and risks of this procedure ([Royal College of Surgeons, 2018](#)).

Patient decision aids can take a variety of forms including leaflets, questionnaires and videos. People can access the aids either during or outside of consultations ([NHS Rightcare, 2018](#)).

Why implement patient decision aids?

If patients have better-quality information about cataract surgery before they are referred in to secondary care:

Patients using decision aids should be better informed about what the surgery involves and can decide whether they wish to have the surgery before being referred in to secondary care.

Practitioners such as consultants should see the right people at the right time.

There should be a reduction in the number of additional referrals in to secondary care (e.g. referrals resulting in no further treatment), thus reducing waiting time for those who do want the surgery.

We know it works:

Since the start of the one hundred days in Lincolnshire:

- A Cochrane review of 105 studies of patient decision aids found that people's knowledge of options is improved and they feel better informed when patient decision aids are used. They increase shared decision making and do not worsen health outcomes ([Stacey et al., 2017](#)).
- The team produced a video detailing the process of cataract operations which, during the 100 Day Challenge, proved popular with patients and was viewed by more than 500 people online.
- Since the video has been live, there have been approximately 30 referrals in to secondary care, of which 95% have been converted to surgery, much higher than the previous 57% conversion rate.
- An updated information leaflet was also produced for patients who prefer written information.




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a. Patient decision aids

How to achieve success: implementing patient decision aids

The sections below include learning from sites in Wave 2 of the Elective Care Development Collaborative:

Ensure that the local team feels it has ownership of the material being produced

• **Organisational support and local ownership are vital for engagement.** This was clear through the Elective Care Transformation Programme and has been documented elsewhere (e.g. [Implementing shared decision making in the NHS: lessons from the MAGIC programme \(Joseph-Williams et al., 2017\)](#)).

• **Promote your resources.** Approach local communications team, either in the CCG or the trust to help you produce your information resources.

Review and build on existing resource

• **Work in partnership with clinicians and people with lived experience to gain a broad sense of what is most and least helpful.**

• **Spend a bit of time reviewing the resources already out**

there and seeking feedback on these. You may find that there is information available but people aren't aware of how to access it, in which case you may wish to focus on consolidating and promoting this material.

• **Develop appropriate resources based on feedback and potential impact.** If existing resources are not quite right in the local context, design your own based on the things that work best in the versions you have previously reviewed.

Use a range of formats

• Some people prefer written information, others prefer visual or verbal information. Consider this as you are developing your resources and as you seek feedback on their accessibility and impact.




• **Consider the health literacy of your cohort.** Health Education England have a useful [toolkit](#).

People you may wish to involve from the start:

- GP
- CCG representative
- consultant
- people with lived experience
- optometrists (both hospital and community)
- business manager
- administrative support
- orthoptists
- healthcare assistant
- communications team



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Actively seek feedback and ensure clinicians and patients are fully involved in the development process

- Consider online options and ensure that the survey is circulated to all stakeholders to gauge their reaction and determine how it influenced their decision-making.
- Engage clinicians. Have them as part of the core project team, send full updates and take the opportunity to present information at any local meetings or events for clinicians.

Publicise resources widely

- Consider sharing online. Creating patient decision aids (e.g. videos) that can be shared through social media provides a way for optometrists to easily access content in their practices and enables patients to share content with family and friends after their consultation.
- Engage key stakeholders to help publicise your resources. Publicising decision aids through local trust or GP practices' social media pages can also provide an easy and effective way to reach a wider audience.

Resources required:

- Review of existing resources including local and national videos and information leaflets.
- Meeting room to film video interviews.
- Video production costs (i.e. internal communications team time for planning, filming and editing).
- Costs for printing re-designed information packs/leaflets.






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a. Patient decision aids: Lincolnshire case study



Metrics to consider for measuring success

Think about how you are going to provide evidence of the impact you are having. This is not an exhaustive list. However, the following metrics could be used to help demonstrate impact.

Quantitative

- Number of views for video or number of leaflets taken by patients.
- Conversion rate from referral to surgery.
- Number of referrals in to secondary care.
- Waiting time for outpatient appointment/surgery.
- Number of additional referrals (local definition required, but could use referrals resulting in no further treatment as a proxy).

