# UKOA Quarterly Meeting

Wednesday 5 June 2019

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# Agenda

| Item | | Speakers |
|---|---|---|
| **Arrival and refreshments** | 09:30 – 10:00 | |
| **Introduction/UKOA Update** | 10:00 – 11:00 | **Melanie Hingorani**<br>UKOA Board |
| **GIRFT Ophthalmology Report: Key Emerging Themes** | 11:00 – 12:30 | **Allison Davies**<br>GIRFT |
| **UKOA Regional Strategy** | | **Melanie Hingorani**<br>UKOA Board |
| **GIRFT Review: Cataract/Glaucoma and Retinal Recommendations** | | **Allison Davies**<br>GIRFT |
| **Group Discussion and Feedback** | | **All** |
| **Lunch & Networking** | 12:-30 – 13:00 | |
| **Procurement update** | 13:00 – 13:45 | **Kath Ibbotson** NHS Supply Chain<br>**Scott Pryde** GIRFT Procurement |
| **Ophthalmic Device Maturity Level (ODM Level)** | 13:45 – 14:30 | **Glyn Wood**, Manchester Royal Eye Hospital |
| **Managing appointments when there is limited capacity**<br>• The patient's view<br>• The All Party Parliamentary Group (APPG) conclusions<br>• Practical aspects in the clinic Moorfields approach<br>• Newcastle approach (informal)<br>• Discussion | 14:30 – 15:30 | **Michael Tupper**<br>**Helen Lee** RNIIB<br>**Alex Stamp**<br>Moorfields Eye Hospital<br>**Miranda Middleton-Howard**<br>Newcastle NHS Trust |
| **Summary & Close** | 15:45 – 16:00 | **Melanie Hingorani & Allison Beal**<br>UKOA Board |

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# UKOA update

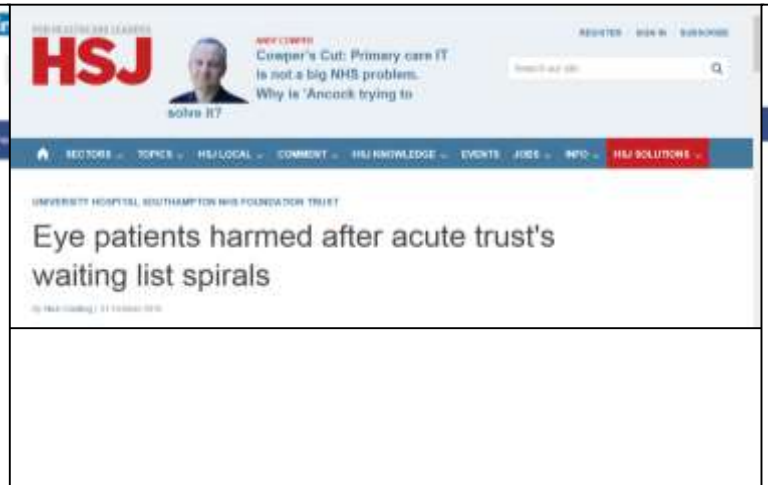
Melanie Hingorani
Consultant Ophthalmologist, Moorfields,
Chair UKOA

www.uk-oa.co.uk

**UKOA quarterly meeting 5th June 2019**

# Why do we need to do something?

- Not enough doctors and hospital staff
- Not enough space, money, resource
- Fragmentation commissioning and services
- Huge capacity and demand mismatch with >200 patients per year undergoing serious visual loss; 1/5 patients having treatments or clinics cancelled; “scandals” in media



# Solutions

- Effectively making the case for more locally, regionally, nationally
- Solutions are emerging:
  - Efficient practices and joined up pathways
  - Use MDT and non–medical roles better
  - Community optometry work preventing referrals or sharing care
  - Virtual clinical (telemedicine), AI and automated processes
  - National programmes: GIRFT, NECT, Right Care etc

But the “ophthalmic sector” are working in silos – professional, organisational - we need to work together to request, find and implement solutions **more consistently and more rapidly**.

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# UKOA: UK Ophthalmology Alliance

- Now 78 hospital ophthalmology unit members across the UK
- Stakeholder members include: RCOphth, RCN, BIOS, College of Optometrists, GIRFT, RNIB, IGA, Macular Society, Vision UK

- Multidisciplinary – patients and charities, clinical all roles, managerial, everyone
- Support and buddying, mutual learning
- Practical tools
- Establish standards
- Link with national programmes and raise concerns nationally

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# UKOA Update: Stakeholder representation

Trying to ensure all the right people can input or hear about crucial national and regional work impacting ophthalmology:

- NECT/HII (High Impact Intervention) and EyesWise
- Right Care
- Model Hospital
- NCIP – national clinical improvement programme – consultant level metrics
- HSIB
- Industry Vision Group parliamentary round table and actions
- GIRFT
- Transforming outpatients
- Regional GIRFT meetings – working with regional teams to develop their knowledge of UKOA and link into trusts to promote involvement

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# The NHSE High Impact Interventions - HII

**Ophthalmology Failsafe Prioritisation**:

Documents including report and resources published

Completeness: Audit results

Action 1: 70% complete, 15% on track, at risk 15%

Action 2: 66% complete, 17% on track, 17% at risk

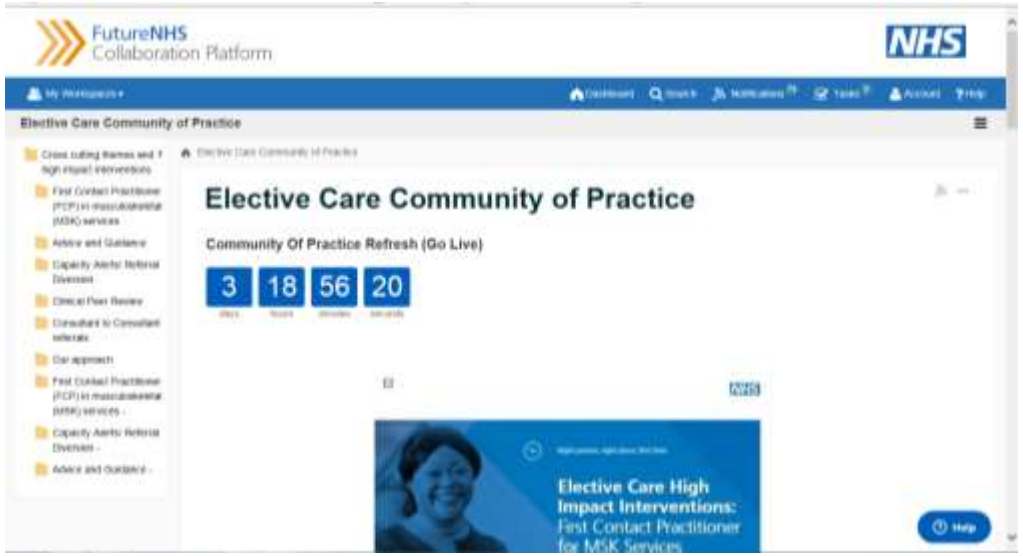
Action 3: Complete 70%


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

CE

# HII: Elective Care Community of Practice

- Visit https://future.nhs.uk/connect.ti (email ECDC-manager@future.nhs.uk for access)
- **Contact email**: england.electivecare@nhs.net
- **Visit the Elective Care Webpage**: https://www.england.nhs.uk/elective-care-transformation




# HII - **Elective Care Community of Practice**

- Reports and publications
- Forums for questions and discussion
- Webinars
- Case studies
- Shared resources from trusts eg
  - Failsafe officer JDs
  - Capacity and demand /eye health needs
  - Clinical policies and guidelines
- Please use and upload more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# How to tackle measuring your follow up delays

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

NHS Digital

70 YEARS OF THE NHS 1948 - 2018

The ROYAL COLLEGE of OPHTHALMOLOGISTS

# Elective Care High Impact Interventions – Ophthalmology

## Guidance for providers – Measuring follow up timeliness

**This guidance has been developed by The Royal College of Ophthalmologists, supported by NHS England Elective Care Transformation Programme and High Impact Intervention Programme and NHS Digital.**

Hospital eye services are experiencing unprecedented demand and eye clinic patients can experience delays in receiving their follow-up appointments. For some patients, especially those with chronic eye conditions, delay can result in adverse outcomes including visual loss and blindness.

The NHS England Elective Care Transformation Programme Ophthalmology Failsafe Prioritisation draft guidance requires action from trusts and commissioners to address this problem. Action one requires **trusts responsible for Hospital Eye Services (HES) to develop failsafe prioritisation processes and policies to manage risk of harm to ophthalmology patients**

# PAS and the metric – what do you have to do?

- Clinical decision taken as to appropriate safe timing of follow up
- Admin staff record target / desired date in your PAS using / mapped to *Earliest Clinically Appropriate Date* field and return to NHS Digital in the clinical dataset for SUS
- Admin, operational, performance staff compare desired date to actual date and calculate the delay for patients
- Use that data to:
  - Identify individual patients who are delayed and take action where appropriate
  - Regularly report against the national delay metric locally and to commissioners
- In an ideal world record the level of risk and/or diagnosis

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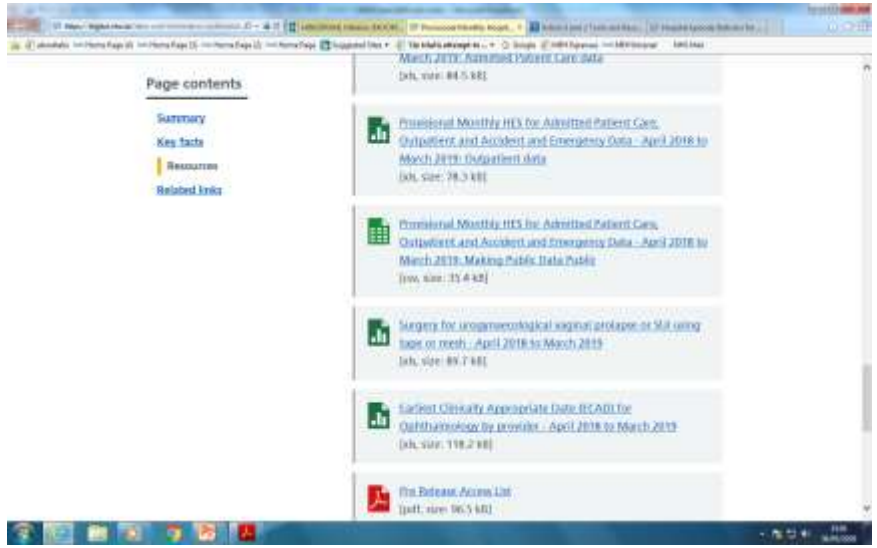
NHS Digital are now publishing quarterly at

https://digital.nhs.uk/data-and-information/publications/statistical/hospital-episode-statistics-for-admitted-patient-care-outpatient-and-accident-and-emergency-data/april-2018---march-2019-m12

Show usage vs number of ophthalmology outpatients seen to get a % for every unit

- Last quarter only 5 NHS trusts
- This quarter (Jan-Apr) 34 NHS trusts and 20 private providers of NHS care using
- Request for this to be mandatory field and also reporting of the metric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**Report to show Proportion of Ophthalmology Patients with Earliest Clincially Appropriate Date (ECAD) Present (1st April 2018 - 31st December 2018) - provisional Outpatients data**

**The counts shown below are where the treatment function code 130 - Ophthalmology is present**

| Provider code and name | Apr-18 | | | May-18 | | | Jun-18 | | | Ju | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | ECAD is prese | Total | Percenta | ECAD is prese | Total | Percenta | ECAD is prese | Total | Percenta | ECAD is prese | Tot |
| NT409 - BMI - CHELSFIELD PARK HOSPITAL | 40 | 40 | - | 40 | 40 | - | 50 | 50 | - | 25 | 25 |
| RTX - UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST | 0 | 7,230 | 0% | 0 | 7,060 | 0% | 0 | 6,630 | 0% | 0 | 7,4 |
| RWW - WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST | 2,195 | 3,465 | 63% | 2,275 | 3,535 | 64% | 2,310 | 3,675 | 63% | 2,445 | 3,9 |
| RMP - TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST | 595 | 785 | 76% | 530 | 790 | 67% | 655 | 850 | 77% | 1,055 | 1,2 |
| NT490 - BMI SOUTHEND PRIVATE HOSPITAL | 435 | 435 | 100% | 505 | 505 | 100% | 555 | 555 | 100% | 555 | 55 |
| NV302 - CIRCLE BATH HOSPITAL | 265 | 265 | - | 225 | 225 | - | 190 | 190 | - | 170 | 17 |
| NV323 - CIRCLE READING HOSPITAL | 155 | 155 | - | 225 | 225 | - | 235 | 235 | - | 175 | 17 |
| NV313 - CIRCLE - NOTTINGHAM NHS TREATMENT CENTRE | * | * | * | 10 | 10 | - | 10 | 10 | - | 10 | 10 |
| RQ6 - ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST | 65 | 10,370 | 1% | 70 | 10,480 | 1% | 75 | 10,615 | 1% | 65 | 10,7 |
| 8HP46 - 3VH LTD | 0 | 50 | - | 0 | 55 | - | 0 | 45 | - | 0 | 7 |
| AAH01 - TETBURY HOSPITAL TRUST | 0 | 145 | - | 0 | 115 | - | 0 | 130 | - | 0 | 13 |
| AAV02 - COMMUNITY HEALTH AND EYECARE LIMITED (PRESTON) | 0 | 55 | - | 0 | 15 | - | 0 | 10 | - | 0 | 2 |
| AAV18 - KENMORE MEDICAL CENTRE | 0 | 0 | - | 0 | 55 | - | 0 | 40 | - | 0 | 4 |
| AAV19 - FACE & EYE CLINIC | 0 | 0 | - | 0 | * | * | 0 | * | * | 0 | 1 |
| AAV20 - PARK LANE OPTICIANS | 0 | 0 | - | 0 | * | * | 0 | * | * | 0 | 1 |
| AAV21 - WENDY DIDDAMS OPTOMETRIST | 0 | 0 | - | 0 | * | * | 0 | 0 | - | 0 | 0 |
| AAV22 - WATERS GREEN MEDICAL CENTRE | 0 | 0 | - | 0 | 10 | - | 0 | 15 | - | 0 | 3 |
| ACG02 - COMMUNITY GLAUCOMA SERVICE | 0 | 540 | 0% | 0 | 275 | - | 0 | 485 | 0% | 0 | 48 |
| ACG03 - NEWMEDICA COMMUNITY OPHTHALMOLOGY - BASSETLAW - RETFORD PRIMARY CARE CENTRE | 0 | 125 | - | 0 | 105 | - | 0 | 85 | - | 0 | 9 |
| ACG04 - NEWMEDICA COMMUNITY OPHTHALMOLOGY - BASSETLAW - WORKSOP (NEWGATE HEALTH CENTRE) | 0 | 0 | - | 0 | 20 | - | 0 | 15 | - | 0 | 0 |
| ACG05 - NEWMEDICA COMMUNITY OPHTHALMOLOGY - SWINDON - SWINDON (TAW HILL MEDICAL CENTRE) | 0 | 135 | - | 0 | 175 | - | 0 | 100 | - | 0 | 18 |
| ACG07 - NEWMEDICA COMMUNITY OPHTHALMOLOGY - LEICESTERSHIRE - LEICESTER (STONEYGATE EYE HOSPITAL) | 0 | 150 | - | 0 | 190 | - | 0 | 170 | - | 0 | 21 |
| ACG08 - NEWMEDICA OPHTHALMOLOGY - NUNEATON - CAMP HILL - GP LED HEALTH CENTRE | 0 | 235 | - | 0 | 205 | - | 0 | 240 | - | 0 | 24 |
| ACG09 - NEWMEDICA COMMUNITY OPHTHALMOLOGY - NORTH DERBYSHIRE - BARLBOROUGH TREATMENT CENTRE | 0 | 215 | - | 0 | 305 | - | 0 | 300 | - | 0 | 26 |
| ACG10 - NEWMEDICA COMMUNITY OPHTHALMOLOGY - BRISTOL - BRISTOL | 0 | 260 | - | 0 | 200 | - | 0 | 230 | - | 0 | 20 |
| ACG12 - NEWMEDICA COMMUNITY OPHTHALMOLOGY - NORTH EAST LINCOLNSHIRE - GRIMSBY | 0 | 430 | 0% | 0 | 445 | 0% | 0 | 390 | - | 0 | 35 |
| ACG13 - NEWMEDICA COMMUNITY OPHTHALMOLOGY - GLOUCESTERSHIRE - GLOUCESTER (ASPEN CENTRE) (ACG13) | 0 | 280 | - | 0 | 320 | - | 0 | 355 | - | 0 | 48 |
| ACG16 - NEWMEDICA COMMUNITY OPHTHALMOLOGY - NORTH DERBYSHIRE - WINGERWORTH SURGERY | 0 | 30 | - | 0 | 15 | - | 0 | 0 | - | 0 | 0 |
| ACG17 - NEWMEDICA COMMUNITY OPHTHALMOLOGY - BRISTOL - BEDMINSTER FAMILY PRACTICE | 0 | 120 | - | 0 | 135 | - | 0 | 130 | - | 0 | 13 |
| ACG18 - NEWMEDICA COMMUNITY OPHTHALMOLOGY - NORTH SOMERSET - WESTON SUPER MARE | 0 | 125 | - | 0 | 170 | - | 0 | 160 | - | 0 | 15 |
| ACG19 - NEWMEDICA COMMUNITY OPHTHALMOLOGY - LEEDS | 0 | 0 | - | 0 | 15 | - | 0 | 25 | - | 0 | 8 |
| ACG20 - NEWMEDICA - BRISTOL - LITFIELD HOUSE | 0 | 0 | - | 0 | 0 | - | 0 | 0 | - | 0 | 0 |
| ACG21 - NEWMEDICA - IPSWICH - TWO RIVERS MEDICAL CENTRE | 0 | 0 | - | 0 | 0 | - | 0 | 0 | - | 0 | 0 |
| ACG22 - NEWMEDICA - BRIGG - RIVERSIDE SURGERY | 0 | 0 | - | 0 | 0 | - | 0 | 0 | - | 0 | 0 |
| ADP02 - KIMS HOSPITAL (NEWNHAM COURT) | 0 | 35 | - | 0 | 35 | - | 0 | 50 | - | 0 | 55 |
| AP201 - EAST SUSSEX OUTPATIENT SERVICES (ESOPS) | 0 | 0 | - | 0 | * | * | 0 | * | * | 0 | * |
| NAM01 - PROBUS SURGICAL CENTRE | 0 | 190 | - | 0 | 205 | - | 0 | 125 | - | 0 | 21 |
| NEQ01 - PHOENIX HEALTH SOLUTIONS LIMITED | 0 | 105 | - | 0 | 185 | - | 0 | 205 | - | 0 | 95 |
| NEH01 - SOMERSET SURGICAL SERVICES | 0 | 290 | - | 0 | 270 | - | 0 | 300 | - | 0 | 19 |

# How did Moorfields tackle this?

- Were struggling at first
- Brought together PAS supplier, IT, admin, operational, clinical and learning/development team reps
- Identified a field called “Search date” which would retain the data and PAS supplier mapped to ECAD for data submissions
- Wrote a step by step document to advise involved staff what to do
- Created a video step by step for admin staff
- Updated the current admin staff with training
- Now in induction and mandatory training for all admin staff going forward
- Set up P&I processes for doing the calculations
- Once all in place a cut off for active monitoring and reporting in divisions and trustwide

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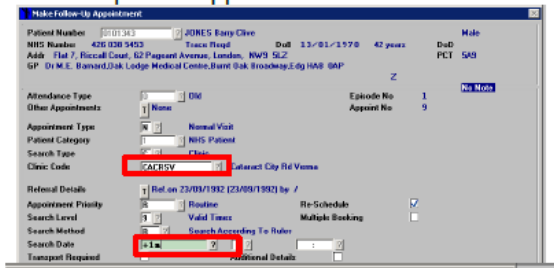
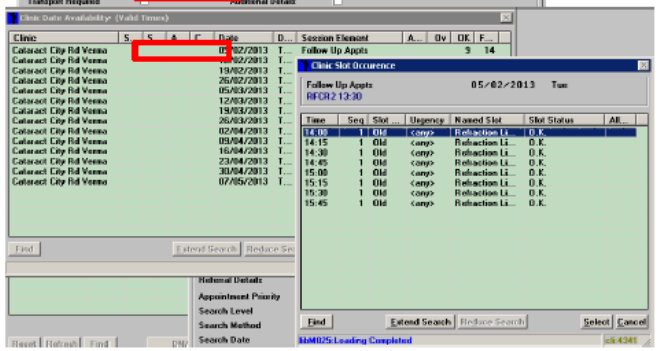
# Make Follow-Up Appointments

Outpatient Care > Manage Patient Appointments
RClick patient appointment > Select Make follow-up Appointment

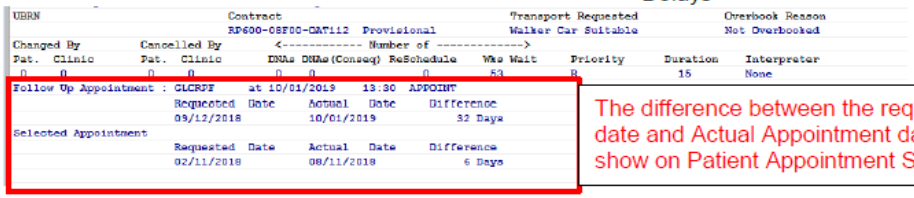


Enter Clinic Code
Enter Search Date as requested by Clinician e.g. +1w = 1 week, +1m = 1 month, +3m = 3 months, +1y = 1 year. **Do not** use C for current
PAS will search for the nearest available dates requested. Book the appointment.
For Linked Appointment only – Select Appt. Procedure e.g. RF (Refraction) or Post-Op Click **OK**



Select Correct Element e.g. follow-up
Select **Date** and **Time**
Confirm and Print letter if required

Toggle Box showing Appointment Delays



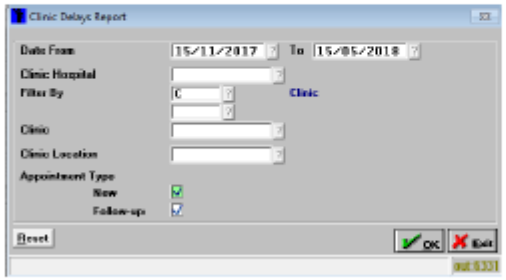
The difference between the requested date and Actual Appointment date will show on Patient Appointment Summary

The first available date after this date will be offered. If there is a delay this will be reflected in the

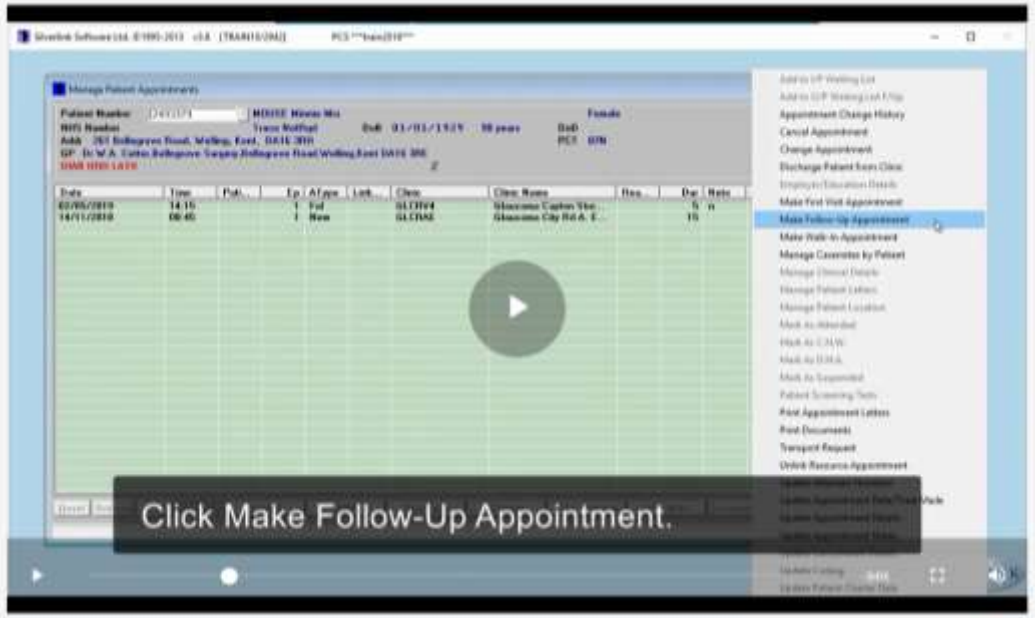
A new report has been added:
Outpatient Care>> Reports >>Appointment Reports>> Clinic Delays Report