Qualitative

- Patient feedback on understanding of the surgery and ability to make a decision prior to appointment.
- Patient and practitioner feedback on the extent of shared decision making between both parties in the development of patient care, as well as confidence in those decisions.

The following standards and guidance may be useful:

[NICE guideline NG82](#)

[Choosing Wisely UK – Recommendations 2018 \(Royal College of Ophthalmologists\)](#)

[Diabetic Retinopathy Guidelines \(Royal College of Ophthalmologists\)](#)

[Cataract in Adults: 1.1 Patient information \(NICE, 2018\)](#)

[Get Well Soon – patient leaflet for recovery from cataract surgery \(Royal College of Surgeons, 2018\)](#)

[Shared Decision Aid for Cataracts \(Healthwise, 2018\)](#)

[Royal College of Ophthalmologists Patient Information Booklets \(Royal College of Ophthalmologists, 2017\)](#)

[Cataract Operation Guidance for Those with Learning Disability \(Seeability, 2017\)](#)

[Flashes and Floaters Patient Information Sheet \(Local Optical Committee Support Unit Minor Eye Conditions Service Pathway, 2016\)](#)




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a. Patient decision aids: Lincolnshire case study

The challenge – why here and why now?

In Lincolnshire the conversion rate for patients being referred for cataract surgery who actually had surgery was estimated at 57%. This meant an increase in waiting times, with the percentage of patients referred to ophthalmology starting treatment within 18 weeks falling from 94% to 88% between 2016 and 2017. Patient satisfaction decreased, resulting in a loss of income to some service providers.

The team believed that helping patients become informed about their options before referral into secondary care (e.g. for surgery) would mean that fewer people would opt out of surgery after referral in to secondary care. Clinicians' time would therefore be spent seeing the right people, at the right time.

The intervention – what did they do and how did they do it?

The team worked across primary and secondary care involving GPs, commissioners, consultants, patient representatives, nurses, orthoptists and healthcare assistants, supported by business managers and secretaries. For both the video and leaflet, action planning was by weekly meetings via video conference.

To produce the patient information video, the team undertook the following:

- **Reviewed existing online videos**, concluding that none were appropriate for local purposes, so decided to design and film their own.
- **Publicised the patient video on social media** by asking optometrists in select practices to show it to patients and by promoting through the hospital trust Facebook group.
- **Arranged for the communications team to film the video** at the department with primary and secondary care practitioners. This was based on a video already designed by another trust.
- **Tested the idea with a survey** designed to measure patient experience before and after the publication of the new information.
- **Used support from an executive sponsor to unblock barriers** around the lack of resources for filming.
- **Continued to promote the video** and decided to look into shooting a 'more professional' version.




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a. Patient decision aids: Lincolnshire case study

To produce patient information leaflets the team undertook the following:

- **Adapted existing leaflets** to produce one that gave all the information relevant to all sites.
- **Liaised with the CCGs** regarding logos as the CCGs preferred this to be a county-wide project, rather than solely United Lincolnshire Hospitals NHS Trust (ULHT).
- **Shared leaflets** with clinicians across care settings.

Lessons learned

- Using existing patient information resources as a template can help to avoid duplication of effort and integrate best practice.
- Involving partners from across the system in the design of patient decision aids helps to ensure that a clear and joined-up message is presented.
- Agreeing early on the process for collecting feedback on the new approach is important. This was agreed quite late in Lincolnshire and without full consultation of team members, contributing to the low number of responses to the feedback survey.
- Take time to explain the process to key stakeholders (clinicians and patients) as this can allay concerns surrounding the new process, e.g. additional time.
- Making the video available on YouTube allowed all optometrists to show it easily in their surgery.

- Publicising the video through the hospital trust's Facebook page brought a considerable number of views and positive comments.
- Involving optometrists in the design can help gain their buy-in and encourage them to distribute the leaflet and display the video for patients.