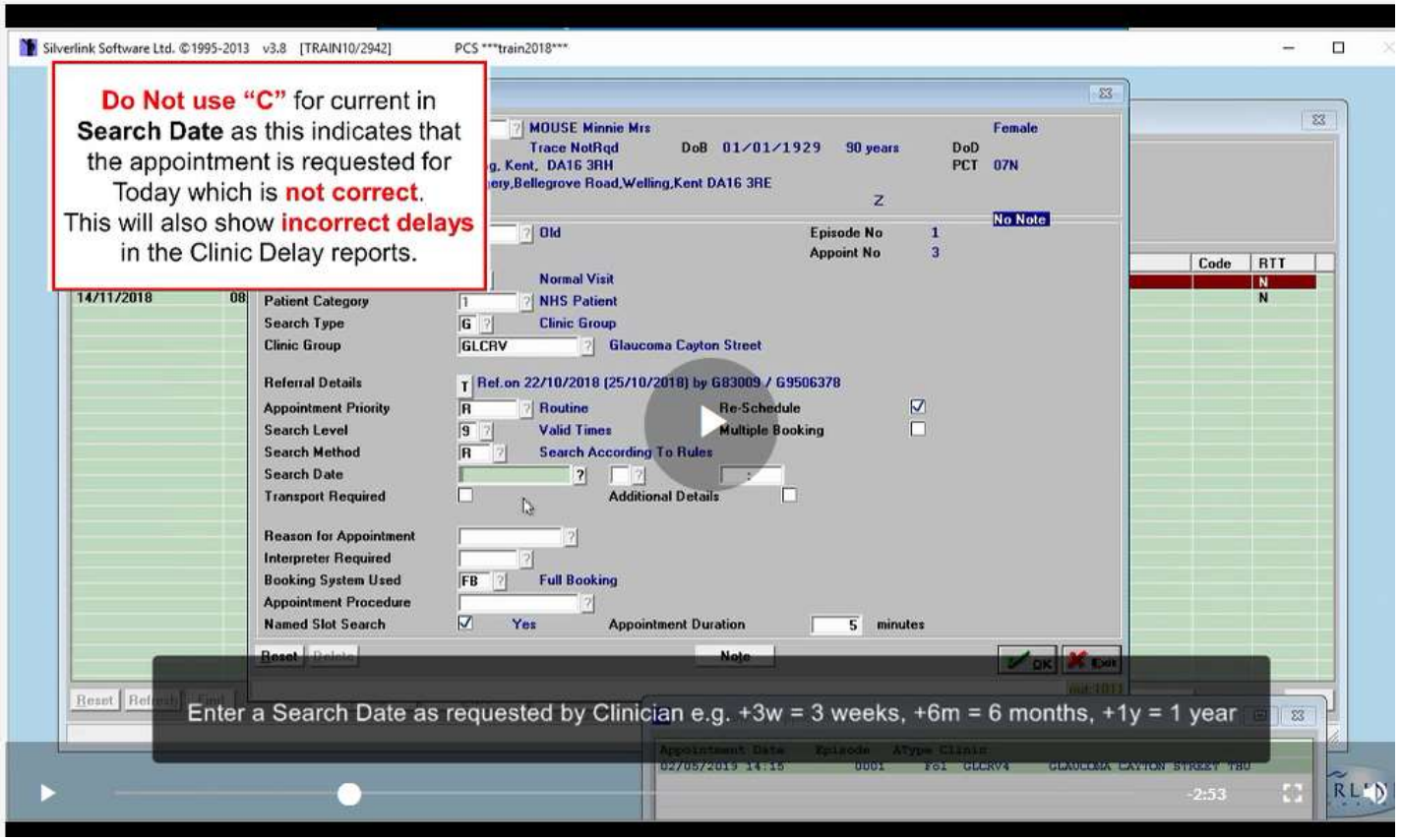
| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Clinic Delays Report | X | None | | | 0 | out633 | 0 | U |

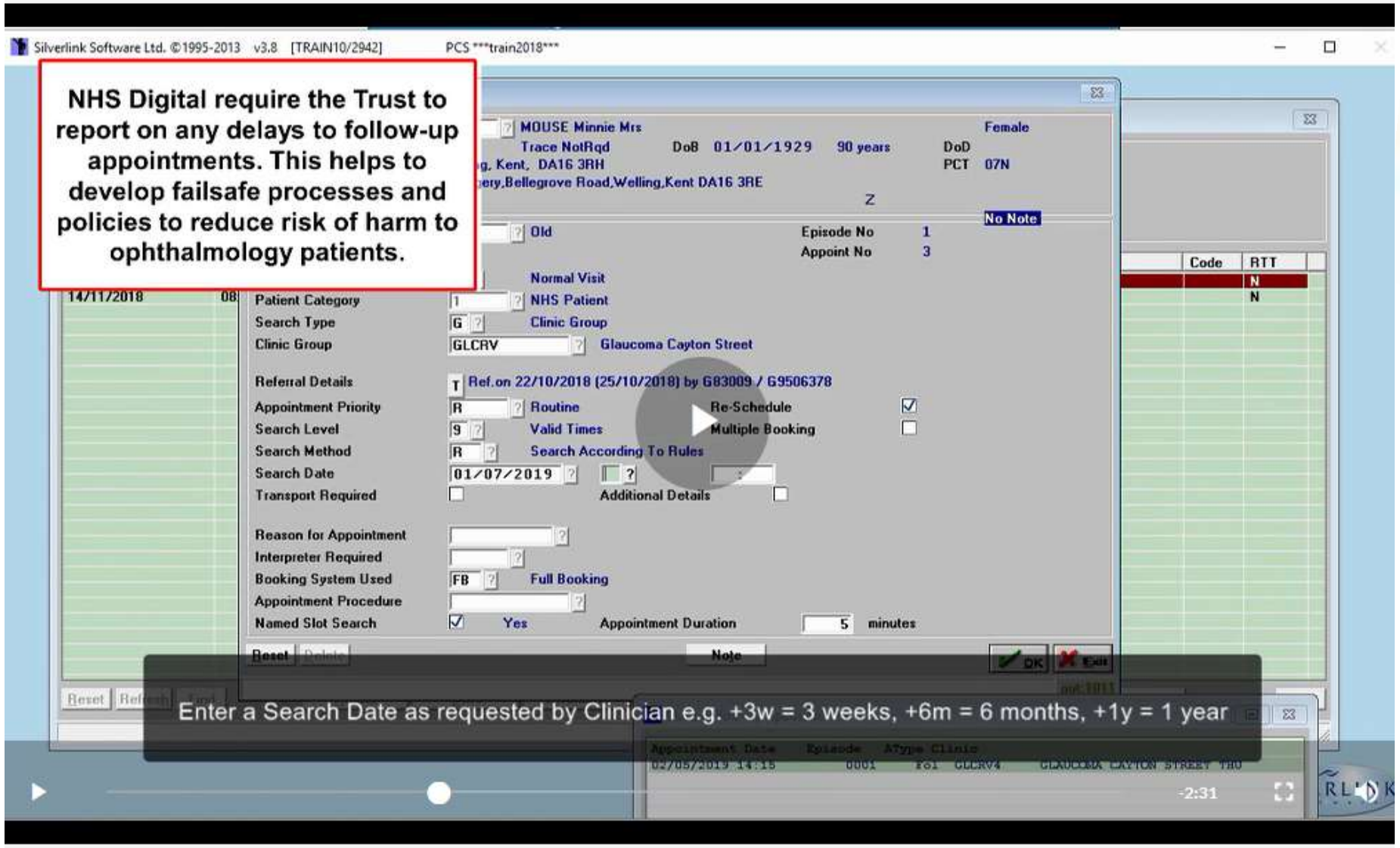
A new report has been provided so the delays between the requested Appointment date and the actu
appointment date are shown. The difference being shown in days.



The difference between the requested date and Actual Appointment date will show on the Clinic Delays report.


Click Make Follow-Up Appointment.


Do Not use "C" for current in Search Date as this indicates that the appointment is requested for Today which is not correct. This will also show incorrect delays in the Clinic Delay reports.
Enter a Search Date as requested by Clinician e.g. +3w = 3 weeks, +6m = 6 months, +1y = 1 year

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## Measuring follow up timeliness

- Delays to patient's follow-up appointment, especially those with chronic eye conditions, can result in adverse outcomes including visual loss and blindness.
- The Trust needs to actively monitor and take action on any delays to Patient Appointments requested by Clinicians.
- The expected Timescale – Follow up patients must be seen within 25% of the Requested Appointment date.
- **If patient cannot be fitted into a slot within the required safe timescale, please discuss with a clinician before booking.**

| Requested Appointment Date | Delays must not exceed |
|---|---|
| 1 month | 7.5 days |
| 2 months | 15 days |
| 3 months | 22.5 days |
| 4 months | 30 days |
| 5 months | 37.5 days |
| 6 months | 45 days |

-0:07

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EyesWise

- From Recommendation to Implementation
- Virtual clinics for glaucoma
- 5 test sites/systems
- Monthly webinars for all
- Publications, resources and standards on virtuals to support wider implementation
- Identify and try to solve systemic barriers

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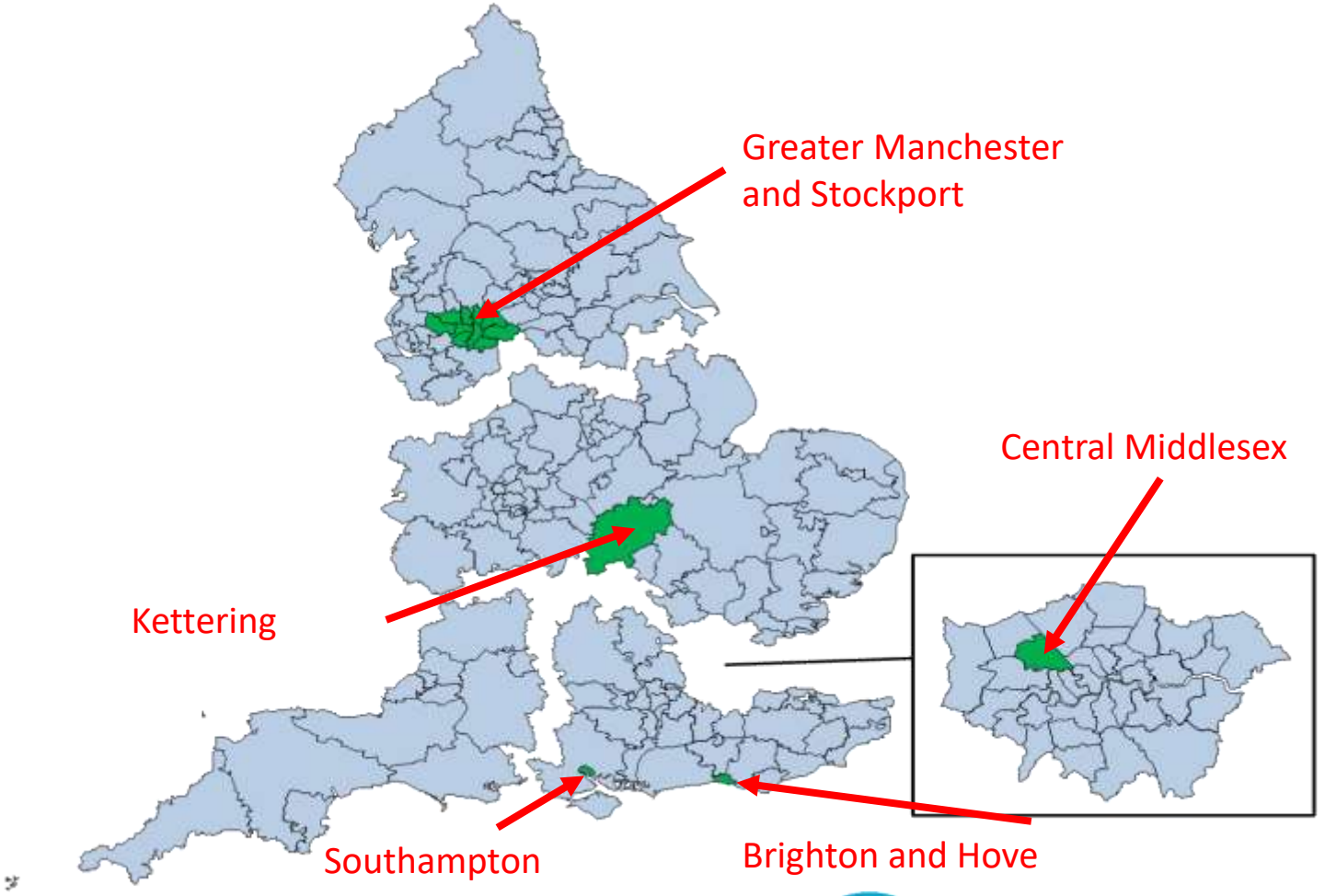
## EyesWise Virtual Development Collaborative

# Core members

We are working directly with 5 local systems to implement virtual clinics in ophthalmology.




Alternative models of outpatients

**We will be taking questions throughout the webinar today, so please feel free to ask at any time. Questions will be addressed periodically.**

To ask a question: Please click on the Q&A tab indicated by a question mark sign (?) in the top right hand side of your WebEx screen, type your question and click send to all panellists.



EyesWise Virtual Development Collaborative

# Four core strands underpinned by key enablers

EyesWise

Transforming ophthalmology outpatient services

| Failsafe prioritisation | Eye health capacity review | Alternative models of outpatients | 100 voices campaign |
|---|---|---|---|

Development of relevant tariff and payment systems

Workforce issues, training and job planning

Technology and interoperability to support alternative outpatient models

Data collection, audit, analysis and IT systems

**Transformation work is underpinned by sharing knowledge, evidence, resources and case studies via the Eyeswise Hub on the Elective Care Community of Practice online platform.**

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EyesWise

EyesWise
100 Voices

# Seeking the stories of patients, families, carers and staff

The key aims of the 100 Voices campaign are to:

- Seek, collect and share at least 100 patient and staff stories to raise awareness of relevant issues in ophthalmology and the impact of transformation;
- Collect and share resources to enable HES and commissioners to use patient stories as part of decision making throughout their transformation work;
- Work with RNIB and other key stakeholders to instigate a YouTube channel and 100 day social media campaign to share stories and learning.


EyesWise
100 Voices
#EyesWise #AreyouEyesWise?

Touchi's story

Touchi is 40 years old, married with 2 children and works as a process engineer. She first started experiencing headaches and left eye ache at home. She then decided to self-medicate on paracetamol thinking it was a persistent headache that would go away. On the second day of self-medicating, she began to experience a temperature and became concerned as she also became sensitive to light.

The following day she was taken to hospital in an ambulance and was investigated for meningitis. Investigations were negative and she was discharged home. However, the left eye pain continued.

After presenting to her GP with persistent left eye pain, she was referred to her local eye hospital. At the hospital she was investigated and was informed that the pressure in her left eye was low however, the nerves in her left eye were "wired wrongly" and it is likely that she was "born like that". She was subsequently discharged, with the left eye pain.

She went home and continued self-medicating confident that everything was ok because the specialist hospital had told her so.

A few days later she presented at her local eye hospital A & E department with the feeling of "I felt my left eye was going to pop out". At this presentation she was informed that she was very close to going blind in her left eye and she was informed that she had glaucoma.

Touchi now has pin hole vision in her left eye. She has had 2 operations to relieve the pressure in her left eye and remains under the Consultant Ophthalmologist for the rest of her life. She is constantly having to have her eye pressure checked. Her work and home environment had to be adapted because of her vision impairment. At the moment, she is frustrated that her appointments are always cancelled and it is always a challenge booking an appointment.

100 voices campaign

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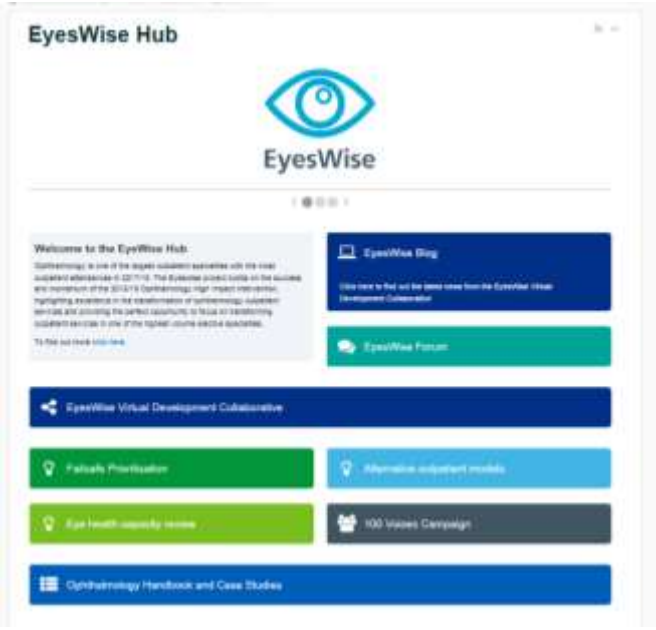
EyesWise

# EyesWise Support

Future EyesWise Virtual Development webinars :

- 13:00-14:30 6 Jun 2019
- 13:00-14:30 18 July 2019
- 13:00-14:30 18 Sep 2019
- 13:00-14:30 6 Nov 2019




Seminar Programme

The ROYAL COLLEGE of OPHTHALMOLOGISTS

**RCOphth and NHS National Elective Care Transformation Joint Seminar**

Chaired by

Mrs Melanie Hingorani, Consultant Ophthalmologist, Moorfields Eye Hospital & Professor Carrie MacEwen, Ninewells Hospital and Medical School, Dundee & Chair of the Academy of Medical Royal Colleges

**Friday 21 June 2019**

Venue:
The Royal College of Ophthalmologists
18 Stephenson Way
London
NW1 2HD

Book via RCOphth webite or email julie.hodgkinson@rcophth.ac.uk

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# NHS Right Care

- Aimed at CCGs and STPs for system/population improvement

- Builds on the Atlases of Variation & Health Improvement Packs

- **Clinical engagement**
- **Clinical leadership**
- **Leading to change and improvement and implementation of accepted recommendations**

*All systems will work with the NHS RightCare programme to implement national priority initiatives for key conditions, and will be expected to address variation and improve care in additional pathways outside of the national priority initiatives.*

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The NHS RightCare delivery methodology is based around three simple principles of working with local systems:

- **Diagnose** the issues and identify the opportunities with data, evidence and intelligence
- **Develop** solutions, guidance and innovation
- **Deliver** improvements for patients, populations and systems


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- *To support the implementation of NHS RightCare, every local health system in England has an NHS RightCare team working with them, led by a Delivery Partner, providing the data and intelligence and focussing support for transformation.*
- *NHS RightCare supplies the Delivery Partners with tools and products to structure and shape their conversations with health systems and Delivery Partners are then able to share evidence-based best practice, developed with our national partners, at the moment that local clinicians are considering what good looks like in that area of their system.*

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# Right Care Data packs

- The three main data sources:
  - Secondary Uses Service (SUS+) inpatient and outpatient data
  - Quality and Outcomes Framework (QOF)
  - ePACT prescribing data

In other words already available national data not NOD, EPR etc

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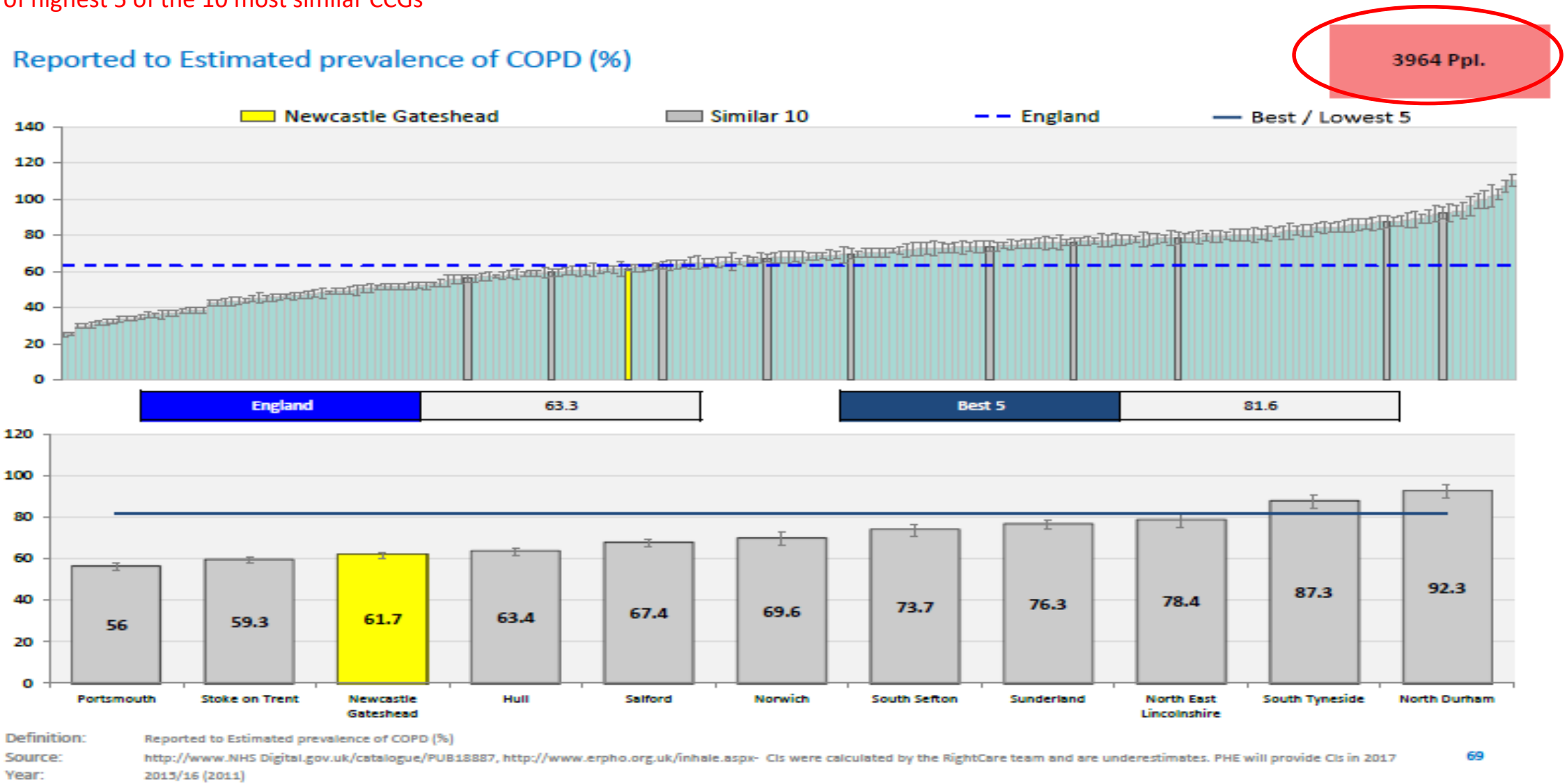
- As health conditions are linked to demographic factors such as deprivation and age, NHS RightCare compares systems to their closest demographically similar geographies to provide realistic comparisons
- By comparing 10 demographically similar CCGs, ensures that comparisons are fair and meaningful.
- NHS RightCare has developed the ‘Similar 10 CCG Explorer tool’ which allows users to investigate all the different demographic variables that comprise the similar ten calculations and see how similar their CCG is to the similar 10 CCGs on each these factors.  The tool also allows users to create their own bespoke similar ten grouping by changing the weightings of any of the different variables

Opportunity in the top right hand corner is how many additional people with COPD would be diagnosed if the CCG achieved the average of highest 5 of the 10 most similar CCGs



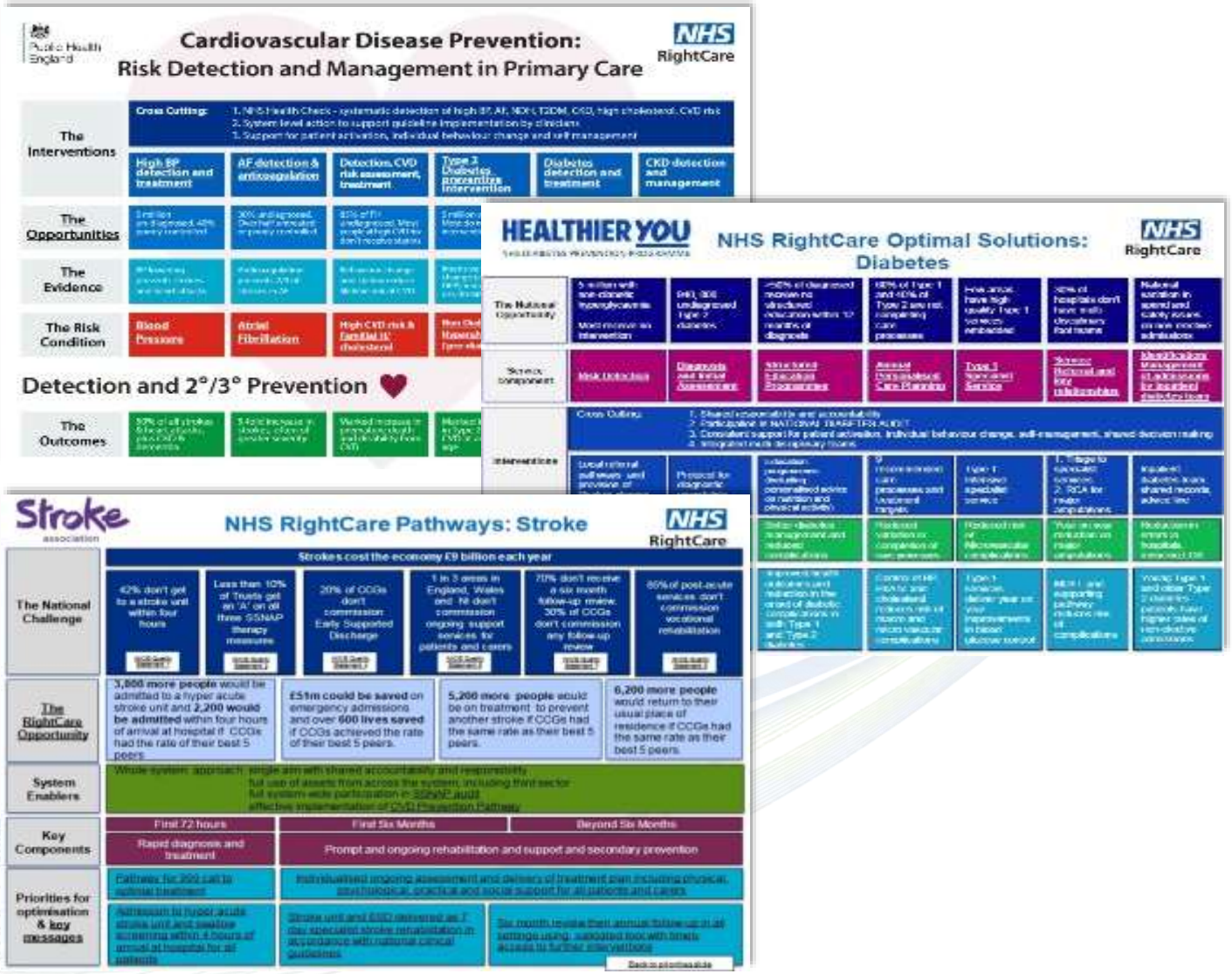



*Source: RightCare Long Term Conditions Focus Pack*

# Optimal design - NHS RightCare Pathways

- CVD disease prevention
- Diabetes
- Stroke
- Falls & Fragility Fractures
- COPD

- Coming soon/ in development:
  - CVD for people with SMI,
  - Progressive neurology,
  - Headache and Migraine,
  - Frailty, MH, MSK, Vision,
  - Rehabilitation…



| | C | D | E | F | G | H |
|---|---|---|---|---|---|---|
| 31 | Presentation/Referral | Secondary Care - Inpatient Spend | Total elective spend on disorders of sclera, cornea, iris and ciliary body per 1,000 age-sex weighted population | 2017/18 | National Commissioning Data Repository (NCDR); SUS Plus (Secondary Uses Services) | CCG |
| 32 | Presentation/Referral | Secondary Care - Inpatient Spend | Total spend on disorders of lens per 1,000 age-sex weighted population | 2017/18 | National Commissioning Data Repository (NCDR); SUS Plus (Secondary Uses Services) | CCG |
| 33 | Presentation/Referral | Secondary Care - Inpatient Spend | Total elective spend on disorders of lens per 1,000 age-sex weighted population | 2017/18 | National Commissioning Data Repository (NCDR); SUS Plus (Secondary Uses Services) | CCG |
| 34 | Presentation/Referral | Secondary Care - Inpatient Spend | Total spend on disorders of choroid and retina per 1,000 age-sex weighted population | 2017/18 | National Commissioning Data Repository (NCDR); SUS Plus (Secondary Uses Services) | CCG |
| 35 | Presentation/Referral | Secondary Care - Inpatient Spend | Total elective spend on disorders of choroid and retina per 1,000 age-sex weighted population | 2017/18 | National Commissioning Data Repository (NCDR); SUS Plus (Secondary Uses Services) | CCG |
| 36 | Presentation/Referral | Secondary Care - Inpatient Spend | Total non-elective spend on disorders of choroid and retina per 1,000 age-sex weighted population | 2017/18 | National Commissioning Data Repository (NCDR); SUS Plus (Secondary Uses Services) | CCG |
| 37 | Presentation/Referral | Secondary Care - Inpatient Spend | Total spend on glaucoma per 1,000 age-sex weighted population | 2017/18 | National Commissioning Data Repository (NCDR); SUS Plus (Secondary Uses Services) | CCG |
| 38 | Presentation/Referral | Secondary Care - Inpatient Spend | Total elective spend on glaucoma per 1,000 age-sex weighted population | 2017/18 | National Commissioning Data Repository (NCDR); SUS Plus (Secondary Uses Services) | CCG |
| 39 | Presentation/Referral | Secondary Care - Inpatient Spend | Total spend on disorders of vitreous body and globe per 1,000 age-sex weighted population | 2017/18 | National Commissioning Data Repository (NCDR); SUS Plus (Secondary Uses Services) | CCG |
| 40 | Presentation/Referral | Secondary Care - Inpatient Spend | Total elective spend on disorders of vitreous body and globe per 1,000 age-sex weighted population | 2017/18 | National Commissioning Data Repository (NCDR); SUS Plus (Secondary Uses Services) | CCG |
| 41 | Presentation/Referral | Secondary Care - Inpatient Spend | Total spend on disorders of optic nerve and visual pathways per 1,000 age-sex weighted population | 2017/18 | National Commissioning Data Repository (NCDR); SUS Plus (Secondary Uses Services) | CCG |
| 42 | Presentation/Referral | Secondary Care - Inpatient Spend | Total spend on disorders of ocular muscles, binocular movement, accommodation and refraction per 1,000 age-sex weighted population | 2017/18 | National Commissioning Data Repository (NCDR); SUS Plus (Secondary Uses Services) | CCG |
| 43 | Presentation/Referral | Secondary Care - Inpatient Spend | Total elective spend on disorders of ocular muscles, binocular movement, accommodation and refraction per 1,000 age-sex weighted population | 2017/18 | National Commissioning Data Repository (NCDR); SUS Plus (Secondary Uses Services) | CCG |
| 44 | Presentation/Referral | Secondary Care - Inpatient Spend | Total spend on visual disturbances and blindness per 1,000 age-sex weighted population | 2017/18 | National Commissioning Data Repository (NCDR); SUS Plus (Secondary Uses Services) | CCG |
| 45 | Presentation/Referral | Secondary Care - Inpatient Spend | Total non-elective spend on visual disturbances and blindness per 1,000 age-sex weighted population | 2017/18 | National Commissioning Data Repository (NCDR); SUS Plus (Secondary Uses Services) | CCG |
| 46 | Presentation/Referral | Secondary Care - Inpatient Spend | Total spend on other disorders of eye and adnexa per 1,000 age-sex weighted population | 2017/18 | National Commissioning Data Repository (NCDR); SUS Plus (Secondary Uses Services) | CCG |
| 47 | Presentation/Referral | Secondary Care - Inpatient Spend | Total non-elective spend on disorders of conjunctiva per 1,000 age-sex weighted population | 2017/18 | National Commissioning Data Repository (NCDR); SUS Plus (Secondary Uses Services) | CCG |
| | Presentation/Refer | Secondary Care - Inpatient | Total non-elective spend on disorders of sclera, cornea, iris and ciliary body | 2017/18 | National Commissioning Data Repository (NCDR); SUS Plus | CCG |

| | C | D | E | F | G | H |
|---|---|---|---|---|---|---|
| 73 | Diagnosis and Treatment | Secondary Care | Rate of simple cataract surgeries for patients with a comorbidity of Diabetes, Glaucoma, Uveitis, or AMD per 100,000 age-sex weighted population | 2017/18 | National Commissioning Data Repository (NCDR); SUS Plus (Secondary Uses Services) | CCG |
| 74 | Diagnosis and Treatment | Secondary Care | Rate of simple cataract surgeries per 100,000 age-sex weighted population | 2017/18 | National Commissioning Data Repository (NCDR); SUS Plus (Secondary Uses Services) | CCG |
| 75 | Diagnosis and Treatment | Secondary Care | Rate of cataract surgeries with a complication of Endopthalmitis per 100,000 age-sex weighted population | 2017/18 | National Commissioning Data Repository (NCDR); SUS Plus (Secondary Uses Services) | CCG |
| 76 | Diagnosis and Treatment | Secondary Care | Rate of Strabismus surgery per 100,000 age-sex weighted population | 2017/18 | National Commissioning Data Repository (NCDR); SUS Plus (Secondary Uses Services) | CCG |
| 77 | Diagnosis and Treatment | Secondary Care | Rate of cornea graft procedures per 100,000 age-sex weighted population | 2017/18 | National Commissioning Data Repository (NCDR); SUS Plus (Secondary Uses Services) | CCG |
| 78 | Diagnosis and Treatment | Secondary Care | Rate of Vitreoretinal - scleral buckling procedures per 100,000 age-sex weighted population | 2017/18 | National Commissioning Data Repository (NCDR); SUS Plus (Secondary Uses Services) | CCG |
| 79 | Diagnosis and Treatment | Secondary Care | Rate of Trabeculectomy procedures per 100,000 age-sex weighted population | 2017/18 | National Commissioning Data Repository (NCDR); SUS Plus (Secondary Uses Services) | CCG |
| 80 | Diagnosis and Treatment | Secondary Care | Rate of Tube surgery procedures per 100,000 age-sex weighted population | 2017/18 | National Commissioning Data Repository (NCDR); SUS Plus (Secondary Uses Services) | CCG |
| 81 | Diagnosis and Treatment | Secondary Care | Rate of Intravitreal injection procedures per 100,000 age-sex weighted population | 2017/18 | National Commissioning Data Repository (NCDR); SUS Plus (Secondary Uses Services) | CCG |
| 82 | Diagnosis and Treatment | Secondary Care | Rate of second eye cataract surgeries per 100,000 age-sex weighted population | 2017/18 | National Commissioning Data Repository (NCDR); SUS Plus (Secondary Uses Services) | CCG |
| 83 | | | Total spend on primary care prescribing for problems of vision per 1,000 ASTRO-PU weighted population | 2017/18 | NHS Business Services Authority | CCG |
| 84 | Diagnosis and Treatment | Primary Care Prescribing | Total spend on primary care prescribing for Anti-infective eye preparations per 1,000 ASTRO-PU weighted population | 2017/18 | NHS Business Services Authority | CCG |
| 85 | Diagnosis and Treatment | Primary Care Prescribing | Total spend on primary care prescribing for Corticosteroids and other anti-inflammatory preparations per 1,000 ASTRO-PU weighted population | 2017/18 | NHS Business Services Authority | CCG |
| 86 | Diagnosis and Treatment | Primary Care Prescribing | Total spend on primary care prescribing for Treatment of glaucoma per 1,000 ASTRO-PU weighted population | 2017/18 | NHS Business Services Authority | CCG |
| 87 | Diagnosis and Treatment | Primary Care Prescribing | Total spend on primary care prescribing for Miscellaneous ophthalmic preparations per 1,000 ASTRO-PU weighted population | 2017/18 | NHS Business Services Authority | CCG |

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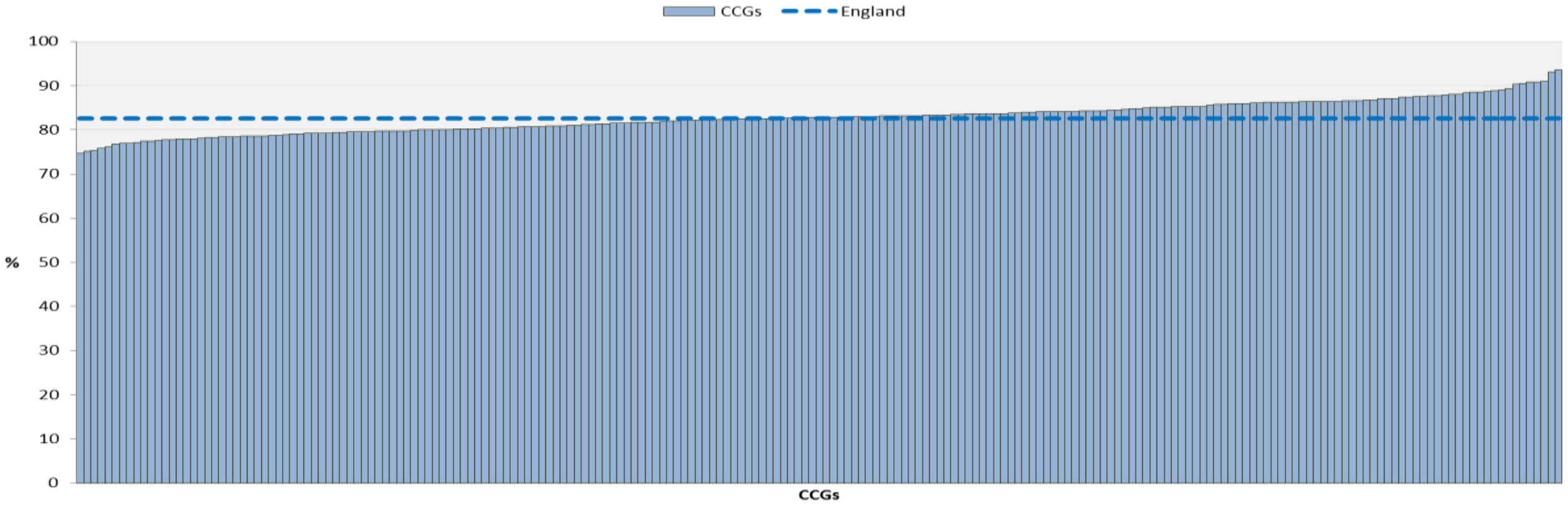
| | C | D | E | F | G | H |
|---|---|---|---|---|---|---|
| 121 | Other | Outcome | Crude rate of sight loss due to age related macular degeneration (AMD) in those aged 65+ per 100,000 population | 2016/17 | Public Health Outcomes Framework, PHE | Upper Tier Local Authority |
| 122 | Other | Outcome | Crude rate of sight loss due to glaucoma in those aged 40+ per 100,000 population | 2016/17 | Public Health Outcomes Framework, PHE | Upper Tier Local Authority |
| 123 | Other | Outcome | Crude rate of sight loss due to diabetic eye disease in those aged 12+ per 100,000 population | 2016/17 | Public Health Outcomes Framework, PHE | Upper Tier Local Authority |
| 124 | Other | Outcome | Crude rate of sight loss certifications per 100,000 population | 2016/17 | Public Health Outcomes Framework, PHE | Upper Tier Local Authority |
| 125 | Patient Support | Outcome | Rate of blind/severely sight impaired persons on the register at the reporting period end - aged 75 and over per 100,000 weighted population | 2016/17 | NHS Digital - Registered Blind and Partially Sighted People, England 2016-17 | Upper Tier Local Authority |
| 126 | Patient Support | Outcome | Rate of partial sight/sight impaired persons on the register at the reporting period end - aged 75 and over per 100,000 weighted population | 2016/17 | NHS Digital - Registered Blind and Partially Sighted People, England 2016-17 | Upper Tier Local Authority |
| | Patient Support | Incidence | Rate of blind/severely sight impaired persons new to the register during the year - aged 75 and over per 100,000 weighted population | 2016/17 | NHS Digital - Registered Blind and Partially Sighted People, England 2016-17 | Upper Tier Local Authority |

Full Indicator List

# % of diabetes patients having retinal screening in the previous 12 months

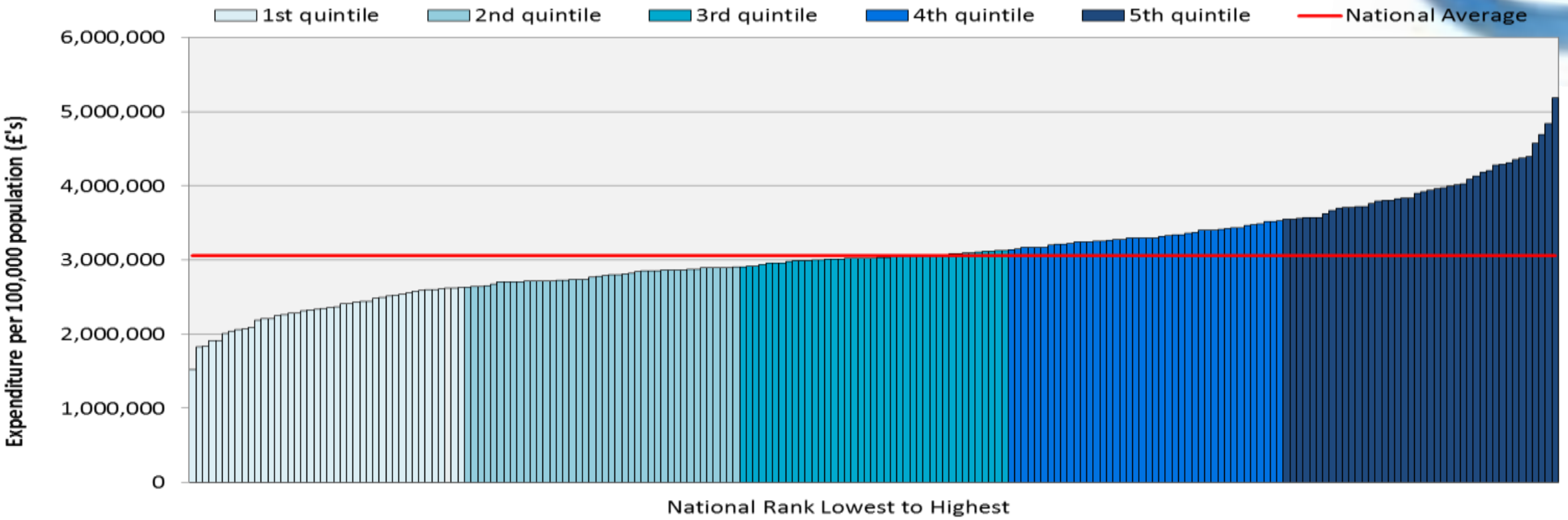
- Over 88,000 patients would be screened if each CCG improved to level of their best 5 CCGs of their similar 10 demographic peers.




Source: Quality and Outcomes Framework (QOF), NHS Digital, 2013/14

**2016/17 UNPUBLISHED DATA**

# Expenditure per 100,000 of population for 'Problems of Vision' across the 'Care Settings Recommended for Benchmarking'




This distribution shows 2016/17 CCG spend per 100,000 weighted population on problems of vision for the following activity:

- Primary Care Prescribing;
- Inpatient and outpatient activity which has a nationally mandated price;
- High cost drugs and devices.

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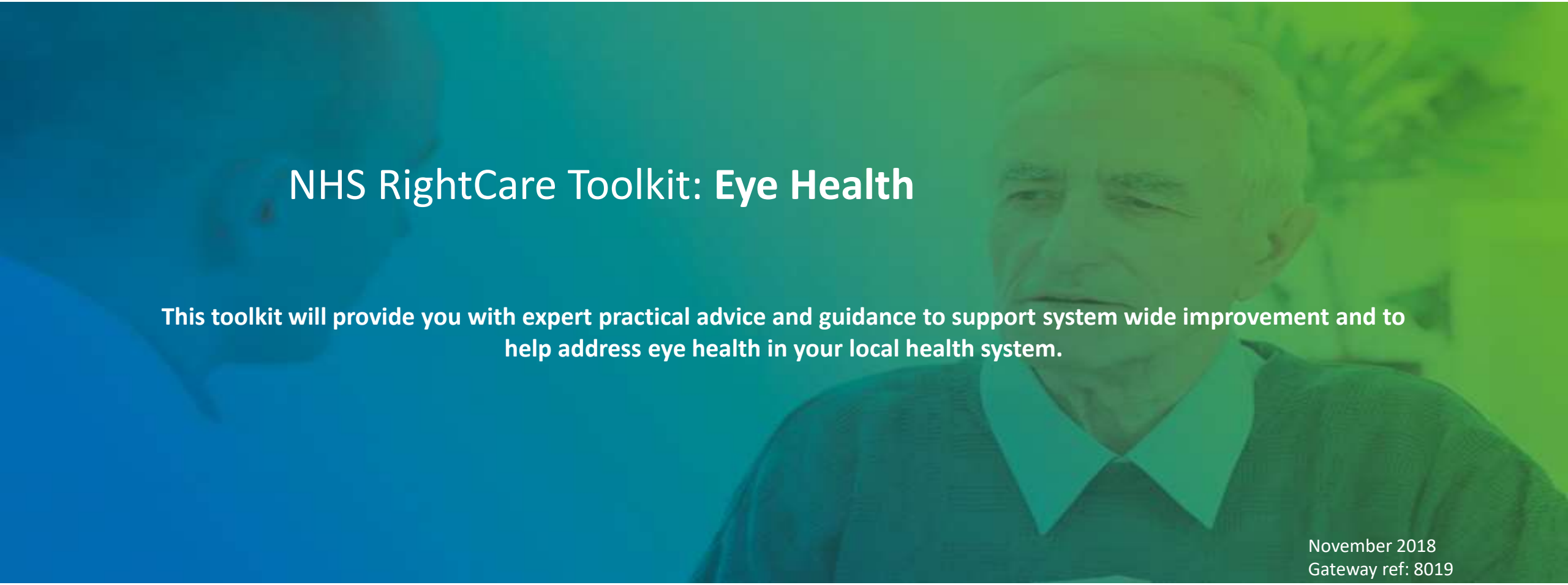

# NHS RightCare Toolkit: **Eye Health**

**This toolkit will provide you with expert practical advice and guidance to support system wide improvement and to help address eye health in your local health system.**

November 2018
Gateway ref: 8019

*Supported by*

NICE National Institute for Health and Care Excellence

# System Improvement Priorities

**Understand your system**

**Stratification & prioritisation of patients based on clinical need**

**Optimise infrastructure & resourcing to meet growing demand**

**Coordinated services across the system**

**Experience of Care**

**Personalised care**

**Self assessment checklist**

NHS RightCare Eye Health Toolkit:

# System Improvement Priorities

## Understand your system

- Understand your population in order to meet current and future demand for eye health services across your system
- Map out your current patient journeys through the system
- Undertake a whole systems analysis of services that are currently commissioning and delivered in your system across all sectors

## Stratification & prioritisation of patients based on clinical need

- Risk stratify, the current demand on HES services across all lists
- Prioritise high risk and high impact diseases, identified through risk stratification strategies, for current and new patients to reduce the risk of harm
- Implement the ECTP HII failsafe processes
- Treat low risk patients in community based services or through virtual clinics and non-medically delivered HES care.
- Improve referral processes to reduce unnecessary or inappropriate referrals to secondary care and improve the quality of appropriate referrals

## Optimise infrastructure & resourcing to meet growing capacity needs

- Better use of existing physical spaces and equipment (including IT systems) to increase number of patients being treated both in HES and outside of the hospital setting (where clinically appropriate)
- Training and upskilling of the current workforce
- Recruitment plans to ensure a sustainable workforce for the future to meet increasing demand
- Use of ECLOs in HES to undertake non-clinical support to patients to free up clinical capacity
- Ensure that AQPs, community and primary providers commissioned within the local area are integrated into the overall care pathway

## Coordinated services across the system

- Development of system wide pathways to include all stakeholders in the system
- Clear communication between primary, community and hospital services
- Easier patient navigation of the services across the system

## Personalised care

- Effective personalised care planning with patients and shared decision making
- Use of patient activation strategies

## Experience of care

- Improving the experience of care for people and their carers who live with poor eye health

Self assessment checklist

# System Improvement Priority: **Understand your system**

| Actions to take: | |
|---|---|
| Understand your population in order to meet current and future demand for eye health services across your system | • Work with partners to ensure that prevention strategies are embedded at a local level; these includes vision screening for children aged 4-5 years, uptake of diabetic retinopathy screening, targeting of hard to reach groups to access screening services and availability of lifestyle behavioural interventions.<br>• Use local intelligence such as the Joint Strategic Needs Assessment to understand your current and future demographic profile.<br>• Work with local public health or intelligence teams to understand the impact of changing demographics (including specific patient groups, areas of known deprivation and prevalence of chronic conditions) on the expected increase in prevalence of different eye conditions and the demand for eye health services over the next 5-10 years.<br>• Assess your current demand across the whole system (including primary care, backlog, unmet need etc) for services against current service and capacity. |
| Map out your current patient journeys through the system | • Map out the current commissioned and provided services in your area to identify any duplication, overlap or gaps or barriers to effective communication. This should encompass the referral process, how data sharing takes place across different sites and providers and also what mechanisms are in place for feedback on performance and quality issues<br>• Work through each of your local patient journeys for AMD, cataract, glaucoma and urgent eye care to see if your current service provision aligns to the steps outlined in the SAFE pathways<br>• Identify any gaps or deviances from the SAFE pathways and understand whether this is having an impact on patient care, treatment and outcomes, and cost effectiveness |
| Undertake a whole systems analysis of services that are currently commissioned and delivered in your system across all sectors | • Actively manage contracts commissioned across different providers to understand the interface between them and the quality of services provided<br>• Have an agreed set of system wide metrics in place to assess the quality of the services commissioned and delivered.<br>• Undertake regular contract monitoring of commissioned activity against delivered activity<br>• Agreed system wide finances to deliver the services (take a programme budgeting approach to commissioning)<br>• Have measurable quality and outcome measures consistent for all providers built into local contracts in line with NICE guidance |

# System Improvement Priority: **Stratification & prioritisation of patients based on clinical need**

| Actions to take: | |
|---|---|
| Risk stratify the current / backlog demand on HES services across all lists | • Undertake HES waiting list cleansing and clinical risk stratification in line with ECTP/Eyeswise, using non relevant non clinical staff to minimise clinician time requirements.<br>• Take action to assess , manage and protect delayed high risk patients; discharge where safe. |
| Prioritise high risk and high impact diseases identified through risk stratification strategies for current and new patients to reduce the risk of harm | • Risk stratify patients, using virtual methods where helpful, against recognised clinical risk stratification criteria<br>• Direct patients to stratified care based on risk and individual clinical situation<br>• Develop IT systems that can identify high risk cases and monitor them, and report on the HII follow up target using the Earliest Clinically Appropriate Date<br>• Use local data to assess the new to follow up ratios for high risk disease separately from the overall ophthalmology ratio |
| Implement the ECTP HII failsafe processes / EyesWise | • Appoint failsafe officers in line with the ECTP HII<br>• Implement a local system to identify and act on any delays to follow up and to new patients, prioritised by risk.<br>• Involve clinicians in decisions to rebook or discharge DNAs and cancellations/deferments |
| Treat low risk patients in community based services, through virtual clinics and non-medically delivered HES care | • Implement referral filtering by community optometrists, virtual clinics and advice and guidance<br>• Use the community MDT team to provide care and monitoring outside of a hospital setting (~~CCEHC framework~~)<br>• Use the MDT team in hospital in extended roles and advanced practice to manage low risk cases independently and to work alongside doctors in consultant clinics<br>• Actively manage HES patients against clear protocols, to discharge back to primary care where appropriate<br>• Support patients with behavioural changes eg smoking, drinking, obesity to lower their risk of vision deterioration |
| Consistent referral processes to reduce unnecessary or inappropriate referrals to secondary care and improve the quality of appropriate referrals | • Improve the IT interface between primary and secondary care for referrals (e.g connectivity to e-Referral services across the locality) including a mechanism to provide feedback on the appropriateness of referrals<br>• Implement standardised referral processes, to ensure equity of access for patients and that include explicit criteria within them, across the system in line with current guidance and standards.<br>• Implement referral filtering services to ensure that referrals are accurate and appropriate and directed to the most appropriate setting and professionals<br>• Provide education and training to those who will be making referrals to secondary care |

# Guidance and Best Practice

This section contains all the relevant guidance, evidence and case studies aligned to each of this toolkit's system improvement priority and key areas for focus. It supports development of improvement actions when system priorities have been identified.