Headline achievements in 100 days

- Produced patient information leaflet and published a video that was viewed over 500 times.
- From the day the video went live to day 100, there were 22 referrals in to secondary care, of which 95% converted to surgery. This compared to a baseline of 57%.
- A survey was given to new patients experiencing the new pathway:
 - 100% reported that they had understood what the healthcare professional had explained about their procedure, enabling them to make an informed decision.
 - 75% of patients seen reported that they had seen the video.

You can find further information about this work, as well as other case studies on the [Elective Care Community of Practice](#) pages. For more information, please email: england.electivecare@nhs.net



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What are virtual clinics?

Community-based clinicians or technicians collect quantifiable diagnostic information via a patient consultation and share it virtually with a secondary care specialist clinician.

These diagnostics are reviewed through a virtual clinic model. This allows specialist clinicians to decide on treatment and ongoing management options after the community-based patient consultation has taken place, without the need for face-to-face consultation with every patient.

This process enables secondary care clinicians to review more cases, meaning that they should have more time available to see patients who require specialist treatment.

Why implement virtual clinics?

If diagnostic information is collected in a community setting and reviewed by consultants virtually (rather than at in-person appointments):

Patients should be able to access diagnostics, advice and guidance closer to home in community settings, which should improve patients' experience and satisfaction with regard to the service.

Practitioners should be able to use their skills and expertise to diagnose, treat and manage patients within appropriate care settings.

There should be fewer follow-up appointments ([The King's Fund, 2017](#)) and shorter waiting times within secondary care from the sample size.

We know it works:

Various studies have found virtual clinics to be effective:

In London, a stable monitoring service for glaucoma was introduced using virtual consultant review. Patient journey times through this service were 51 minutes compared to 92 minutes in the standard outpatients service ([Kotecha, 2015](#)).

In Leicester, a virtual clinic for age-related macular degeneration improved capacity. The time between patient follow-up appointments reduced from 6.9 weeks to 5.3 weeks and the time taken for each appointment reduced from an average of 71.4 minutes to an average of 47.3 minutes. This was accompanied by an average visual increase of >15 letters in 23.1% of patients compared to 6.1% prior to the virtual clinics ([Tsaousis, 2015](#)).

Since the start of the one hundred days in Stockport:

- Of the 32 optical practices in Stockport, six agreed to trial delivering the new virtual clinic model.
- 12 optometrists took part in training, designed and delivered by the lead optometrist and a consultant ophthalmologist.
- A sample of 35 glaucoma patients from one GP practice were asked about the virtual clinic idea as part of the team's research into patient satisfaction; 80% responded that they would be happy to be seen in this way in future.
- 22 patients due for follow-up glaucoma outpatient appointments were identified and contacted by the trust to take part in the first virtual clinic cohort.




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How to achieve success: implementing virtual clinics

The sections below include learning from sites in Wave 2 of the Elective Care Development Collaborative:

Develop the service specification involving stakeholders from across the system

- **Make sure that clinical governance is covered.** Achieving consensus can take time (for example, should patients remain under the care of consultants? Who is liable if inaccurate images are provided?). Balancing these discussions and decisions with 'going live' and beginning the testing phase can be a challenge. Good communication and strong cross-system relationships will help.

Set up the clinics

- **Identify settings** (e.g. optical practices or community hospitals) to participate in a trial of virtual clinics and attend training with the consultant and lead optometrist.
- **Use an email survey to assess the availability of equipment for virtual reviews locally** within optical practices and other community settings, such as community hospitals.
- **Address gaps in availability of equipment.** Consider applying for funding if there is a clear case for the setting being appropriate for the virtual clinic (e.g. staffing, room capacity and accessibility for patients).

Obtain IT support

- **Check IT requirements and set up a shared IT system.** This needs to enable information to be shared securely between primary and secondary care. Effective two-way communication between optical practices and secondary care is an important enabler for virtual clinic models.
- **Consider using IT systems that are not integrated into trust systems.** If access is difficult, an independent system that is accessible across both settings can help to enable rapid roll out.
- **Ensure that systems for reviewing images are of good quality.**
- **Consider implementing and/or refining coding within ophthalmology outpatients.**

People you may wish to involve from the start:

- ophthalmologist
- business manager
- optometrists
- GP
- nurse
- CCG representative
- people with lived experience
- IT department and information governance leads
- Local Optical Committee Support Unit




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Ensure staff are working to the full extent of their banding

- **Ensure staff are undertaking tasks appropriate to their skill level.** This helps to keep costs down.
- **Run training sessions for optometrists/clinicians involved in the virtual clinics.** Offering free training helps to build relationships across the system and achieve buy-in from optical practices.

Ensure appropriate patient are seen in virtual clinics

- **Identify patient cohorts and invite them to attend the clinic.** Non-specific coding of patients can make patient identification difficult. Lists may need to be reviewed manually to identify patients to invite to the virtual clinics.
- **Book patients in and run the clinic.**

Gather data to track progress and refine clinics

- **Agree the process for tracking the impact of the clinic.** Obtain feedback from patients and practitioners and use it to inform and adjust the design of the virtual clinic.
- **Collect and monitor impact data and feedback from patients and professionals involved.** Use this to make improvements to the clinic and build a convincing case for spread and sustainability.
- **Make the case to commissioners.** Where possible, compare costs between the current and new pathway (e.g. how much time consultants spend reviewing each diagnostic and anticipated annual growth in glaucoma patients in the local population).

Resources required:

- Optical coherence tomography machine (if using this as part of virtual clinics).
- Equipment required to perform the following tests: visual fields, drops in pupils to dilate, pressure measurement and photos of inside the eye.
- Optometrists' time to run the virtual clinics (collect and share additional diagnostic information).
- Space, facilities and staff to run virtual clinics in the chosen setting.
- Room for training and resources to deliver it (projector, etc.).
- Shared IT platform to enable diagnostic information to be shared securely.




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Metrics to consider for measuring success

Think about how you are going to provide evidence of the impact you are having. This is not an exhaustive list. However, the following metrics could be used to help demonstrate impact.

Quantitative

- Waiting time (glaucoma).
- Waiting list (glaucoma).
- Number of referrals (glaucoma).
- Number of follow-up attendances (glaucoma).
- Number of virtual diagnostics completed (by whom and where).
- Number of visits.
- Costs
- Time spent reviewing diagnostics by specialist clinician.
- Outcome of diagnostics review, e.g. discharge to community/referred for follow up).
- Practices/other community settings taking part in the trial.
- Number of patients within relevant cohort.
- How many patients needed/asked to be seen in person instead.

Qualitative

- Patient survey of who was considered in the virtual multidisciplinary clinics on convenience and quality of care provided by clinics.
- Focus groups with practitioners on effectiveness of clinics including convenience and quality of care.

Intended benefits:

- Improved access to diagnostics, advice and guidance closer to home in community settings and improved satisfaction for patients.
- There should be fewer follow-up appointments and shorter waiting times within secondary care.

The following standards and guidance may be useful:

[Standards for Virtual Clinics in Glaucoma Care in the NHS Hospital Eye Service \(Royal College of Ophthalmologists\)](#)

[The Way Forward – Glaucoma \(Royal College of Ophthalmologists, 2017\)](#)




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a. Virtual clinics (community-based diagnostics): Stockport case study



The challenge – why here and why now?

In Stockport, glaucoma was identified as a rapidly growing condition potentially affecting 10% of over-70s. On average, there were 430 glaucoma referrals to an outpatient appointment at Stockport Foundation Trust, of which 90% were follow-up appointments.

Of the 8,000 patients in the area with glaucoma, 20% are estimated to have ocular hypertension and non-complex glaucoma cases. Follow-up appointments for this group could be seen in primary care optometry through virtual clinics rather than taking place in secondary care.

Moving these cases into primary care optometry would allow for a large impact on patient satisfaction, quality of care (being seen closer to home and with less delay) and also the sustainability of the system. There is capacity within optical practices for virtual clinics to be expanded and an opportunity to further develop optometrist training and qualifications (accreditation). This means more tests and assessments could be delivered in primary care in future, including the delegation of the review to appropriately trained primary care optometrists.