## Key Guidance referenced throughout document (see supporting slides for hyperlinks to each document)

- **NICE guidance**
  - **Cataracts in adults: management (NG77) – Oct 17** - including baseline assessment tool
  - **Glaucoma: diagnosis and management (NG81) – Nov 17**
  - **Age-related macular degeneration (NG82) – Jan 18**
- **SAFE** Pathways
- **Elective Care Transformation Board** Ophthalmology handbook
- **Getting It Right First Time** Ophthalmology report

# HSIB

**HealthCare Safety Investigation Branch**:

- Funded by the Department of Health & Social Care and hosted by NHS Improvement, but operates independently. Also independent from regulatory bodies like the Care Quality Commission (CQC).
- *By offering a new perspective and developing meaningful and influential recommendations we aim to drive positive change at a wider level*

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# HSIB


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# HSIB - IOLs

- *The MHRA should strongly recommend the manufacturers of ophthalmology electronic patient record systems (including systems for making and storing ocular biometry measurements), where they fall under the remit of the Medical Device Regulations, undertake an assessment against the MHRA Human Factors and Usability Engineering guidance and this should form part of the documents assessed by a Notified Body as part of any declaration or assessment of conformity with the requirements of the Medical Device Regulations).*
- *The Department of Health and Social Care commissions a set of standards for the NHS that utilises appropriate technologies to provide digital alerts when incorrect intraocular lens are selected.*
- *The Royal College of Ophthalmologists establish an expert working group to evaluate the variance of practice for cataract surgery, and subsequently establish standardised and workable processes to minimise the risk that a patient will receive an incorrect intraocular lens*.

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# HSIB – Lack of timely monitoring for patients with glaucoma

**Notification of investigation**

The HSIB was made aware of a woman who was referred to hospital eye services for urgent assessment of glaucoma. Due to a lack of capacity, there was a delay in the patient's first appointment and her subsequent appointments over the course of 13 months. By this time her sight had deteriorated to the point where she was registered as severely sight impaired.

After a preliminary investigation with the full cooperation of local care providers, HSIB has decided to launch a full investigation. The focus of this will be the lack of timely monitoring for patients with glaucoma. Specifically, the systemic factors that contribute to the safety risk, the adequacy of the risk controls in place and opportunities to mitigate the risk.

Please contact enquiries@hsib.org.uk to register for email updates on this investigation.

**Timeline**

May 10 2019 Notification of investigation

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# Transforming outpatients expert clinical working group

- NHSE and NHSI
- Hosted by the Elective Care Transformation Programme
- Chaired by Professor Donal O’ Donaghue, Registrar of the Royal College of Physicians
- RCP, RCGP, RCS, RCOphth, Public Health, NECT, GIRFT Ophthalmology, GIRFT Director of policy and implementation
- Whole systems approach to transforming outpatients across specialties .

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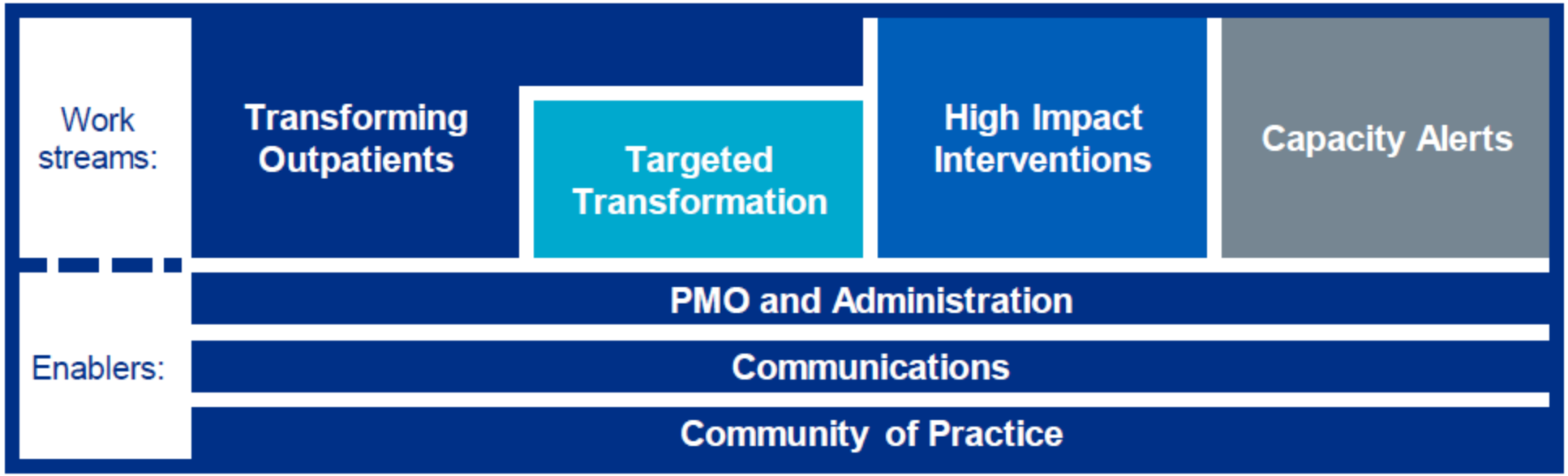
# Introduction

## The Elective Care Transformation programme

The national Elective Care Transformation Programme enables whole system transformation of elective outpatient services, which helps to ensure that only the people who need to be in secondary care are referred there. We work with clinicians to develop guidelines and tools that support frontline health professionals so that more people see the **right person in the right place, first time**.

The work streams below contribute to achieving the Elective Care Transformation Programme objectives. A number of enablers also need to be in place to enable the work streams to function effectively and achieve maximum impact:



# Whole system transformation of outpatients

# Background

## There is an ambition in the NHS Long Term Plan to reduce the number of face-to-face outpatient appointments by up to one third over the next five years.

Traditionally, elective care services in England are delivered via hospital-based models. Patients often have one or more outpatient attendances for specialist diagnostics or assessment before either being discharged or receiving treatment. Following treatment, they may have further outpatient attendances for post-operative assessment and/or ongoing monitoring.

Most of these outpatient attendances are face-to-face, with telephone and virtual consultations accounting for just 2.8% of consultant-led specific-acute outpatient attendances for the 12 months to the end of December 2018.[1]

It is recognised that often this model of care is not the best for patients. In addition, despite still being below plan, the rate of referrals and the rate of growth of GP referrals is of concern in some areas.

Opportunities exist to improve delivery of elective outpatient services and implement alternative models of outpatient services across the entire patient pathway. This includes empowering and enabling patients to better manage their own health condition(s), greater use of virtual consultations, better integration of primary, community and hospital-based services and changing how consultants, nurses and other health care professionals work together to support care delivery.


**The NHS Long Term Plan sets out the ambition to avoid up to a third of outpatient appointments over the next five years.**



[1] Please refer to Annex 1 for an example of summary data.

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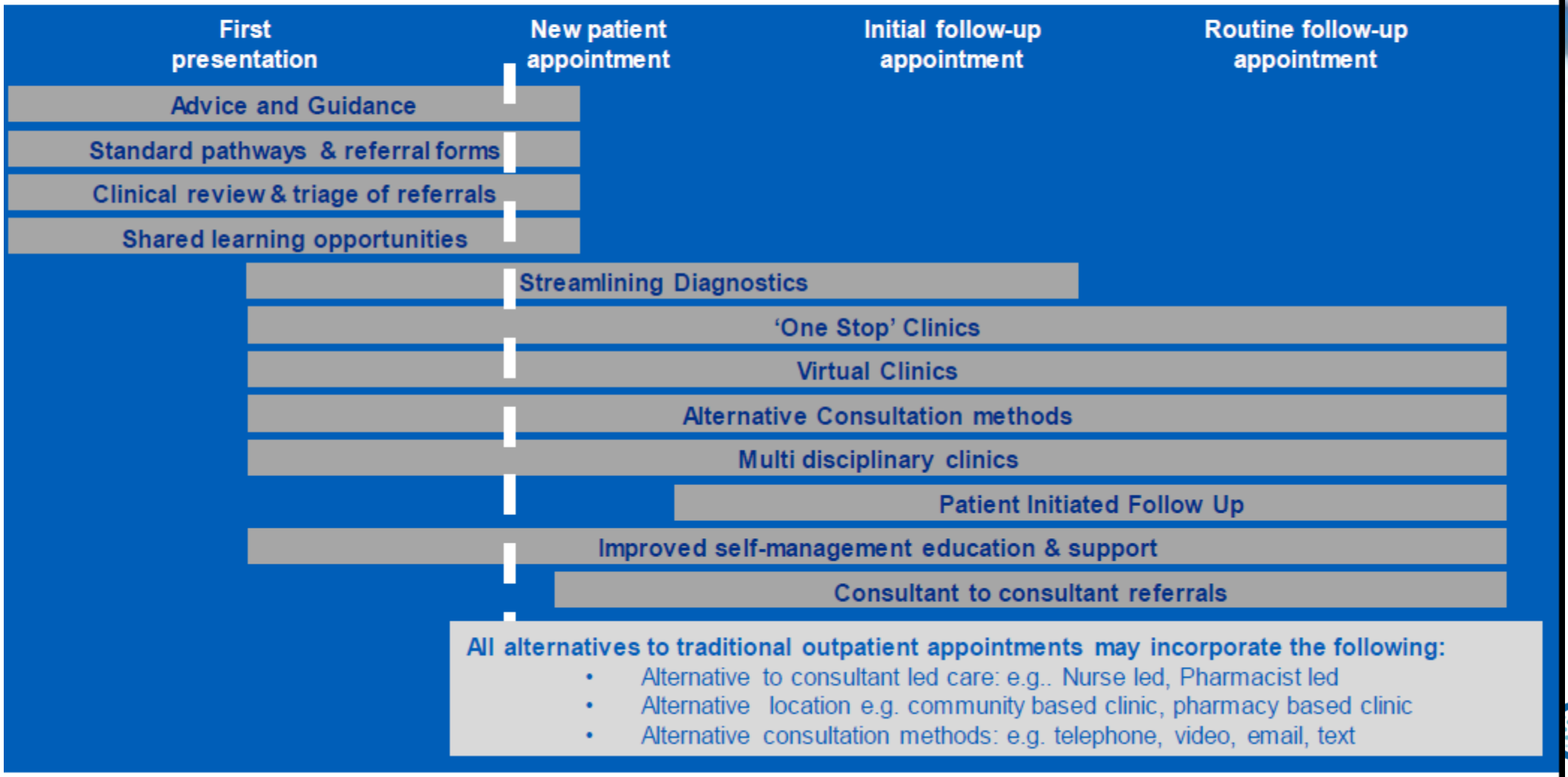
Elective Care Transformation Programme
Whole system transformation of outpatients

# Demand management solutions

# Supporting alternative models of outpatients



# Whole system outpatient transformation

# Pro-active delivery

## Tranches 2 and 3 of pro-active local implementation

- ✓ We have identified the first local system that we will be working with to reduce the number of face to face outpatient appointments. We are due to attend their transformation board meeting on 1st May 2019 to confirm the specific focus.

We are using a phased approach to:

- ➢ Identify further local systems across the country where there is the most opportunity to reduce the number of face to face outpatient appointments;
- ➢ Work with local systems to identify the most appropriate interventions from the menu of opportunities, the potential impact and the most appropriate change methodology;
- ➢ Support local systems to implement and evaluate interventions;
- ➢ Run virtual development collaboratives to support local implementation and share the learning.

## Transforming Outpatients Expert Clinical Working Group

- ➢ We have set up this group with senior membership from across key stakeholder organisations. The first meeting is on 7th May 2019.
- ➢ We will host this meeting regularly to oversee the work of the transforming outpatients work stream and to ensure alignment across key stakeholders and workstreams

## Advice and Guidance

- ✓ We have developed the Advice and Guidance section on the Elective Care Community of Practice with resources from all five waves of rapid testing.
- ➢ We are undertaking analysis of the usage and utilisation rates for Advice and Guidance and will examine closely those local systems in the upper and lowest quartiles to identify good practice and areas where further work and support is needed.
- ➢ We will work nationally with clinicians and other key stakeholders to identify barriers to implementation and utilisation (such as interoperability and tariff)
- ➢ We will support regional teams to drive implementation and increase utilisation of Advice and Guidance in those local systems that need it.

## Targeted transformation

- ✓ We are working with regional teams to identify those systems where there is a challenge, particularly in terms of GP referral growth.
- ➢ We will work with selected local systems to identify solutions, the potential impact and the most appropriate change methodology;
- ➢ We will support local systems to implement and evaluate these solutions;
- ➢ We will run virtual development collaboratives to support local implementation and share the learning.



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# Staff and services: **Extended roles and advanced practice**

- Completed the survey: look to analyse and publish soon: roles, specialties, banding, training, indemnity etc
- Need to publish – looking to do so with UKOA MDT leaders from BIOS, CoO and RCN
  - To fit with College /BIOS OCCCF establishing training nationally

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# OCCCF- ophthalmic common clinical competency framework

Collaboration between RCOphth, The College of Optometrists, BIOS and RCN, backed by Health Education England (HEE).

The OCCCF creates a common educational pathway for postgraduate optometrists, orthoptists and nurses in **secondary eye care** - develop a set of clinical competencies suitable for delivery of eye care to specific groups of patients in secondary care. It assesses competencies to defined recognised standards.

.

The Framework has four areas covering the highest volume ophthalmology services:

- Cataract
- Glaucoma
- Medical Retina
- Acute & Emergency Eye Care

Curriculum, resources and WBAs are now live on HEEs website.
https://www.hee.nhs.uk/our-work/advanced-clinical-practice/ophthalmology-common-clinical-competency-framework-curriculum

# Training for expanded roles

- Current ad hoc arrangements not sustainable
- Standards outlined and set to improve
- Develop a curriculum to underpin the framework
- Unwarranted variation no longer acceptable

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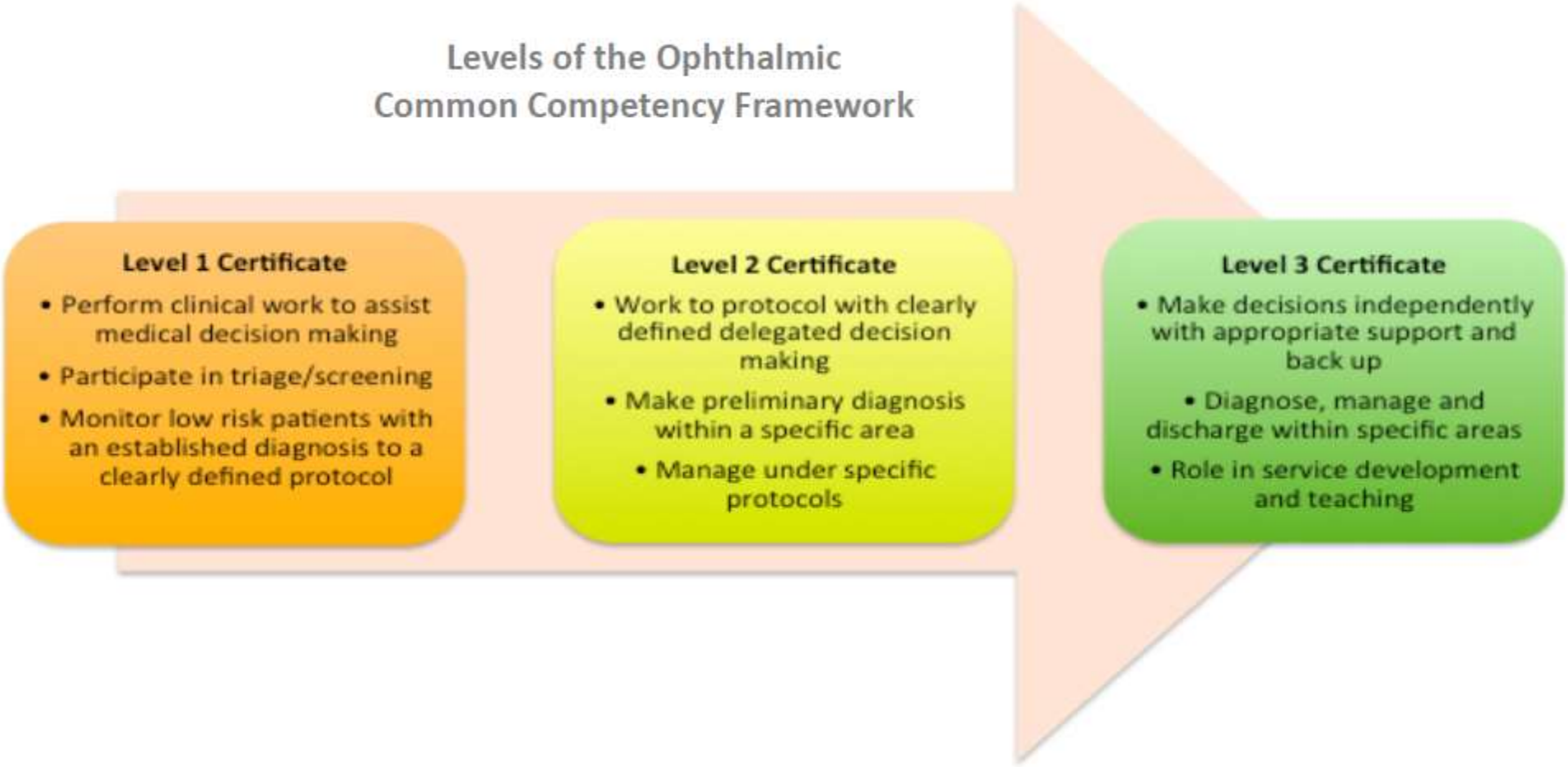
# Levels of the Ophthalmic Common Competency Framework

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A Masters in Advanced Eye Care comprises a Level 3 Certificate in one area for the Clinical pillar, and three generic modules for the pillars in Education, Research and Leadership:


Practitioners with a Level 3 Certificate (ie: the clinical pillar), but not the three generic pillars are said to be performing "at Masters level" for their clinical work.

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**OCCCF Curriculum**

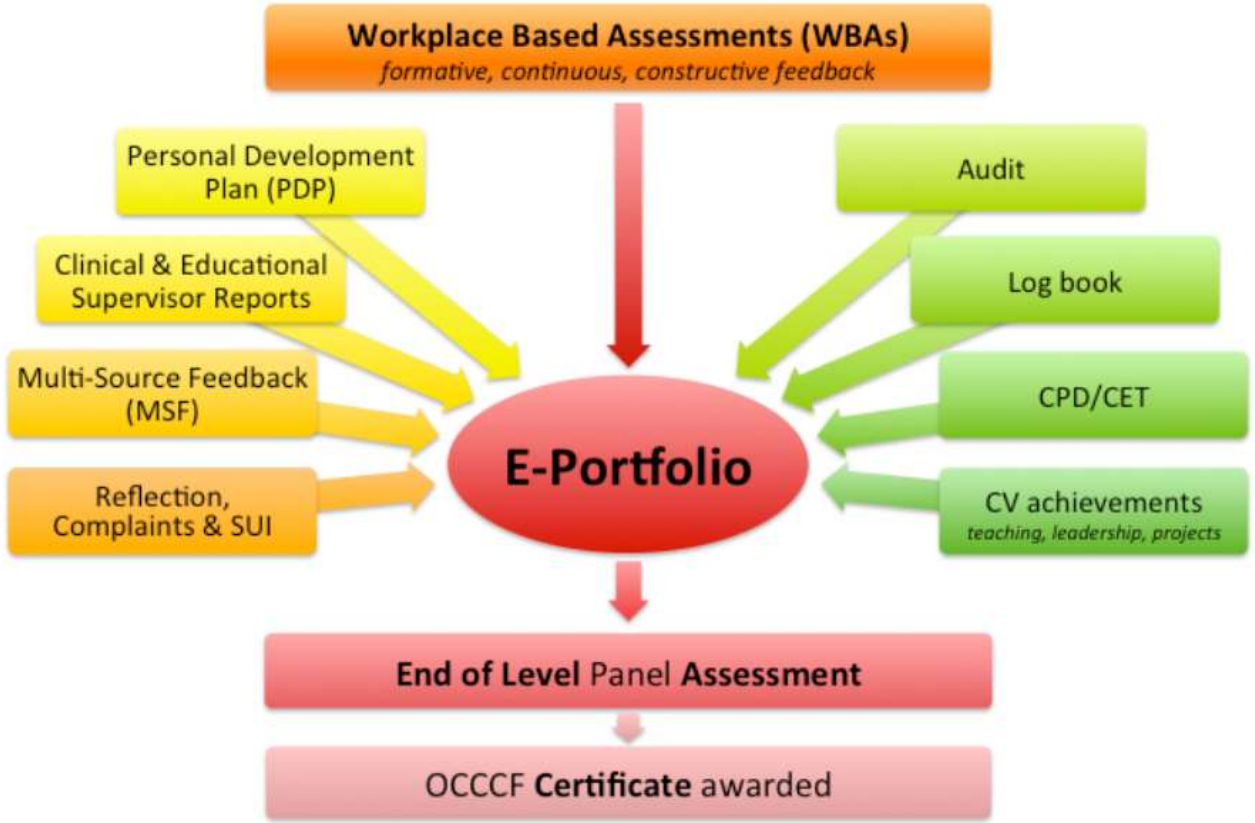
**Learning outcomes**
Mapped online resources

**Learning**
Self-directed learning
Clinical teaching
Supervised work place experience

**Portfolio**
Work place Based Assessments (WBAs)
Evidence of audit, education, research, leadership

**End of Level Assessment** by a panel

**OCCCF Certificate Awarded**
for a particular area and level

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# Benefits for workforce

- Knowledge, skills and experience to be obtained through identified local training associated with post graduate education programmes
- National awareness of each level to improve recruitment and transference of skills
- Removal of duplication of different education and training offerings, which differ in delivery and content
- Recognition of the importance of CPD to maintain and update competences and knowledge
- Transitional arrangements for those who have already been trained and assessed to continue to undertake expanded roles

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# Benefits for the team

- Stability to the ophthalmic team
- Maximises on various skills which are complementary and provide wider input to the team
- Transparent clinical career progression for all
- Recognition of need for resource
- Frees up ophthalmology trainees for more learning opportunities

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# Clinical policy packs

- Key areas of extended role practice
- Building on existing practice and documents from many trusts small and large
- Consensus from UKOA members and advanced practice working group

- Contains:
  - Policy with banding, responsibilities, risk management, exclusions, scope  etc
  - Training details
  - Competencies and work place based assessments (WpBA)
  - Log book (case) proformas
  - Overall sign off documents
  - Risk assessment
  - Outcomes and monitoring
  - Reflective practice template
  - SOP or protocol
  - ***Consent form***

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# Current policy packs on the website

- Finished:
  - Intravitreal injections
  - Paediatric ophthalmology
  - Cataract
  - Community cataract pre and post op
- Draft:
  - Botulinum toxin clinics and injections

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# Current packs in preparation

- Being consulted
  - Corneal and external disease
  - YAG laser capsulotomy
  - YAG laser PI and SLT
- Being drafted:
  - Theatres and minor ops
  - Keratoconus and corneal cross linking
  - Glaucoma

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# Eyefficiency

- Eyefficiency is a global cataract surgery sustainability project: RCOphth Sustainability Working Group & research funding
- Aims to gather information from units across the world to work out the carbon footprint of cataract surgery around the world.
- NHSI funding to develop NHS version for training and risk/case-mix adjusted time and efficiency benchmarking tool for cataract and intravitreal injections

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13:34

WELCOME TO EYEFFICIENCY

Time and Motion Studies for Cataract Operating Lists

EYEFFICIENCY

NEW STUDY

COMPLETED STUDIES

ABOUT US

13:34

INSTRUCTIONS PREFERENCES

Eyefficiency performs a time-and-motion study for your cataract operating list. The banner at the top of the screen can be used to navigate through the study – pressing the word on the right of thescreen takes you forwards, pressing the word on the left takes you backwards.