The intervention – what did they do and how did they do it?

The team took a whole system approach, led by the chair of the Local Optical Committee (and team lead) and working closely with the lead ophthalmologist, business manager and GP to develop the idea:

- **Designed a new patient pathway** and model for clinical data collection within optical practices. Physical checks could be delivered in an optical practice and the details transferred virtually to secondary care for review by a consultant. These tests included visual fields, administering drops to the eye in order to dilate pupils enabling binocular assessment of the optic nerve, pressure measurement and photos of inside the eye.
- **Called 35 glaucoma patients** to assess their enthusiasm for the new model (see patient involvement case study).
- **Developed a service specification for the new model**, including protocols on clinical governance, audit and patient non-attendance (DNAs).




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- **Contacted optometrist colleagues across Stockport.** Eight practices had the necessary equipment and six agreed to take part. Training on the new model was delivered to these practices (see training event for optometrists case study).
- **Designed a survey to gather patient feedback** to compare with results from the same survey completed by hospital patients (see patient involvement case study).
- **Secured use of an IT platform** providing a shared clinic space for primary and secondary care (see shared IT system case study).
- **Identified and contacted 22 eligible patients with delayed follow-up appointments** by phone (using a script) and invited them to be seen in optical practices. Initially, the team identified 50 overdue glaucoma follow-ups from 1,500 eligible glaucoma patients. Out of these, 22 were suitable, i.e. without additional ocular pathologies and 90% of patients who answered the call agreed to be seen in primary care optometry.

What did people say:

“My first patient that attended found the process really smooth, as I saw him on time, did all the relevant tests (including the visual fields) myself and he was away in 40 minutes. He said it was easier for him to get to our practice than the hospital, and that the waiting time and the general overall appointment length was much better.”
Optometrist, Stockport.






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Lessons learned

- Working through and agreeing governance and liability implications before going live can help make the transition smoother.
- Identifying appropriate patients can be a difficult task due to the ways that patients are coded in secondary care systems – for example, by specialty rather than by condition.
- Adapting the booking process so that it becomes part of the referral pathway can help with scaling the model – for example, patients being booked into virtual clinic follow-up appointments at their ‘new patient appointment’, rather than separately by phone.
- Any patient selection and booking process that is rolled out needs to have sight of wider health issues that may affect suitability for virtual clinics – for example, comorbidities.
- Ensure that the communication and language used to invite patients to attend virtual clinics builds their confidence in the quality of the service (for example, use clear, professional and accessible language).
- Providing a cost comparison between the current and new pathway will help make the case to commissioners. It can also be helpful to provide data to demonstrate the annual growth in glaucoma patients that is predicted for the local area.

Headline achievements in 100 days




At day 100 the team was awaiting their initial cohort of patients through the virtual clinic pathway. However, to date:

- Six optical practices had agreed to deliver the virtual clinic model for free during 100 days and attended training (see training event case study).
- 80% of glaucoma patients consulted said they would be happy for follow-up appointments to be in primary care optometry (see patient involvement case study).
- The first nine patients had been booked into virtual clinics and the first patient had been seen.

You can find further information about this work, as well as other case studies on the [Elective Care Community of Practice](#) pages. For more information, please email: england.electivecare@nhs.net



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b. Failsafe prioritisation processes and policies



Failsafe prioritisation processes and policies are incorporated into Action 2 of the Ophthalmology High Impact Intervention specification.

What are failsafe prioritisation processes and policies?

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.

Why implement failsafe prioritisation processes and policies?

These processes and back up mechanisms safeguard against errors that result in patients becoming 'lost to follow-up' or their follow-up being delayed.




Patients at the highest risk of significant avoidable harm should 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 \(VisionUK\)](#). This reduces avoidable vision loss and reduces the risk of patients becoming 'lost' or follow up being delayed.

Practitioners' time is optimised, meaning they see those patients most at risk of preventable sight loss.

There should be a reduction in cancelled appointments and DNAs (where a patient does not attend their appointment).



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How to achieve success: implementing failsafe prioritisation processes and policies

Agree failsafe prioritisation processes between all relevant administrative, managerial and clinical staff.

- Undertake regular audits of adherence to policies and protocols. Ensure everyone is aware of their own responsibilities with regard to these processes.
- Offer training on the nature and progression of eye diseases. This should be for both clinical and for non-clinical staff, where necessary.

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

- Stratify and prioritise all patients according to their clinical risk of harm. Specify a date for follow-up based on individual diagnosis and presentation at each patient attendance, so that all staff can identify patients easily and any delays can be acted on.
- Document and highlight the diagnosis, risk, and intended date for follow-up of each patient. This means that all staff can identify patients easily and any delays can be acted on.

Resources required:

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

People you may wish to involve from the start:

- ophthalmologists
- administrative staff
- service managers




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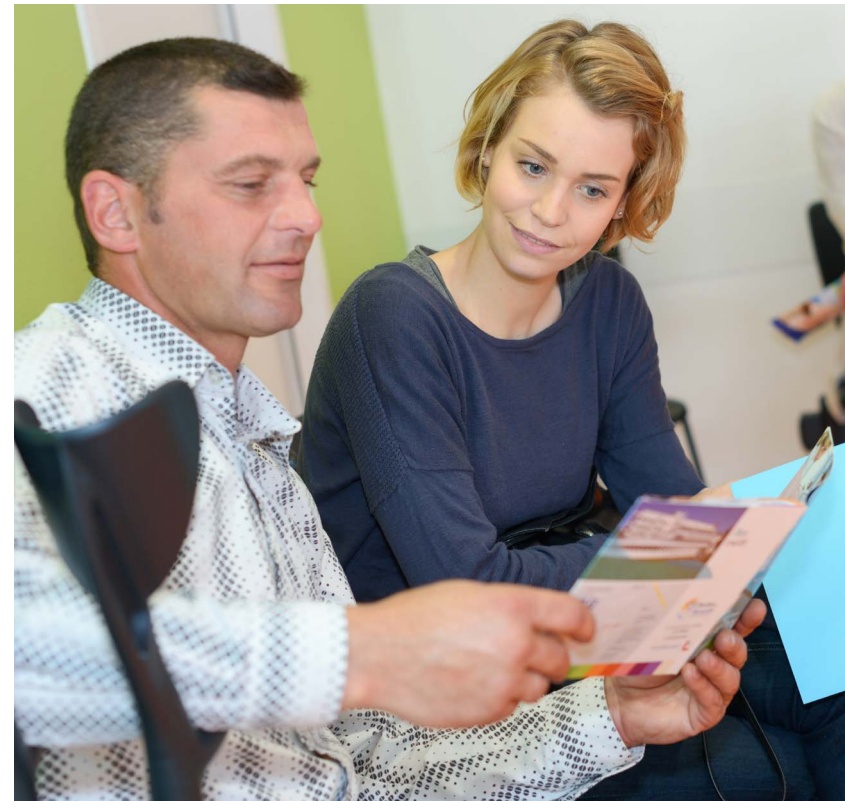
Ensure that review appointments are booked appropriately.

- **Enable high risk patients whose target date for follow-up is within 6 weeks 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.
- **Do not reschedule appointments without clinician input.** Ensure the clinical risk and target date for follow-up for the individual are considered.
- **Ensure there is significant consultant input into decisions to book a review visit.** This reduces unnecessarily frequent re-attendances and increases safe discharge rates. Do not give patients a follow-up appointment without a clear, documented, clinical reason.

Ensure patients are aware of their intended date for follow-up and the importance of attending.

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

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






The following standards and guidance may be useful:

The Royal College of Ophthalmologists has published [Ophthalmic Service Guidance for safe and efficient processes in ophthalmology outpatients](#).



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Ensure a senior clinical lead has overall responsibility for failsafe prioritisation.

- Senior clinical leads should ensure that escalation of lost or delayed follow-ups happens appropriately and action is taken to minimise any delay.

Each sub-specialty should have a nominated failsafe officer.