Before your study starts, you will be asked a few questions about your unit, and how your list is set up.

Before each case, we will ask you about the type of operation you're going to perform, whether it's expected to be a simple case, and the training level of the surgeon.

During a case, you will use the banner to record when a certain event has happened (e.g. patient has entered the theatre, incision closed). If you have made a mistake,for example you have recorded an event too early, you can use the banner to go back(the last event will be on the left of the banner).

At the end of your operating list, you will see a breakdown of your time-and-motion study. Old studies are stored for later review.

When you're ready to start, press on "preferences" in the banner at the top of the screen.

13:34

BED 1 - PATIENT 1 IN PROGRESS

TYPE OF OPERATION SURGEON EXPERIENCE COMPLICATING FACTORS

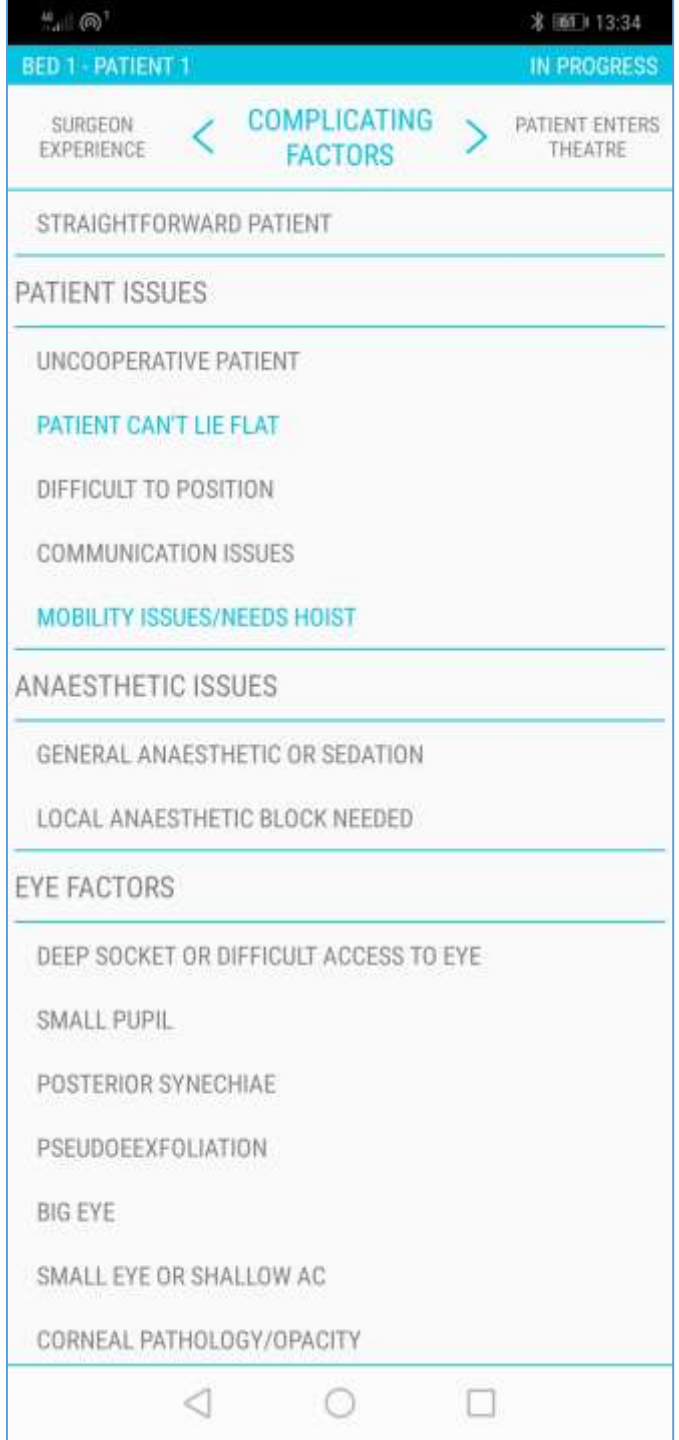
SENIOR SURGEON

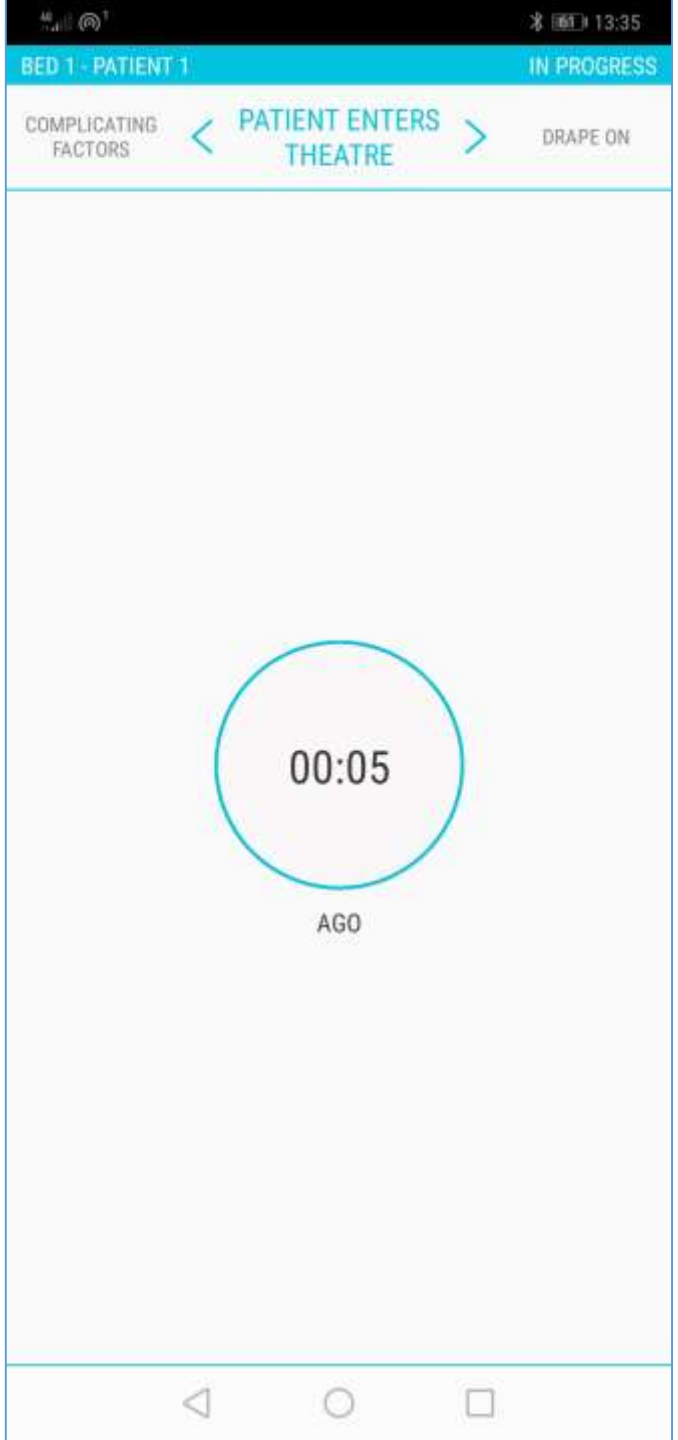
TRAINEE <2 YEARS

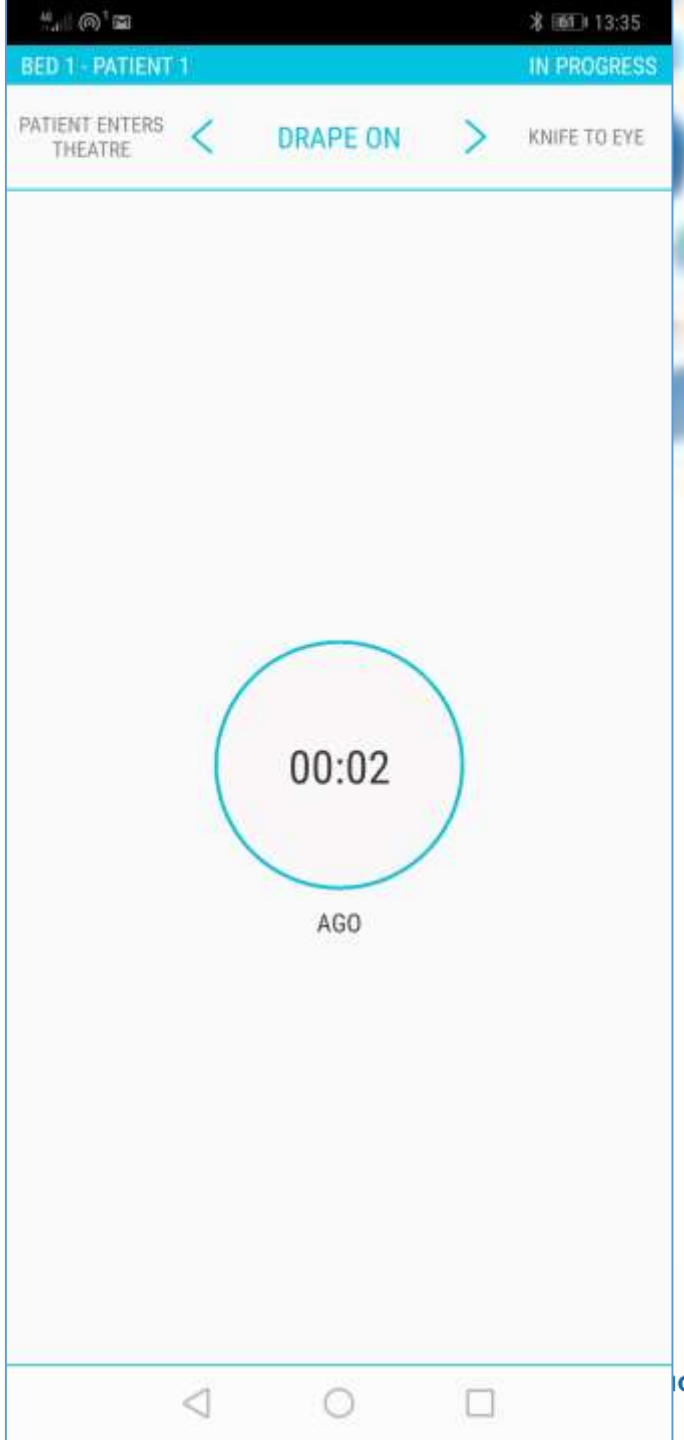
TRAINEE 2-4 YEARS

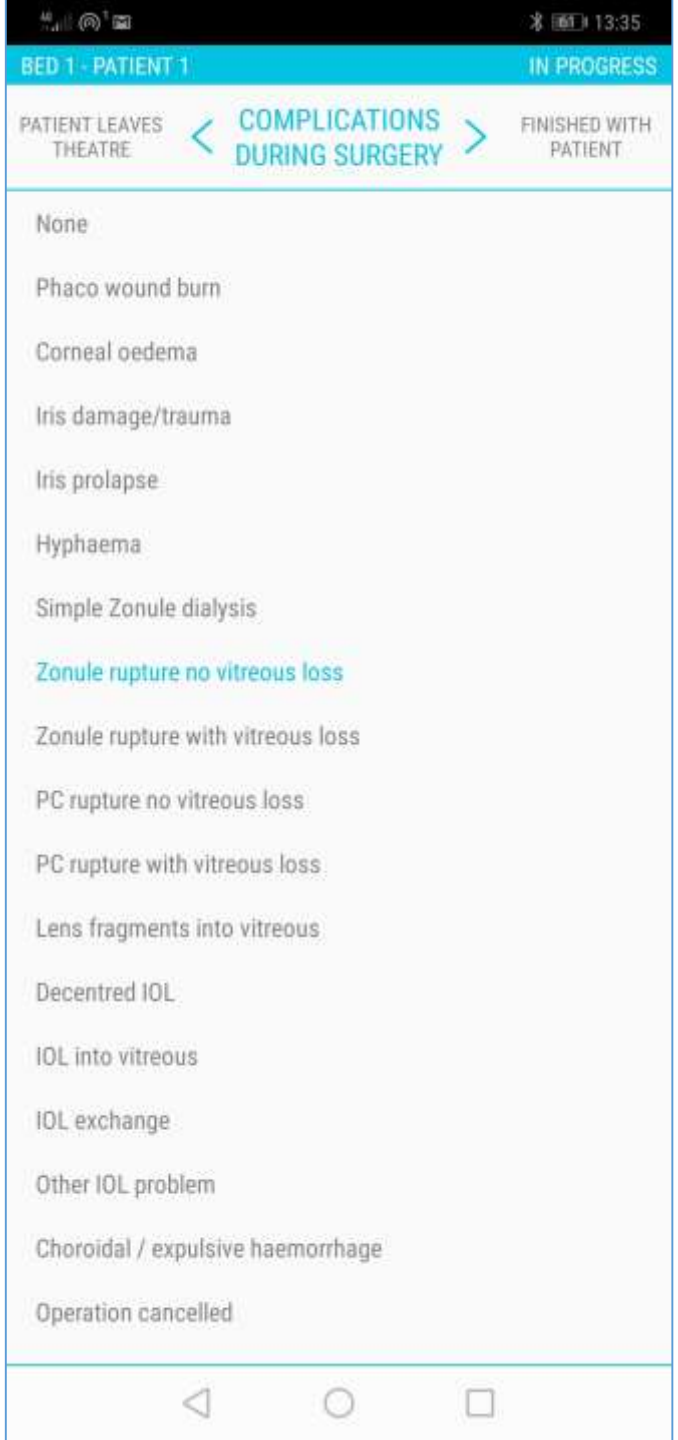
TRAINEE > 4 YEARS

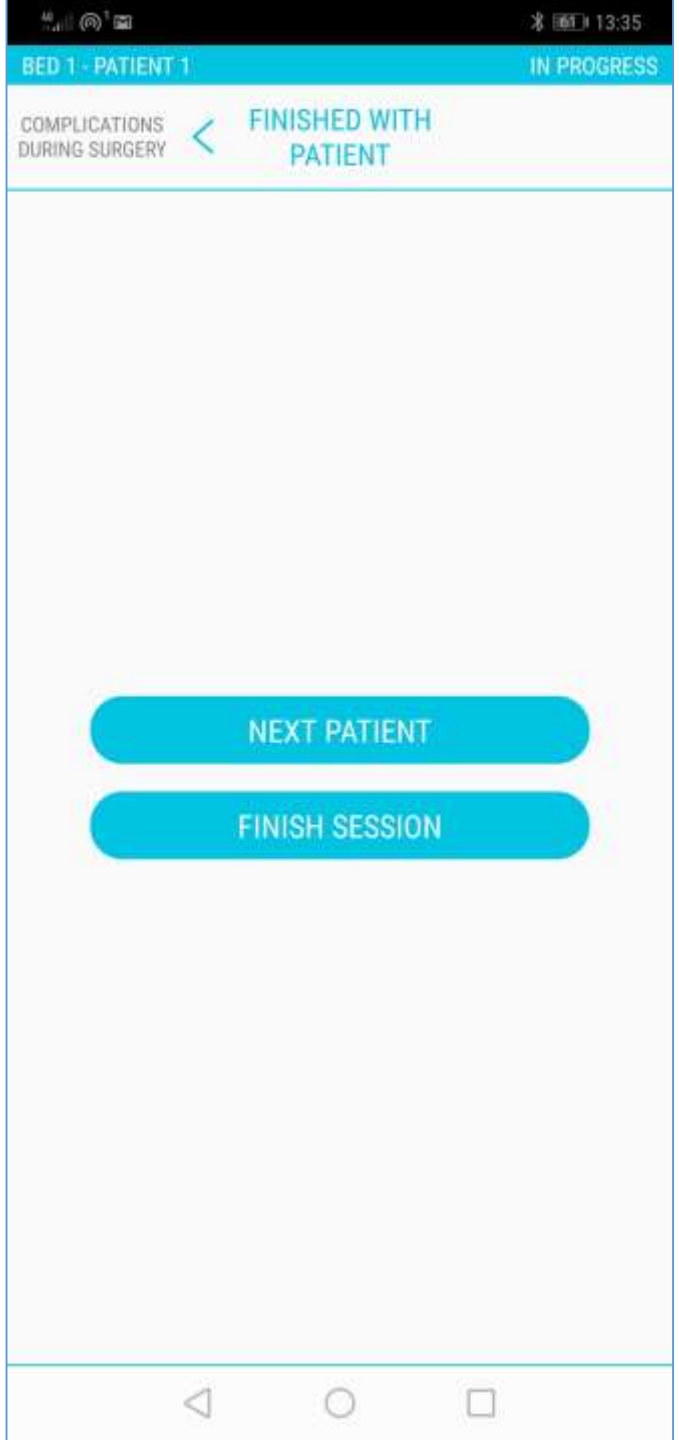
ALLIANCE


13:34
BED 1 - PATIENT 1
IN PROGRESS
SURGEON EXPERIENCE
COMPLICATING FACTORS
PATIENT ENTERS THEATRE
STRAIGHTFORWARD PATIENT
PATIENT ISSUES
UNCOOPERATIVE PATIENT
PATIENT CAN'T LIE FLAT
DIFFICULT TO POSITION
COMMUNICATION ISSUES
MOBILITY ISSUES/NEEDS HOIST
ANAESTHETIC ISSUES
GENERAL ANAESTHETIC OR SEDATION
LOCAL ANAESTHETIC BLOCK NEEDED
EYE FACTORS
DEEP SOCKET OR DIFFICULT ACCESS TO EYE
SMALL PUPIL
POSTERIOR SYNECHIAE
PSEUDOEEXFOLIATION
BIG EYE
SMALL EYE OR SHALLOW AC
CORNEAL PATHOLOGY/OPACITY


13:35
BED 1 - PATIENT 1
IN PROGRESS
COMPLICATING FACTORS
PATIENT ENTERS THEATRE
DRAPE ON
00:05
AGO


13:35
BED 1 - PATIENT 1
IN PROGRESS
PATIENT ENTERS THEATRE
DRAPE ON
KNIFE TO EYE
00:02
AGO

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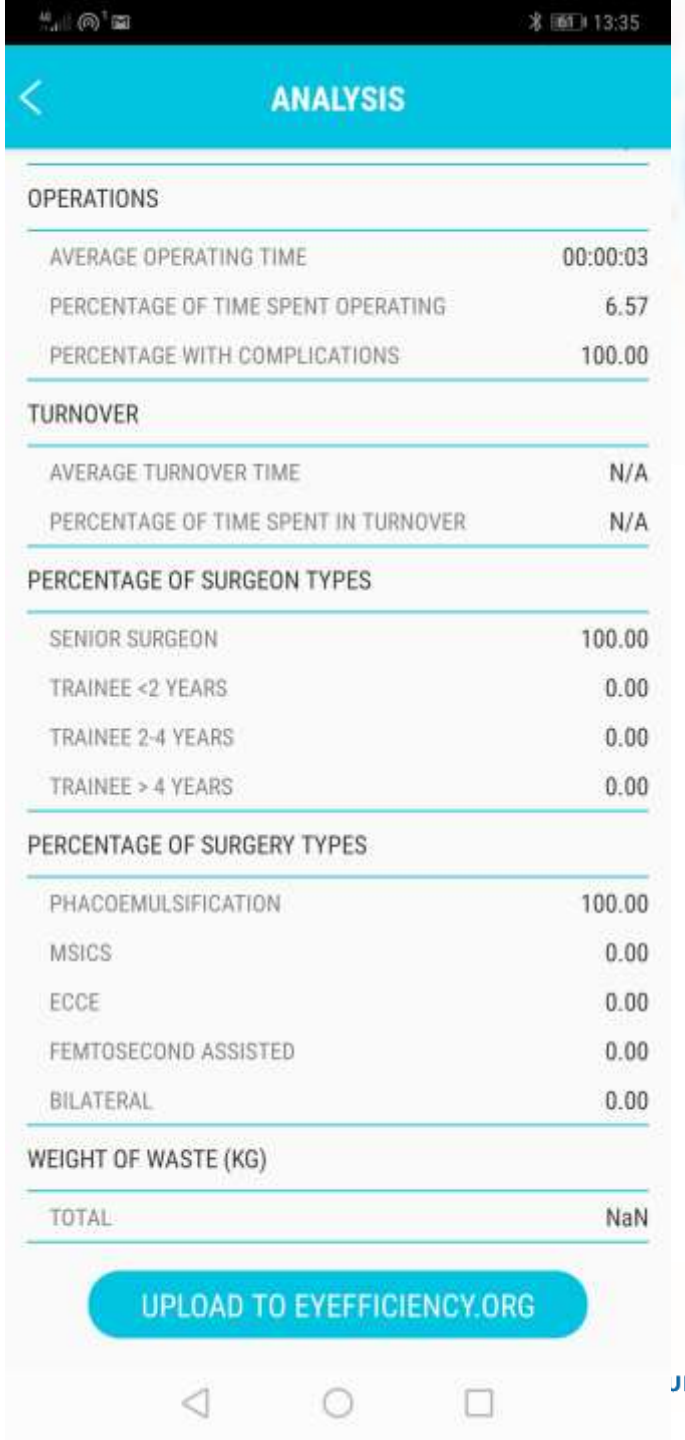


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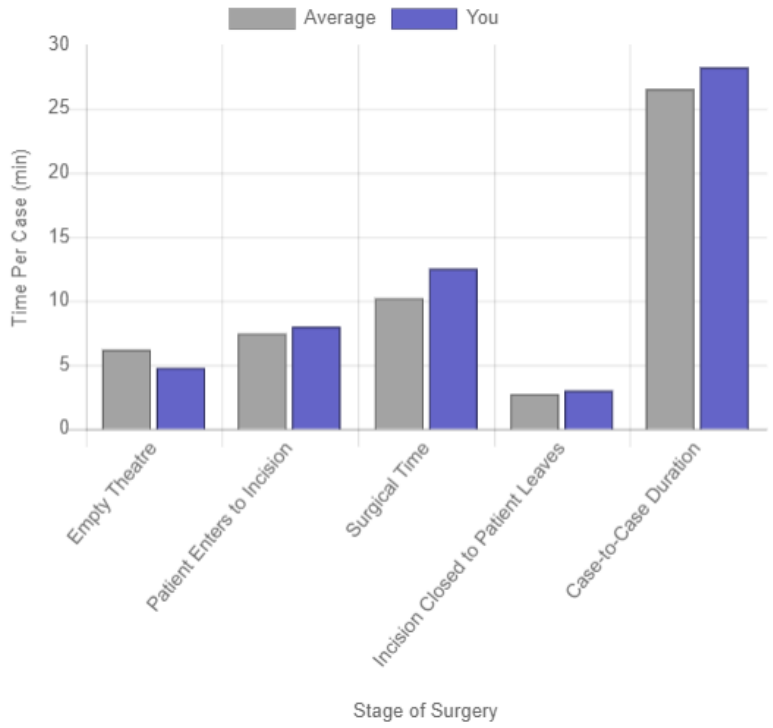
# Configure Analysis for Cataract Time-And-Motion Studies

You can change the averages on this page from global averages to averages in just your country by using the dropdown below.