- **A failsafe officer should be appointed in each ophthalmology department or site (as appropriate).** This is to ensure the failsafe processes below are implemented and to audit their implementation.
- **Ensure that skills are used as effectively as possible.** Band 4 or 5 is suggested for this role, with clear accountability to the senior clinical lead.
- **Consider how this role is covered across 52 weeks of the year.** Ensure there are no gaps in cover that could exacerbate delays.

Failsafe officer responsibilities include:

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

- **Ensure patients in outpatient clinics are booked, rebooked and discharged.**
- **Identify, investigate, report and escalate all overdue appointments.** 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.** Ensure pathways are completed, with outcomes recorded and monitored.
- **Liaise effectively with administrative staff, senior clinicians and colleagues across primary and secondary care.** This may be part of a wider capacity management remit.
- **Ensure the importance of the failsafe officer role is recognised.** The post holder needs the authority 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.
- **Ensure DNAs are reviewed.** 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.




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Metrics to consider for measuring success

Think about how you are going to provide evidence of the impact you are having. This is not an exhaustive list, but the following metrics could be used to help demonstrate impact.

Quantitative

- Number of patients requiring follow up.
- Number of patients 'lost to follow up'.
- Waiting time for follow up appointments.
- Number of patients seen within 25% of their intended target date for follow up.
- Number of patients losing their sight.

Qualitative

- Patient experience and satisfaction measures.
- Clinician experience and satisfaction measures.

Intended benefits:

- Reduced risk of harm to patients from unnecessary delay to follow-up.

You can find further information about this work, as well as other case studies on the [Elective Care Community of Practice](#) pages. For more information, please email: england.electivecare@nhs.net






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All ophthalmology teams made significant progress during Wave 2 of the Elective Care Development Collaborative. The case studies in this handbook show what can be achieved locally in just one hundred days. The ideas reached different stages of implementation but the 100 Day Challenge has proved a catalyst for wider collaborative transformation in ophthalmology across the participating local health and care systems.

There is learning from across the second wave that will be useful for other areas that are transforming ophthalmology elective care services. Useful considerations include:

- 1. Start testing early:** you are dealing with a lot of complexity in ophthalmology, due to the high volume of patients and the range of professionals involved in treatment of cataracts and glaucoma. Bring people together to decide how they can benefit from working together to deal with complexities locally. Things might go wrong at the start and this is fine! You will learn more from failing fast than by doing nothing.
- 2. Involve people from across the system:** working with people from across the system will help you to understand the unintended or unexpected impacts of your ideas and will also help you think differently about what can make the biggest impact. The teams found it particularly helpful to work alongside people with lived experience as they developed and tested their ideas.
- 3. Explore new and alternative ways of working:** there are many ways of working that can prove beneficial for patients, clinicians and the wider system. For example, virtually, in community settings and utilising mobile units etc.
- 4. Consider how to track and measure impact:** using data to inform the development of ideas and to track your progress and impact can help to engage others in testing your ideas and to make the case for scale and sustainability moving forward.
- 5. Develop and maintain relationships with system leaders:** engage with senior leadership to open new lines of communication and create an environment in which frontline staff know they have permission to test their ideas. Foster the development of relationships among all members of the team and be honest about challenges so that system leaders are aware of what is happening and can help to unblock barriers as they arise.



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[Commissioning Guidance – Commissioning Standards \(Royal College of Ophthalmologists, 2018\)](#)

[Royal College of Ophthalmologists Three Step Plan, 2016](#)

[The Way Forward, Royal College of Ophthalmologists, 2017](#)

[Royal College of Ophthalmologists Ophthalmic Service Guidance for safe and efficient processes in ophthalmology outpatients, 2018](#)

[Vision UK Ophthalmic Public Health Committee: Portfolio of Indicators for Eye Health and Care](#)

[National Patient Safety Agency, 2009](#)

[Eye Health Network for London: Achieving Better Outcomes](#)

[Clinical Council for Eye Health Commissioning – System and Assurance Framework for Eye Health \(SAFE\), 2018](#)

[Clinical Council for Eye Health Commissioning Primary Eye Care Framework for First Contact Care](#)

[Clinical Council for Eye Health Commissioning Community Ophthalmology Framework](#)

[Clinical Council for Eye Health Commissioning Low vision, habilitation and rehabilitation framework](#)

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

[Local Optical Committee Support Unit 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](#)

Patient organisations

[Royal National Institute for Blind People \(RNIB\)](#)




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Some interventions tested out within the 100 days can be supported by evidence generated from other initiatives and localities. The table below is a summary of which ophthalmology interventions and more specifically their outcomes and impacts can be supported by this evidence.