All Countries

## Stages of Surgery

### Time in surgery




### Filter Data

Surgical Experience

Senior Surgeon, Trainee > 4 Years, Trainee 2 - 4 Years, Trainee < 2 '

Procedures

Pharmacoemulsification, MSICS, ECCE, Femtosecond Assissted, Bil

Complicating Factors

No Complicating Factors, 1 Complicating Factor, 2 Complicating F

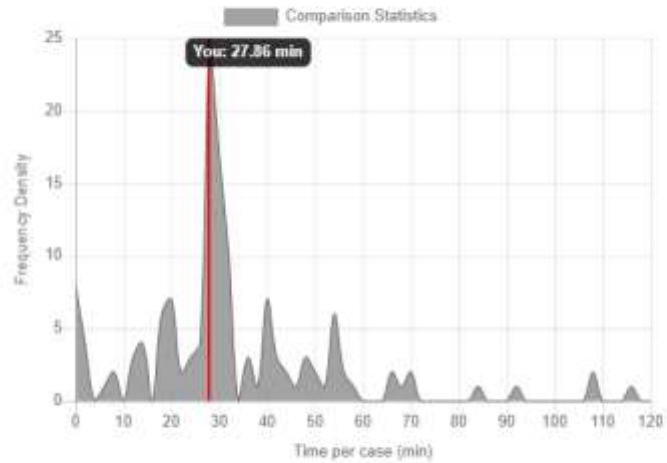
Include Cases Where a Complication Occurred? Yes

Update Graph

Why are these values different to the values for case-to-case duration in the summary table?

# Case Duration

At 00:27:51 minutes per case, you're taking less time than average.




### Filter Data

Surgical Experience

Senior Surgeon, Trainee > 4 Years, Trainee 2 - 4 Years, Trainee < 2

Procedures

Pharmacoemulsification, MSICS, ECCE, Femtosecond Assissted, Bil

Complicating Factors

No Complicating Factors, 1 Complicating Factor, 2 Complicating F

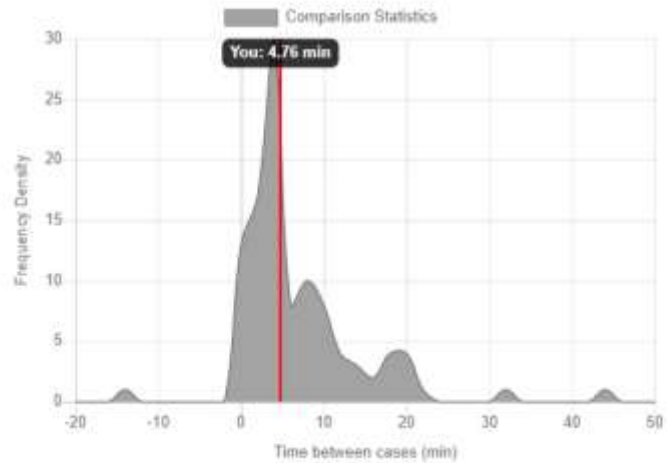
Include Cases Where a Complication Occurred? Yes

Update Graph

# Delay between Patients

### Delay between patients

At 00:04:45 between patients, you're taking less time than average.




### Filter Data

Surgical Experience

Senior Surgeon, Trainee > 4 Years, Trainee 2 - 4 Years, Trainee < 2

Procedures

Pharmacoemulsification, MSICS, ECCE, Femtosecond Assissted, Bil

Complicating Factors

No Complicating Factors, 1 Complicating Factor, 2 Complicating F

Include Cases Where a Complication Occurred? Yes

Update Graph

# Summary Statistics

## Your Performance

| | Your Unit | Average | Relative to Average |
|---|---|---|---|
| Planned Length of List | 04:03:00 | 03:05:46 | +00:57:13 |
| List Over-Run | -00:47:59 | -00:52:30 | +00:04:31 |
| Patients Per List | 7 | 6.18 | +0.82 |
| Start Lateness | 00:07:39 | 03:06:20 | -02:58:40 |
| Case-To-Case Duration | 00:27:51 | 00:21:33 | +00:06:18 |

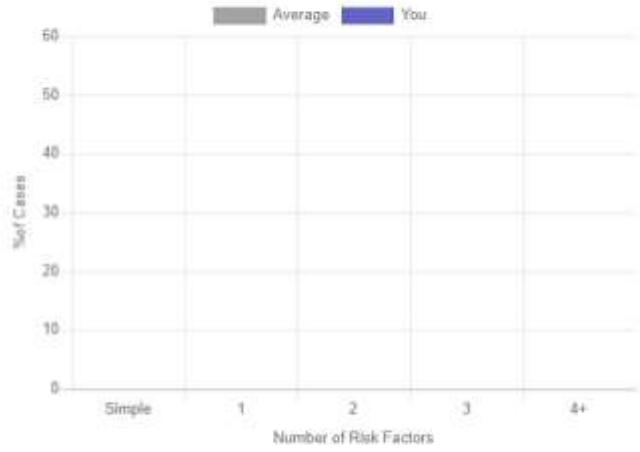
## Time Use Per List

| | Your Studies | Average | Relative to Average |
|---|---|---|---|
| Theatre Empty/Turnover | 00:28:46 (14.78%) | 00:39:52 (0%) | -00:11:05 (+14.78%) |
| Entry → Draped | 00:44:06 (22.65%) | 22:18:10 (39.98%) | -21:34:04 (-17.33%) |
| Drape → Incision | 00:14:54 (7.65%) | 00:23:58 (0%) | -00:09:04 (+7.65%) |
| Incision Made → Incision Closed | 01:26:46 (44.57%) | 14:29:11 (20.01%) | -13:02:25 (+24.56%) |
| Incision Closed → Drape Off | 00:02:31 (1.29%) | 02:59:12 (40.01%) | -02:56:41 (-38.72%) |
| Drape Off → Patient Leaves | 00:17:30 (8.99%) | 00:11:13 (0%) | +00:06:16 (+8.99%) |

# Complicating Factors

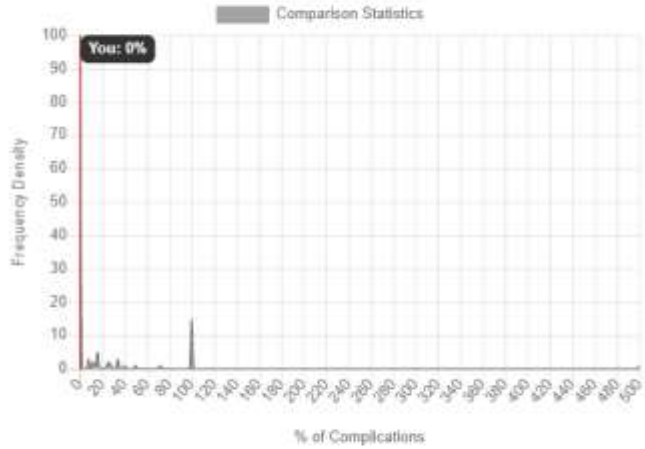
## Casemix

Your cases are more complex than average.




## Complications During Surgery

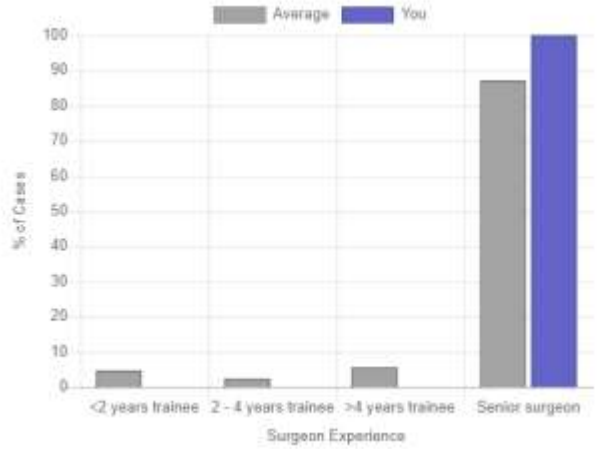
At 0% of cases having complications, you're having less complications than average.




# Unit Statistics

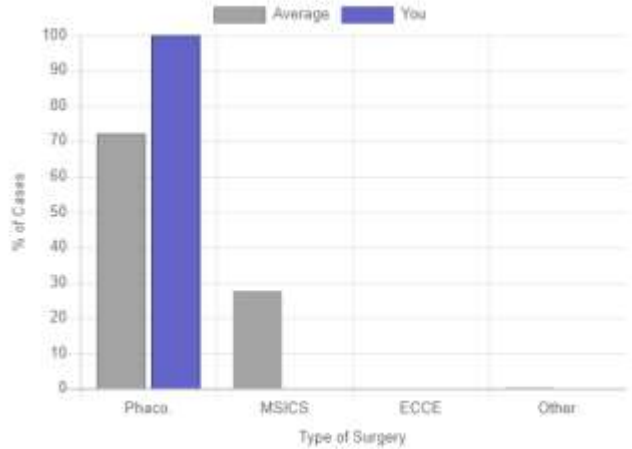
## Training Levels

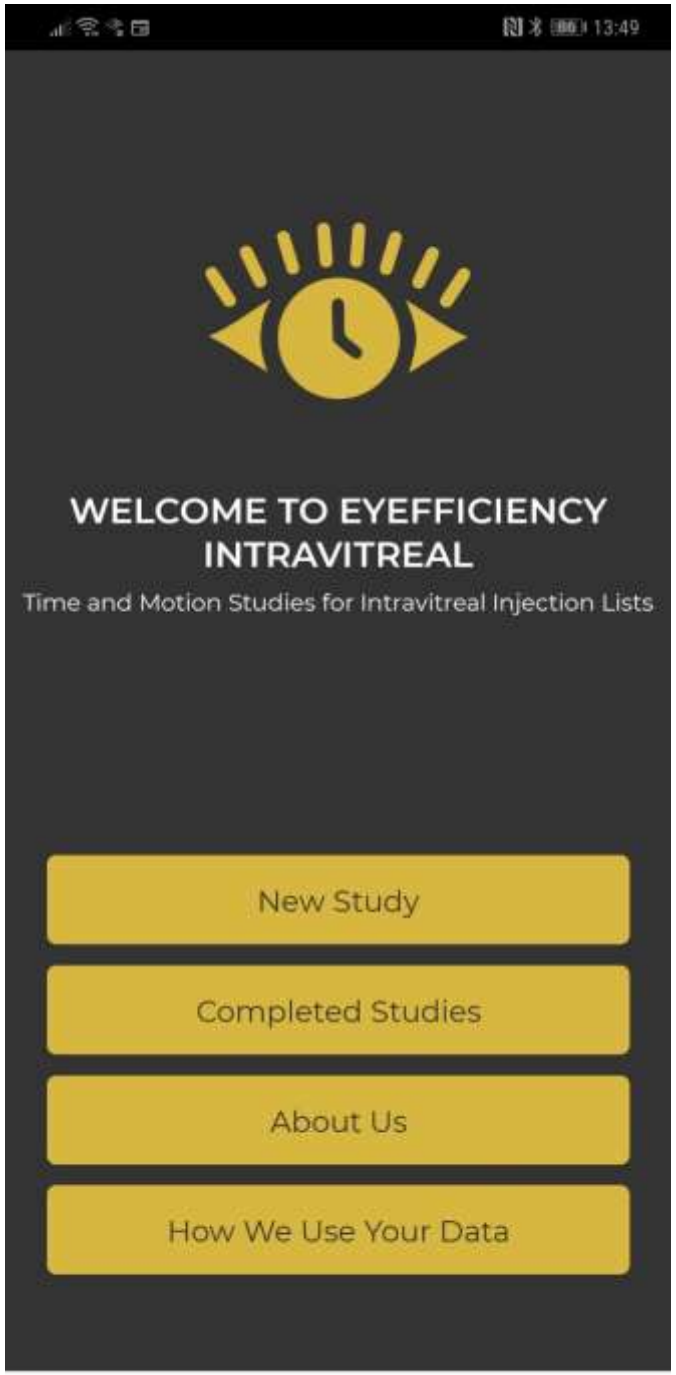
At 10 average training years you're more highly trained than average.

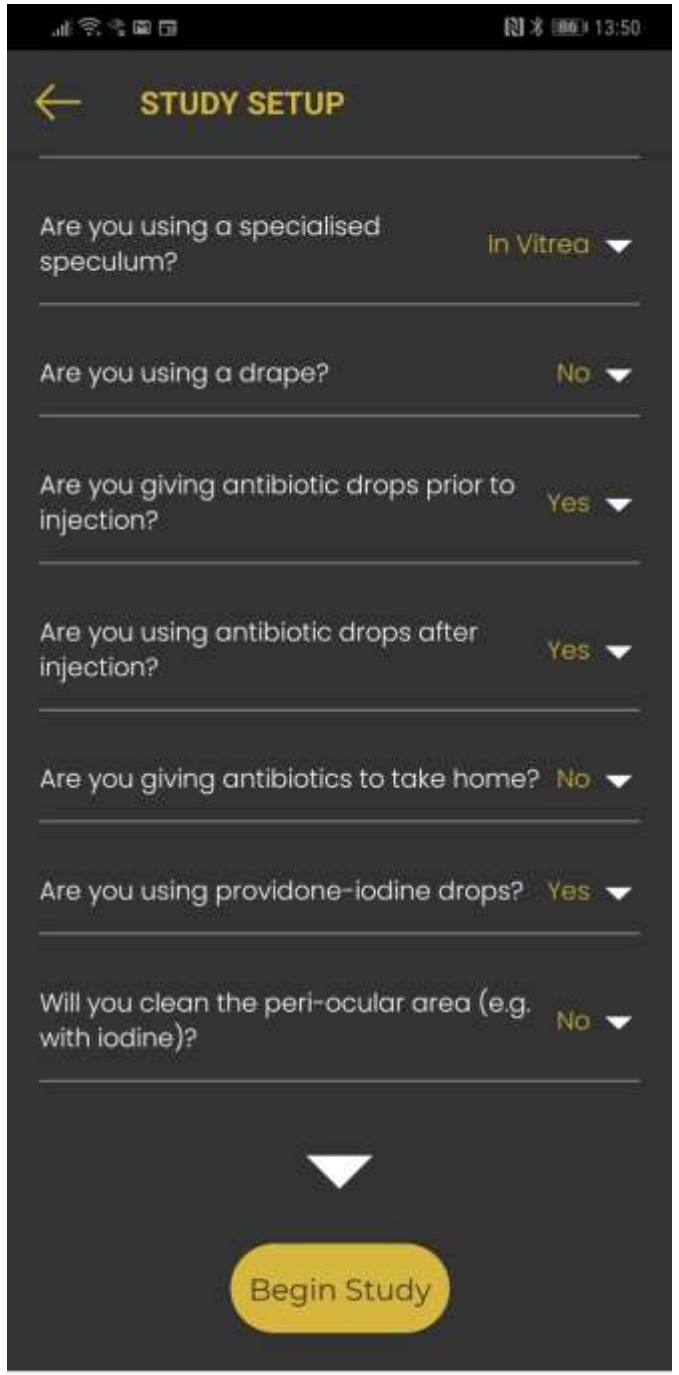


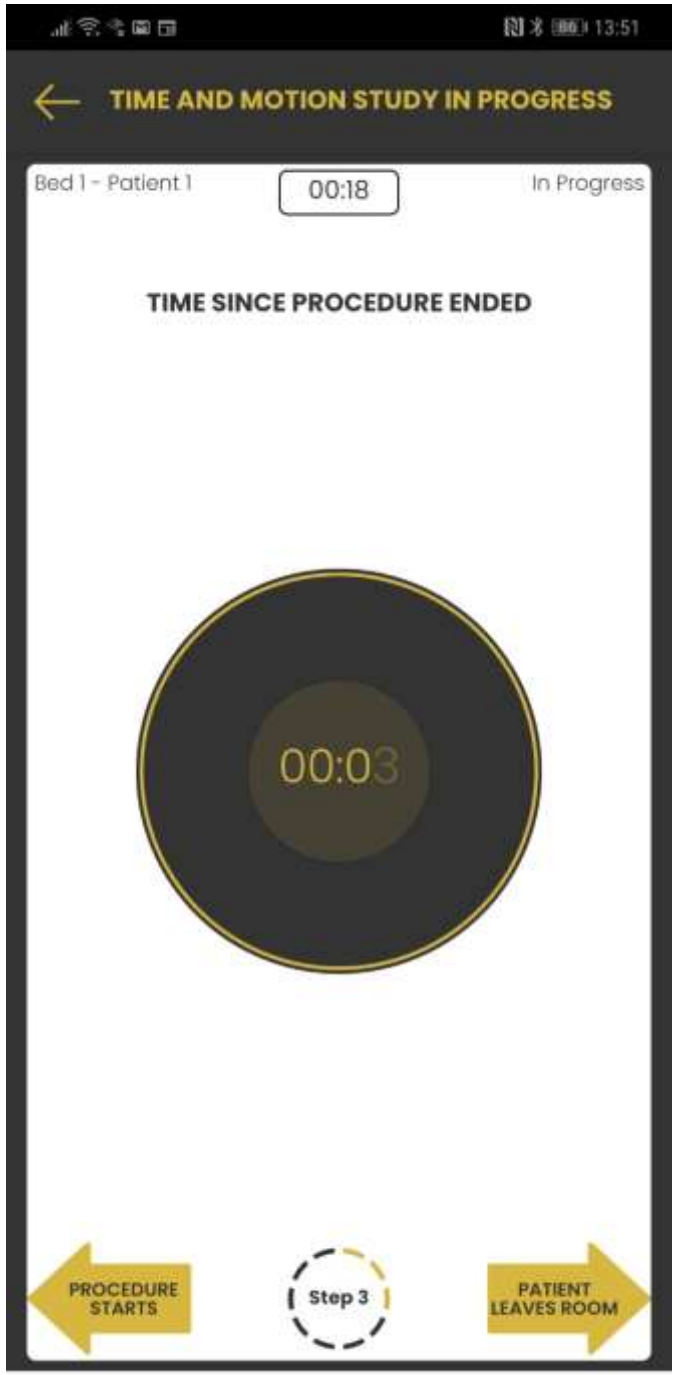

## Operation Types

Your surgery mix compared to the average.

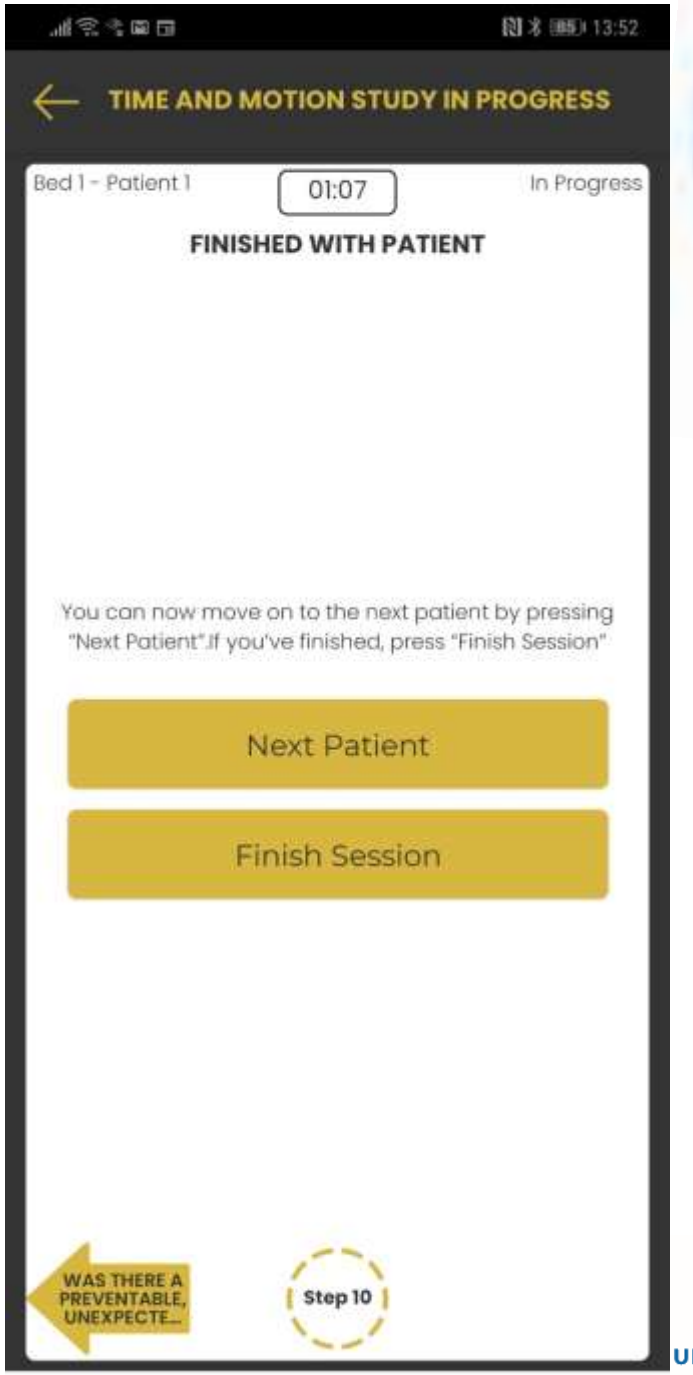






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## List Details

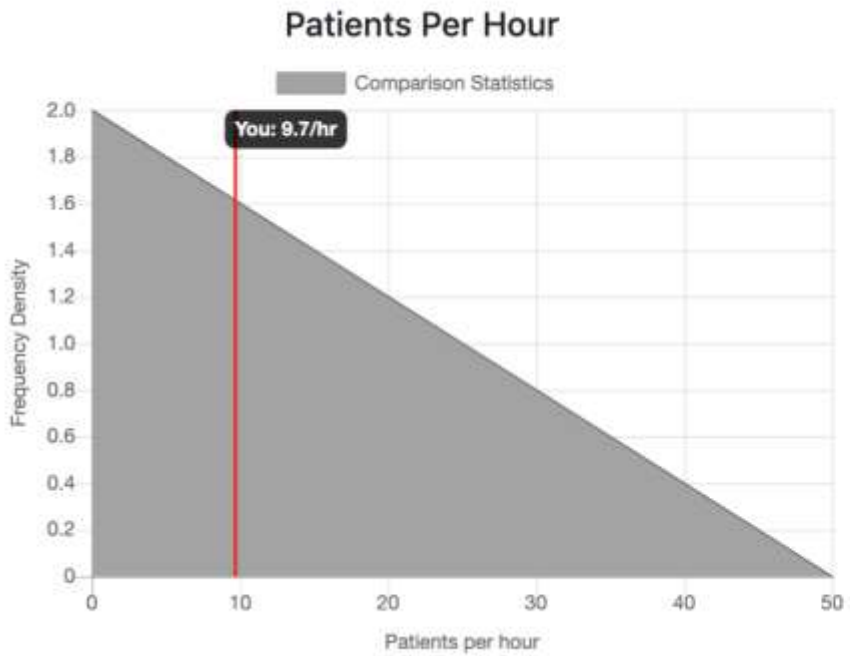
You can filter this section to different injecting staff using the box below.