Intervention	Impact	Link	Description	Location within source
Standard cataract referral form	Reduction in unwarranted access to cataract surgery.	Commissioning Guide: Adult Cataract Surgery (Royal College of Ophthalmologists, 2018)	A commissioning guide around cataract surgery in response to variation in access to cataract surgery across the country. Recommendations include a standard referral pathway that can be personalised to the patient.	Appendix B
	Reduction in number of falls for cataract surgery recipients.	Interventions for preventing falls in older people living in the community (Gillespie et al., 2012)	A review produced by Cochrane summarising interventions that prevent falls in elderly people in the community. One finding concluded that women having cataract surgery on their first affected eye see a reduction in falls.	Main text, paragraph 8
	Increase in patient satisfaction.	QIPP case study: Avoiding unnecessary referral for glaucoma: use of a repeat measurement scheme (NICE, 2017)	A case study from Bexley CCG around an initiative giving optometrists more autonomy around referrals. One finding was a significant improvement in the patient experience.	Quality outcomes delivered




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Intervention	Impact	Link	Description	Location within source
Direct referrals by optometrists into secondary care	Reduction in time spent processing referrals	Helping NHS providers improve productivity in elective care	NHS Improvement report around elective care services, which identifies nine good practices, in looking at two ophthalmology (and two MSK) pathways.	Section 2
	Majority of patients receiving clinical decision in first appointment	Quality indicators in a community optometrist led cataract shared scheme (Bowes et al., 2018)	A study evaluating the impact of direct cataract referrals from optometrists – 86% of patients were listed for cataract surgery upon first appointment.	Results
	Reduction in waiting times for secondary care	Effectiveness of UK optometric enhanced eye care services: a realist review of the literature (Baker et al., 2016)	A study evaluating the impact of enhanced optometrist services. One service is the direct referral from optometrists for cataract surgery – finding a reduction in patient waiting time.	Evidence synthesis, cataract
Triage of glaucoma referrals in to secondary care	Reduction in DNAs	Expanding community eye care for glaucoma: a pilot Ophthalmic Diagnostic and Treatment Centre (RNIB, 2015)		




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Intervention	Impact	Link	Description	Location within source
Patient decision aids	Reduction in waiting times	Decision aids to help people who are facing health treatment or screening decisions (Stacey, 2017)	A Cochrane review of 105 studies of the effects of patient decision aids. The authors concluded that where patient decision aids are used, people feel more knowledgeable, informed and more able to take an active role in decision making. No adverse effects on either health outcomes or satisfaction were evident.	
Virtual clinics	Patients accessing care closer to home in the community	Experiences with developing and implementing a virtual clinic for glaucoma care in an NHS setting (Kotecha et al., 2015)	Patient journey time averaged 51 minutes for virtual clinic users as opposed to 92 minutes.	Results
	Improvement in patient satisfaction	Assessing patient acceptance of virtual clinics for diabetic retinopathy: a large scale postal survey (Ahnood et al., 2018)	A study reviewing patient acceptance of virtual clinics showing that 86.1% were supportive of the virtual clinic idea.	Results
	Practitioners can manage patients within appropriate care settings	Virtual clinics in glaucoma care: face-to-face versus remote decision making (Clarke et al., 2017)	A study reviewing the decision-making in virtual clinics showed misclassifications were rare in virtual clinics, showing they are a safe care setting.	
	Reduction in waiting times	The concept of virtual clinics in monitoring patients with age-related macular degeneration (Tsaousis, 2015)	A study reviewing ophthalmology virtual clinics found a reduction in 1.6 weeks between two appointments after virtual clinic implementation.	

Contact us: england.electivecare@nhs.net