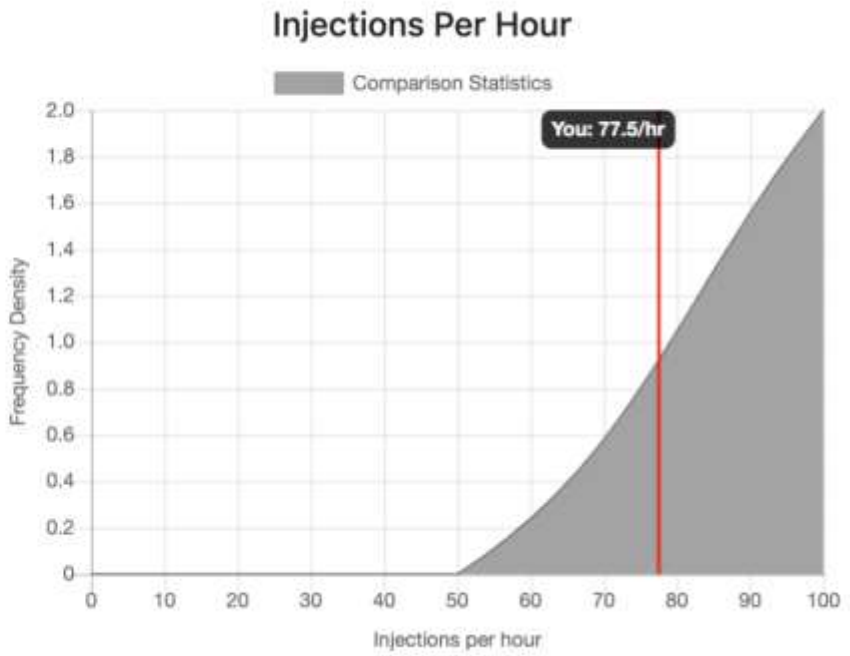
Who is performing the injection?

Trainee Doctor, SAS, Consultant, Nurse Injector, Optometrist, Orthoptist, Other

Update

| | Your Studies | Average | Relative to Average |
|---|---|---|---|
| Patients per list | 6 | 6 | ~0.0 |
| Injections per list | 8 | 8 | ~0.0 |
| Planned list length | 00:03 | 00:03 | ~00:00 |
| Actual list length | 59:00 | 59:00 | ~00:00 |
| Over/underrun | 01:03 | 01:03 | ~00:00 |
| Patients per hour | 9.7 | 9.7 | ~0.0 |
| Injections per hour | 77.5 | 77.5 | ~0.0 |
| Patients needing extra time | 3 (~50%) | 50% | ~0.0% |
| Patients with unexpected delays | 0 (~0%) | 0% | |



# UKOA www.uk-oa.co.uk

- Bringing everyone together – all disciplines, all sectors
- Practical and solution based
- Mutual support and learning
- Input into national programmes and raise national issues effectively
- Please get involved:
  - Use our publications, standards and resources
  - Reply to emails, attend the meetings, engage, feedback on the work
  - Disseminate our work and communications actively, promote and explain the UKOA in your unit
  - Provide key contacts for the key areas of work who will liaise with us or may have time to support the work more actively
  - Lead or participate in the work
    - Share your pathways, documents, good practice, resources
    - Write up your good pathways as “how to” guides with our help
    - Consider hosting a regional session
    - Suggest or present on topics at our meetings or suggest possible areas of work

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GETTING IT RIGHT FIRST TIME

# Getting It Right First Time (GIRFT)

## A national view of Quality Improvement

Alison Davis – co-lead GIRFT Ophthalmology

Carrie MacEwen – co-lead GIRFT Ophthalmology

Lydia Chang – clinical advisor GIRFT Ophthalmology

# Getting It Right First Time

## What is GIRFT?

National Quality Improvement Programme

## Examples of good practice and unwarranted variation

GETTING IT RIGHT FIRST TIME

# How does GIRFT work?

National data pack based on national Hospital Episode Statistics (HES)

Questionnaire sent to each eye unit

Two-hour multidisciplinary deep dive visit

- clinicians, managers, executives, clinical coders

# GIRFT clinical workstream schedule

| Wave | Workstream Start date | Data packs to Trusts | Workstreams | Total |
|---|---|---|---|---|
| 1 | 2012 | Received | Orthopaedics | 1 |
| 2 | Jan-15 | Received | General Surgery, Spinal, Vascular, Cranial Neurosurgery | 5 |
| 3 | Jan-16 | Received | Urology, Cardiothoracic, Paediatric surgery, Opthalmology, ENT, Oral & Maxillofacial, Obstetrics & Gynaecology | 12 |
| 4 | May-17 | Received | Emergency Medicine | 13 |
| 5 | Jul-17 | Received | Hospital Dentistry, Breast Surgery, Diabetes, Endocrinology | 17 |
| 6 | Sep-17 | Received | Radiology, Intensive & Critical, Anaethetics & POM, Cardiology | 21 |
| 7 | Nov-17 | Received | Acute & General Medicine, Renal, Stroke | 24 |
| 8 | Jan-18 | Received | Neurology, Dermatology | 26 |
| 9 | Jan-18 | Apr-19 | Geriatric medicine | 27 |
| 10 | Jan-18 | May-19 | Respiratory | 28 |
| 11 | Mar-18 | May-19 | Rheumatology | 29 |
| 12 | Apr-18 | Jun-19 | Gastroenterology | 30 |
| 13 | May-18 | July-19 | Pathology | 31 |
| 14 | Jul-18 | May-19 | Plastics/Burns | 32 |
| 15 | Jan-19 | TBC | Outpatients, Mental Health (Rehabilitation/CAMHS and Crisis and Acute) | 34 |
| 16 | Jan-19 | Nov-19 | Trauma | 35 |
| 17 | TBC | | Paediatric critical care, Neonatology, Paediatric trauma and elective orthopaedics and Lung Cancer | 39 |

*Please Note that Mental Health is a single workstream but split into multiple areas of focus

GETTING IT RIGHT FIRST TIME

# How does GIRFT work?

Agreed action plan for each unit

Regional GIRFT implementation team

- clinical ambassadors and managers

National report with recommendations

Revisits

GETTING IT RIGHT FIRST TIME

# GIRFT ophthalmology

120 visits

Many examples of exemplary practice

Areas of unwarranted variation

National report with recommendations

GETTING IT RIGHT FIRST TIME

# Key Themes

- Ophthalmology is one of the busiest specialties in the NHS, providing over 7.5 million outpatient appointments a year (representing the highest volume outpatient specialty in England)

- > half a million surgical procedures – including the most common operation offered on the NHS, cataract surgery.

# Key Themes

- 12% increase in demand in the last 5 years
- 20 patients/ month avoidable sight loss
- 2016 Deloitte study calculated that, in total, sight loss in adults costs the UK economy **£28.1 billion a year**

# Key Themes

- Cataract
- Glaucoma
- Medical Retina

# Emergency Care

- 95 (79%) providers have  an emergency care service
- Some restricted number of hours only
- Some in partnership with other local providers
- 26 providers SLA in place with their partners
- Few providers no details of out-of-hours provision

# Workforce

- 98% of providers who answered our questions schedule extra clinics and longer hours outside job plans
- 63% of units in England said they used locums to cover unfilled posts at consultant and specialty doctor level
- Valued MDT working but struggled to find enough time or resource to train willing team members

# Space

- 49 of the 52 lack of space in their department was a limiting factor in the delivery of care
  - innovative approaches e.g. mobile units and opening clinics in community centres and shopping centres

- Virtual clinics and run clinics in evenings or weekends, to make use of the available space as efficiently as possible.

# Data: Use and Quality

- 63% of providers use EPR
  - some of them were very limited in their capabilities to share information with other systems and perform clinical audit.
- EPR systems do not interface with visual field machines, retinal imaging, or main hospital IT system
- NOD submission rates vary between providers
- gaps and inconsistencies when we compared NOD data on case ascertainment to Hospital Episode Statistics (HES).
- Some providers said that to fulfil NOD reporting requirements had to enter data twice

# Litigation

- Clinical negligence claims in ophthalmology as a whole were estimated to cost between £25.3 and £52.1 million per year

- Estimated mean cost of litigation per admission or outpatient procedure was £13.

- Variation £0 to £228

GETTING IT RIGHT FIRST TIME

Through all our efforts, local or national, we will strive to embody the ‘shoulder to shoulder’ ethos which has become GIRFT’s hallmark as we support clinicians nationwide to deliver continuous quality improvement for the benefit of their patients.

UK OPHTHALMOLOGY ALLIANCE

# UKOA future – a regional framework?

Melanie Hingorani
Consultant Ophthalmologist, Moorfields,
Chair UKOA

www.uk-oa.co.uk

**UKOA quarterly meeting 5th June 2019**

# GIRFT Regions

Seven GIRFT Regional Hubs to support Trusts to work with GIRFT clinical leads on implementation plans. The Hubs provide in-depth and on-going support to trusts to interpret their datasets and start improving quality of care for patients and delivering efficiencies, by reducing unwarranted variation.

https://gettingitrightfirsttime.co.uk/regional-hubs-overview-map/

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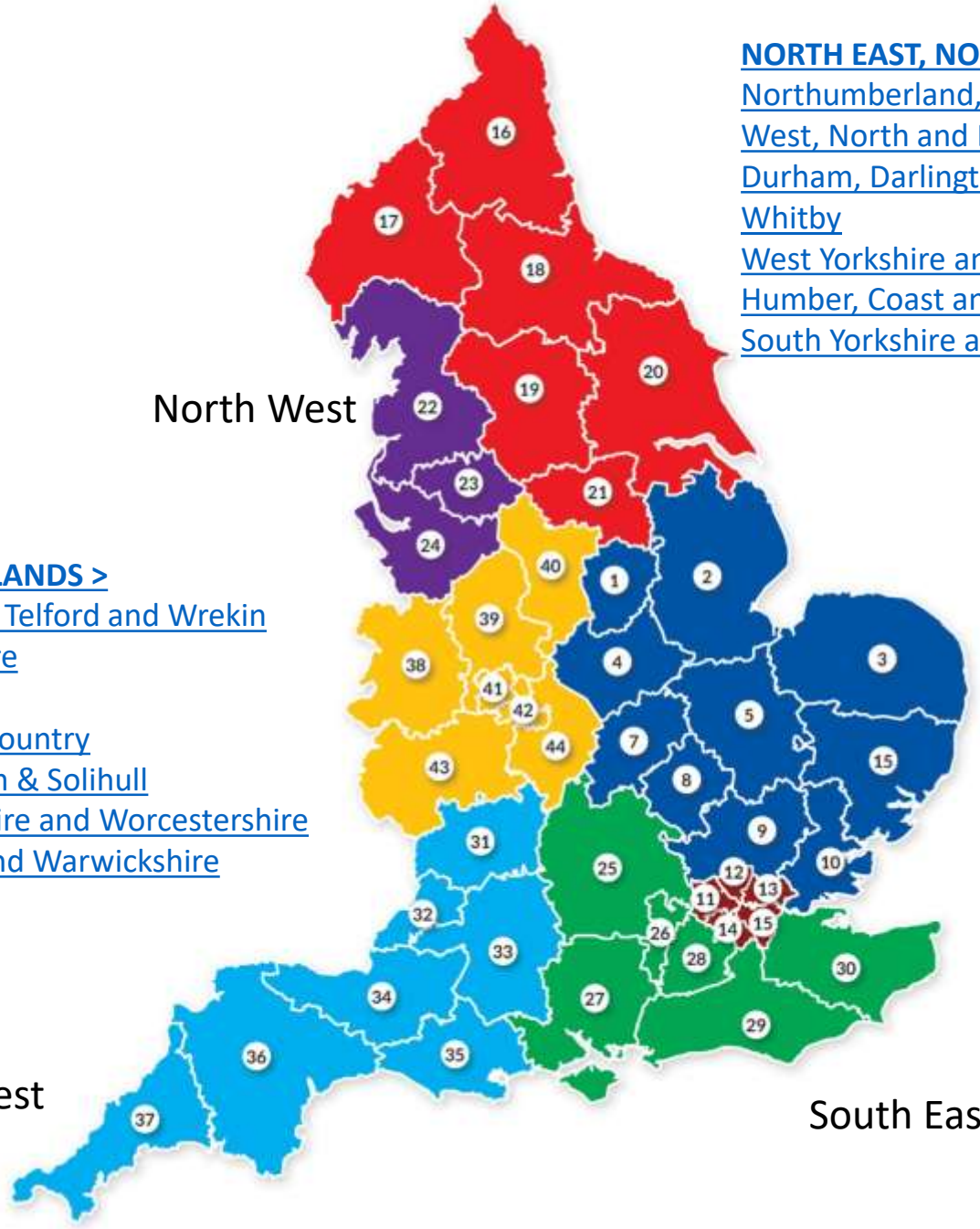
# GIRFT Regions




**NORTH EAST, NORTH CUMBRIA AND YORKSHIRE >**
Northumberland, Tyne and Wear, and North Durham
West, North and East Cumbria
Durham, Darlington, Teesside, Hambleton, Richmond and Whitby
West Yorkshire and Harrogate
Humber, Coast and Vale
South Yorkshire and Bassetlaw

**WEST MIDLANDS >**
Shropshire, Telford and Wrekin
Staffordshire
Derbyshire
The Black Country
Birmingham & Solihull
Herefordshire and Worcestershire
Coventry and Warwickshire

**EAST MIDLANDS AND EAST OF ENGLAND >**
Nottinghamshire
Lincolnshire
Norfolk and Waveney
Leicester, Leicestershire and Rutland
Cambridgeshire and Peterborough
Suffolk and North East Essex
Northamptonshire
Milton Keynes, Bedfordshire and Luton
Hertfordshire and West Essex
Mid and South Essex

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# North East, North Cumbria and Yorkshire

**Joint Hub Director:** Liz Lingard

**Hub Director Email:** liz.lingard@nhs.net

**Joint Hub Director:** Ann Wright

**Hub Director Email:** a.wright18@nhs.net

**Hub Administrator:** Paula Kew

**Hub Administrator Email:** p.kew@nhs.net

**Clinical Ambassadors:** Mark Lansdown, Jean MacLeod & Nick Phillips

**Office Location:** Waterfront 4, Goldcrest Way, Newcastle NE15 8NY

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# North East, North Cumbria and Yorkshire

## SOUTH YORKSHIRE AND BASSETLAW STP

**Clinical Ambassador:** Mark Lansdown
**Implementation Manager:** Jennifer Wilkie and Val Davies
**Email:** jennifer.wilkie@nhs.net, valerie.davies9@nhs.net

Barnsley Hospital NHS Foundation Trust
Doncaster and Bassetlaw Hospitals NHS Foundation Trust
The Rotherham NHS Foundation Trust
Sheffield Teaching Hospitals NHS Foundation Trust

## WEST, NORTH AND EAST CUMBRIA STP

**Clinical Ambassador:** Jean MacLeod
**Implementation Manager:** Terry Phillips
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North Cumbria University Hospitals NHS Trust

## DURHAM, DARLINGTON, TEESSIDE, HAMBLETON, RICHMOND AND WHITBY STP

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County Durham and Darlington NHS Foundation Trust
North Tees and Hartlepool NHS Foundation Trust
South Tees Hospitals NHS Foundation Trust

## HUMBER, COAST AND VALE STP

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Hull and East Yorkshire Hospitals NHS Trust
Northern Lincolnshire and Goole NHS Foundation Trust
York Teaching Hospital NHS Foundation Trust

## NORTHUMBERLAND, TYNE AND WEAR, AND NORTH DURHAM STP

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City Hospitals Sunderland NHS Foundation Trust
Gateshead Health NHS Foundation Trust
The Newcastle Upon Tyne Hospitals NHS Foundation Trust
Northumbria Healthcare NHS
South Tyneside NHS Foundation Trust

## WEST YORKSHIRE AND HARROGATE STP

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**Implementation Manager:** Jacqueline Claydon, Michael Lydon and Val Davies
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Airedale NHS Foundation Trust
Bradford Teaching Hospitals NHS Foundation Trust
Calderdale and Huddersfield NHS Foundation Trust
Harrogate and District NHS Foundation Trust
Leeds Teaching Hospitals NHS Trust
The Mid Yorkshire NHS Trust

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# Regions

NHSI / E regional teams
Right Care teams
Procurement
Regional pharmacy groups
etc

**For discussion:**

- How does this work where you are? STP vs GIRFT region vs other
- Who are the key players?
- Are there reps for ophthalmology?
- How could this fit with the UKOA?

- Procurement will need regional arrangements

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GETTING IT RIGHT FIRST TIME

# Getting It Right First Time (GIRFT)

## A national view of Quality Improvement

Alison Davis – co-lead GIRFT Ophthalmology

Carrie MacEwen – co-lead GIRFT Ophthalmology

Lydia Chang – clinical advisor GIRFT Ophthalmology

# Getting It Right First Time

## What is GIRFT?

National Quality Improvement Programme

## Examples of good practice and unwarranted variation in:

- cataract
- glaucoma
- medical retina

GETTING IT RIGHT FIRST TIME

# Cataract

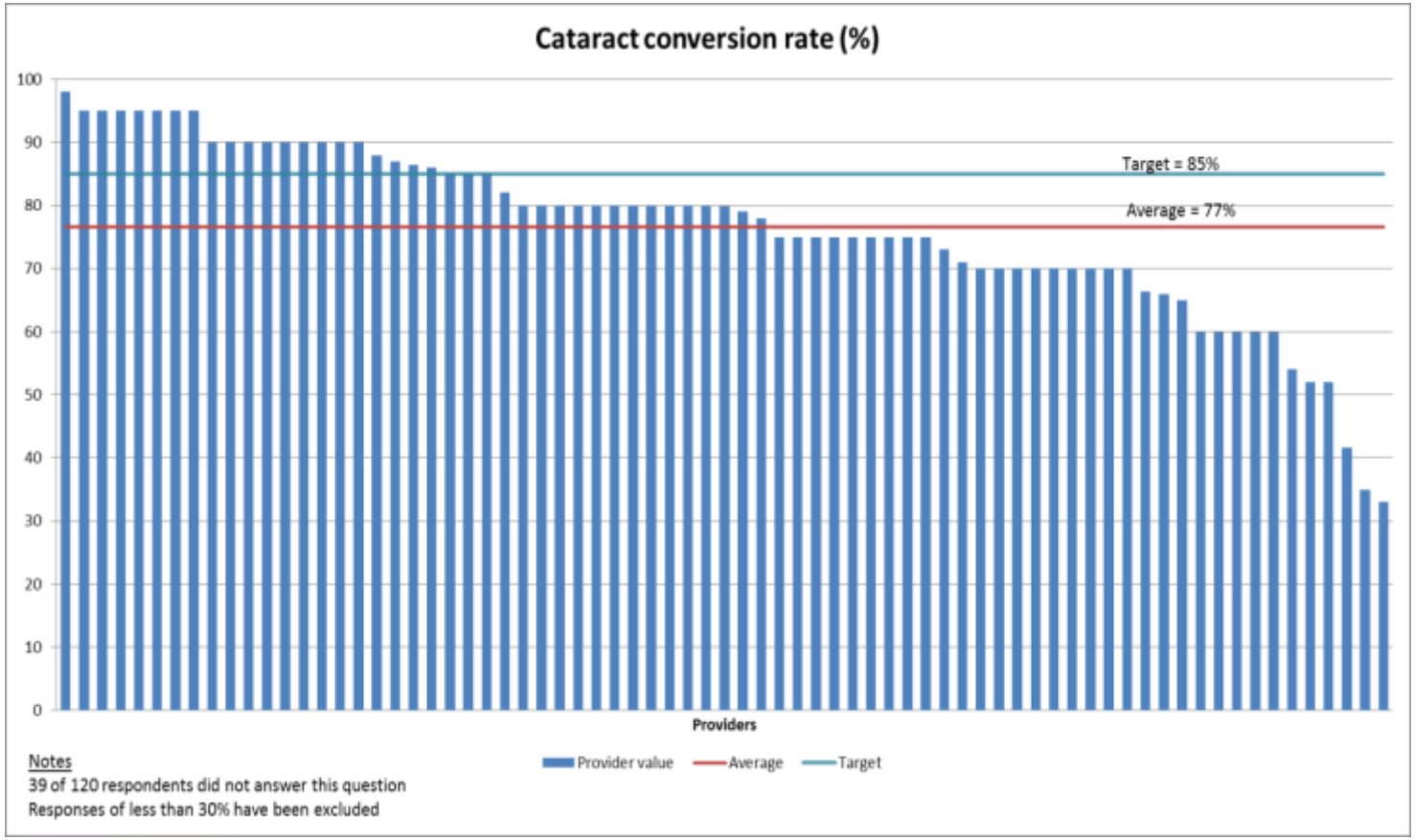
## Referring the right patient?

The proportion of those patients referred to hospital services with cataract, having met referral criteria for surgery, who receive surgery

National average was 77% (first eye data)

# Cataract

## Referring the right patient?




GETTING IT RIGHT FIRST TIME

# Recommendation

- Improve conversion rates for patients referred for cataract surgery to 80-85%
  - Consistent referral criteria
  - Improving training for community optometrists
  - Shared decision-making tools during the referral process
  - Ensure that patients who wish to discuss surgery with an ophthalmologist to make a final decision are able to do so.

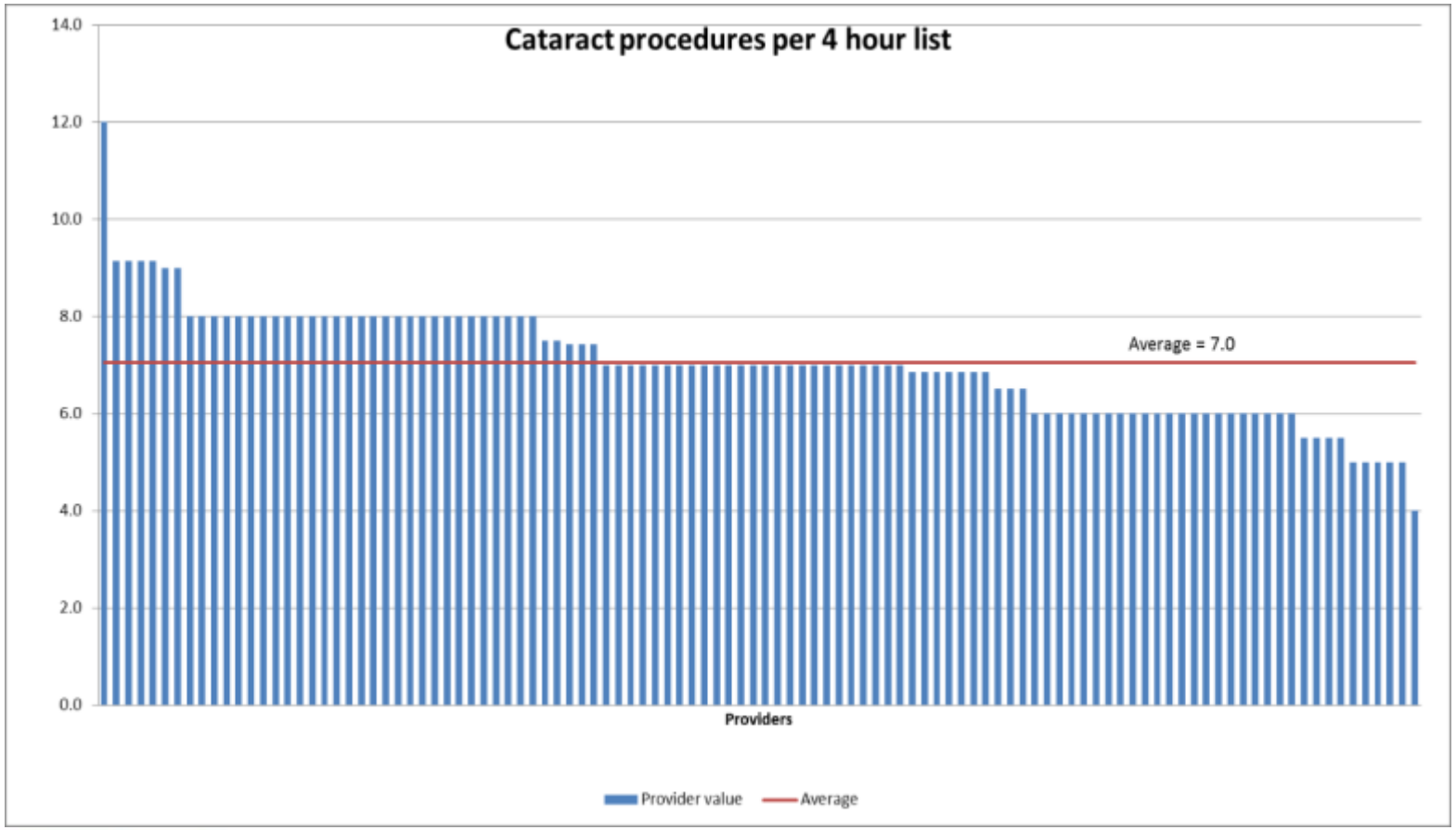
# Cataract

## Cases per list

- Average seven routine cataract procedures on a four-hour surgical list
- Previously recommended best practice of eight per four-hour list
- Some hospitals eight or more procedures
- 22 hospitals complete six
- 10 hospitals complete fewer than six

# Cataract

## Cases per list




GETTING IT RIGHT FIRST TIME

# Recommendation

- Deliver routine cataract surgery in a maximum of 30 minutes of theatre time, through streamlining turnaround processes. This often requires staff to facilitate faster turnaround and does not apply to more complex cases

# Post Operative Review

- 25 providers discharge patients to primary care after cataract surgery
- No clinical issues or concerns
- Additional measures to support discharge
- Ensuring that post-operative visual acuity and refractive data is returned
- Many more providers would like to adopt a similar approach, if it was commissioned in their area

# Recommendation

- Use commissioned primary care optometry services to review patients who have had uncomplicated / routine cataract surgery and have no serious ocular comorbidity

# Glaucoma
## Referral refinement

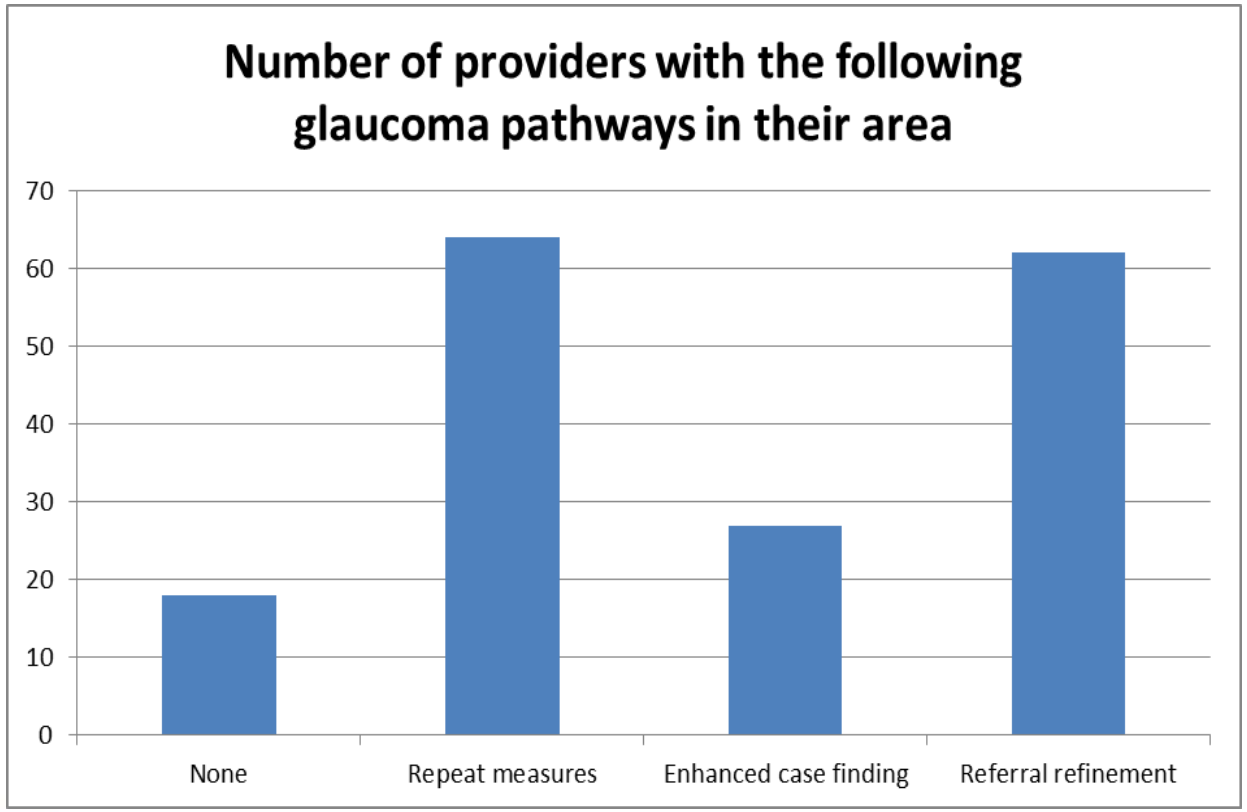
Reduce the number of patients being referred to hospitals with suspected glaucoma

Filtering schemes

- Repeat measures which involves optometrists repeating the intra-ocular pressure (IOP) measurements to determine a reproducible result
- Enhanced case finding - more extensive tests than IOP measurements
- Referral refinement - referring the patient to a second optometrist specifically trained to carry out a more comprehensive set of tests and an evaluation of results

**Referral filtering methods are determined locally**

# Glaucoma
## Referral refinement




GETTING IT RIGHT FIRST TIME

# Recommendation

- Reduce rate of false positive referrals for patients with glaucoma by instituting consistent referral criteria in line with 2017 NICE guideline and referral filtering schemes

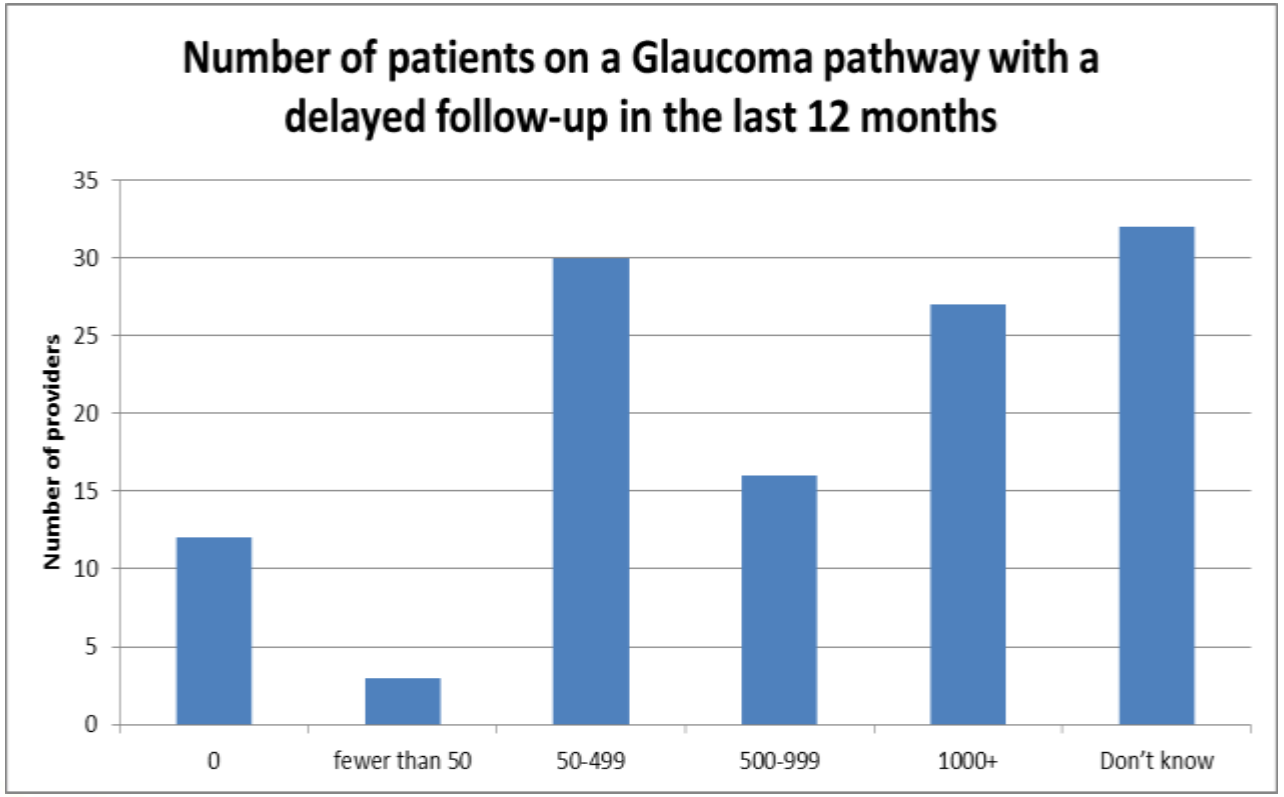
# Glaucoma
# Delayed follow-up

Glaucoma patients are the group at greatest risk of sight loss if follow up is delayed

GIRFT questionnaire asked how many glaucoma patients had experienced a delay in follow-up over the preceding 12 months.

- 7 providers no data
- 101 providers reported some delay
- 12 indicated no delay

# Glaucoma
# Delayed follow-up




GETTING IT RIGHT FIRST TIME

# Recommendation

- Implement the actions of the High Impact Intervention (HII) on failsafe prioritisation for all ophthalmology patients, particularly those with glaucoma and medical retina conditions, and on undertaking a risk audit to identify and discharge those patients that are clinically ready to be discharged

# Medical retina
# Diabetic Maculopathy

Using OCT - the number of referrals for diabetic maculopathy can be reduced by over 50%

GIRFT questionnaire responses

- 45% of providers use OCT to refine referrals for diabetic maculopathy
- 45% of providers stated they do not use OCT
- 10% did not respond

# Recommendation

- Develop a national standardised referral pathway for suspected diabetic maculopathy that includes the use of OCT as a form of referral refinement to reduce unnecessary referrals from screening services

# Medical retina

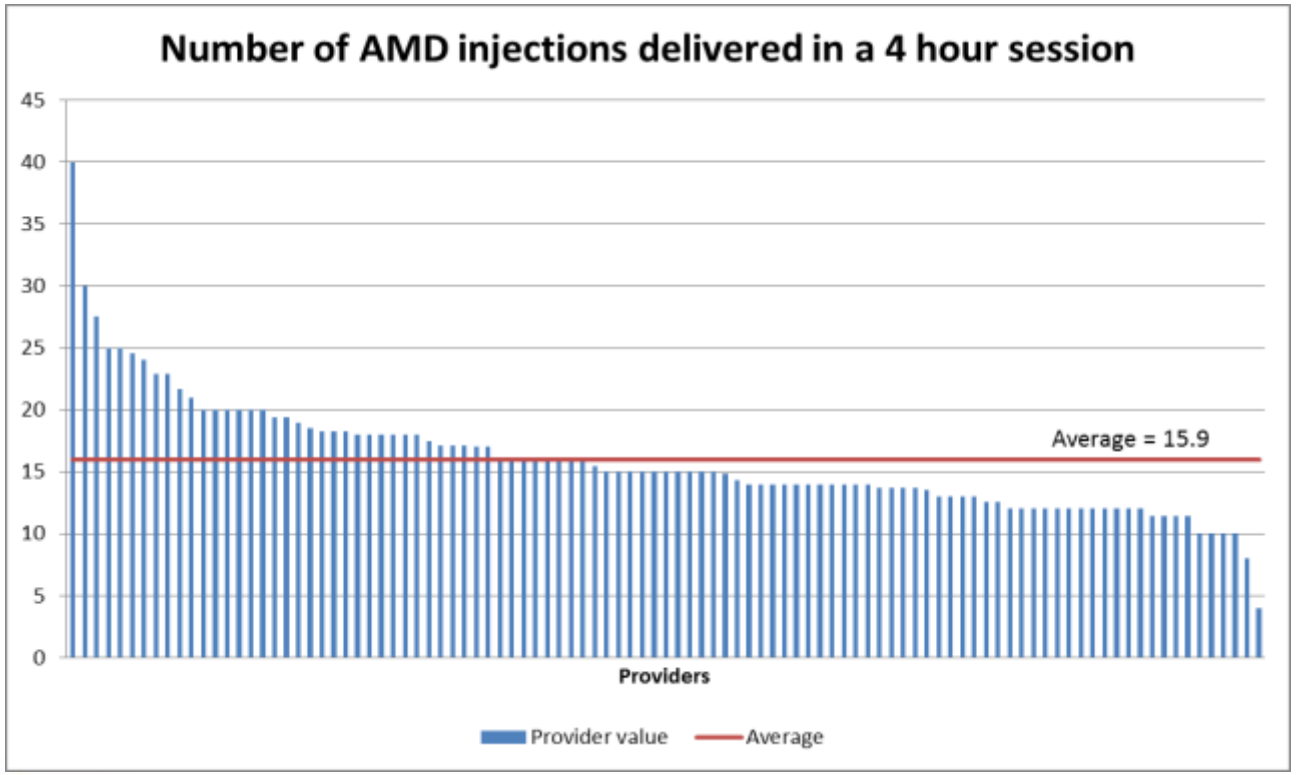
## Age Related Maculopathy (AMD)

Majority of intravitreal injections are performed by nurses or allied health professionals

Some units have set up intravitreal units in community settings

One unit has set up a mobile unit which covers a wide geographical area

# Medical retina
## Age Related Maculopathy (AMD)




GETTING IT RIGHT FIRST TIME

# Recommendation

- Increase the capacity and productivity of wet AMD pathways, through more extensive use of virtual clinics for stable patient monitoring and clean rooms for intravitreal injections, while training more members of the non-medical HCP team to carry out injections

GETTING IT RIGHT FIRST TIME

Through all our efforts, local or national, we will strive to embody the ‘shoulder to shoulder’ ethos which has become GIRFT’s hallmark as we support clinicians nationwide to deliver continuous quality improvement for the benefit of their patients.

# Group Discussion and Feedback

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# Lunch & Networking

12:-30 – 13:00



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# NHS Supply Chain: Orthopaedics, Trauma, Spine and Ophthalmology

**Kath Ibbotson – Tower 4 Director**
**Adele Hancox – Senior Category Manager, Ophthalmology**

# Collaborative Procurement Partnership (CPP)

NHS Supply Chain

## Medical

**Tower 1**
Ward Based Consumables

**Tower 2**
Sterile Intervention Equipment and Associated Consumables

**Tower 3**
Infection Control and Wound Care

**Tower 4**
Orthopaedics, Trauma & Spine, Ophthalmology

**Tower 5**
Rehabilitation, Disability Services, Women's Health and Associated Consumables

**Tower 6**
Cardio-Vascular, Radiology, Audiology and Pain Management

Collaborative Procurement Partnership

# Collaborative Procurement Partnership (CPP)

NHS Supply Chain

**Medical**

| | |
|---|---|
| Tower 1<br>Ward Based Consumables | Tower 4<br>Orthopaedics, Trauma & Spine, Ophthalmology |
| Tower 2<br>Sterile Intervention Equipment and Associated Consumables | Tower 5<br>Rehabilitation, Disability Services, Women's Health and Associated Consumables |
| Tower 3<br>Infection Control and Wound Care | Tower 6<br>Cardio-Vascular, Radiology, Audiology and Pain Management |

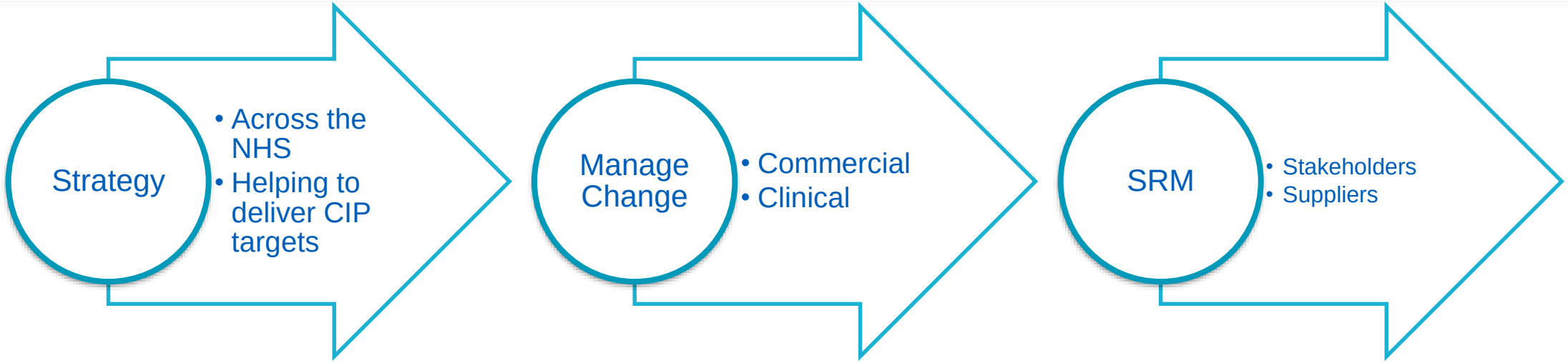
***Award of up to three Towers***

Collaborative Procurement Partnership

| Surrey & Borders | West Suffolk | Guys & St Thomas | Leeds & York |
|---|---|---|---|
| NHS Commercial Solutions | East of England NHS CPH | London Procurement Partnership | North of England CPC |

**NHS Owned Limited Liability Partnership**

# What we do




- Supporting Trust procurement teams on-site
- Providing a proven track record in managing change at a commercial and clinical level
- Focusing on Stakeholder and Supplier Relationship Management and working closely with industry to ensure alignment
- **Developing category strategy across the NHS.**

# Complete Ophthalmic Framework Agreement

## Lots

- Lot 1 Intraocular lenses
- Lot 2 Surgical instruments
  - 2.1 Single use
  - 2.2 Re-usable
- Lot 3 Procedure packs
- Lot 4 Solutions and gases
- Lot 5 General accessories and consumables
- Lot 6 Ophthalmic equipment
  - 6.1 phacoemulsification
  - 6.2 vitreoretinal machines
  - 6.3 ophthalmic microscopes
  - 6.4 diagnostic equipment
  - 6.5 ophthalmic lenses
  - 6.6 additional ophthalmic equipment
- Lot 7 Combination specific lots
- Lot 8 Managed service
- Added value solutions for long term efficiency

# Category Tower Service Provider (CTSP)

4 Workstreams formed part of our Ophthalmology strategy in line with the UKOA work stream,

- IOL's,
- Packs,
- Instruments – Not Yet Started
- Capital Equipment. – on-going, working with DH team re bulk buy deals/aggregation

We were expecting to deliver on the packs / IOL workstream mid-201, however, this hasn't been achieved with the delays that have been experiencing gathering data.

Move all Trusts as is benchmarked data over to the framework by Q2 with the help of SCCL customer engagement team and GIRFT.

We are now looking to deliver the Packs / IOL workstream within the CY2 with the help of Trust engagement.

# Category Tower Service Provider (CTSP)

Following the last UKOA Conference a list of contacts within each UKOA Member Trust was provided to NHS Supply Chain for us to contact them directly to progress the project

All member Trusts were contacted and provided with a template letter to put on their letterheaded paper

Only 18 of the 60 (at the time) members provided us with their authorisation to gather their spend data.

We have had some push back from the Procurement teams that they are not aware of the UKOA or the work that we are doing.

As a result of this we are also looking at engaging with our SCCL Account Managers to provide their procurement contacts with the intention of setting up a sub group of procurement staff to run parallel to the clinical panel to ensure all parties are fully aware of the activities going on with the UKOA group.

# Results of Benchmarking

| Customer | Savings Identified |
|---|---|
| Alder Hey Childrens NHS Foundation Trust | £981.42 |
| Basildon and Thurrock University Hospitals NHS Foundation Trust | £6,147.87 |
| Bolton NHS Foundation Trust | £19,189.00 |
| Cambridge University Hospitals NHS Foundation Trust | £47,641.00 |
| James Paget University Hospitals NHS Foundation Trust | £28,367.00 |
| Mid Essex Hospital Services NHS Trust | £904.32 |
| Moorfields Eye Hospital NHS Foundation Trust | £164,602.00 |
| Norfolk and Norwich University Hospitals NHS Foundation Trust | £10,825.00 |
| Nottingham University Hospitals NHS Trust | £13,380.00 |
| Oxford University Hospitals NHS Foundation Trust | £35,354.00 |
| Royal Cornwall Hospitals NHS Trust | £21,121.00 |
| Salisbury NHS Foundation Trust | £4,321.00 |
| Sandwell and West Birmingham Hospitals NHS Trust | £19,319.00 |
| Southend University Hospital NHS Foundation Trust | £36,367.00 |
| The Newcastle Upon Tyne Hospitals NHS Foundation Trust | £15,917.00 |
| United Lincolnshire Hospitals NHS Trust | £23,223.00 |
| University Hospital Southampton NHS Foundation Trust | £26,961.00 |
| University Hospitals Bristol NHS Foundation Trust | £29,646.00 |
| University Hospitals of Derby and Burton NHS Foundation Trust | £61,327.00 |
| University Hospitals of Leicester NHS Trust | £46,632.00 |
| Total | £612,225.61 |

# Next Steps

**IVT Packs**

Data will be analysed upon receipt in order to understand the level of usage/spend across the Trusts participating in the exercise

Further competition documents will be drafted and will need to be signed off by UKOA. Suggested weightings 40% Price, 60% Quality with the cheapest 3 being taken forward for clinical evaluation
Estimated further competition publication August 2019

Estimated award November 2019

Timeframes subject to change dependant on the engagement from Trusts to commit to Volume

Nicola Atkinson will recommence to IVT workstream when she returns in June.

**Lenses**

Review of the most popular lenses that have been identified across 4 suppliers being supplied to the NHS and do a comparison on cost and volume using PPIB data and NHS Supply Chain transacted Data

# Our 12-18 month workplan

- Category Strategy and Sourcing Strategy in development v2 just starting renewal
- Intraocular lens (IOL) framework ends 31 March 2020.
- Complete Ophthalmology Solutions framework ends 31 March 2021.
- Ophthalmic Capital Equipment framework ends July 2021.
- Tender expected to go out in April 2020.
- We have strict timelines and sign off / Approval requirements governed by the SCCL
- Continue to work with the UKOA on standardisation on IVT packs and IOLs.
- Working with multiple NHS trusts and collaborative groups where aggregation is possible.
- Mick Corti, Procurement Director, Partners Procurement Service (PPS), London, – Trusted Customer contributes a trust perspective to strategies
- UKOA membership is key to our success, clinical input to our strategies and workplan essential to ensure we deliver the right goods and service to the NHS.

# Your asks and ours

- We are an extension of local trust procurement teams
- We have expertise in running multiple successful processes
- We work across all stakeholders and early engagement is key to success
- We require a commitment to follow process
- Allow us to drive through an efficient and effective solution which will benefit the wider NHS, working together
- Work closely with us and the wider NHS Supply Chain to continually develop the strategy and solutions and to work as one, ensure we get the best for NHS patients
- Understand your own organisations' internal barriers to change
- Commit to making a decision
- Help to drive the strategy at a local level
- Avoid isolated solutions in order to allow the national strategies to be a success
- Ensure adequate time – collating data and analysis takes time!

# Thank You

Twitter: @NHSSupplyChain
www.supplychain.nhs.uk

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# GIRFT Clinical Technology Optimisation & Procurement workstream update

UKOA 5th June 2019

# Learning from GIRFT deep-dives

- Procurement data absent from specialty data-packs so deep-dive discussions were a bit like blind leading the blind! So Clinical Leads resorted to questionnaires……
- Established GIRFT CTO&P to work out how to fill the data gap
- PPIB is only national procurement dataset but needed effort to cleanse and place alongside other data such as outcome & HES data for GIRFT Clinical Leads to use in context
- Outcome data does not exist or is not available at national level for many specialties for GIRFT to harvest, but we have continued to clean and categorise PPIB data
- Cleansed data not yet been made available because Towers concerned 'savings opportunities' do not align to their own predictions
- So been running 3 pilots: 2 x ortho (GM & WYAAT) and 1 x cardio (SW) to work out how we can align and enrich the data for trusts, how all trust clinicians can be engaged in the data, how they and their trusts can act upon the data at scale and pace by reducing unwarranted variation across STPs

# Learning from pilots

1. Clinicians don't have ready access to data on safety, outcomes, innovation and value/costs they need to make the best decisions for their patients and the taxpayer – they would welcome such data in one place
2. Clinicians receptive to GIRFT clinically-led discussions on the data and open to ideas about reducing variation – not so receptive if it's a procurement-led discussion
3. Data is incomplete on key dimensions of safety/outcome/innovation/value – but that shouldn't stop us starting discussions now
4. Important not to rush to procurement solutions before engaging all trust clinicians particularly on safety and outcomes and training considerations
5. Whilst clinical aspirations to standardise across STPs are good, reality is we need to engage trust-by-trust on the data first
6. Chasing short-term savings can potentially undermine higher value aggregation opportunities, not least because engagement is on a different dataset

9. Little or no connection between trusts' CIPs and Tower plans and savings methodologies appear to be different

# Consequences: variation

PPIB shows us what is being used, where, and at what cost……


## Early adoption or unnecessary experimentation ?

NHS First generation Bio-resorbable stent volume and price trend

| Providers | Spend | Opportunity (Price) | % Opportunity | % NHSSC | % Spend Top 5 S.. | Suppliers | Brand Count | No. of Products | Quantity |
|---|---|---|---|---|---|---|---|---|---|
| 32 | £1,141K | £21K | 1.6% | 19.9% | 100.0% | 1 | 1 | 73 | 1,772 |

Price Trend with Price Range by PO


This chart shows the profile of the uptake and then removal from the market of a first generation Bio-resorbable Cardiac Stent.

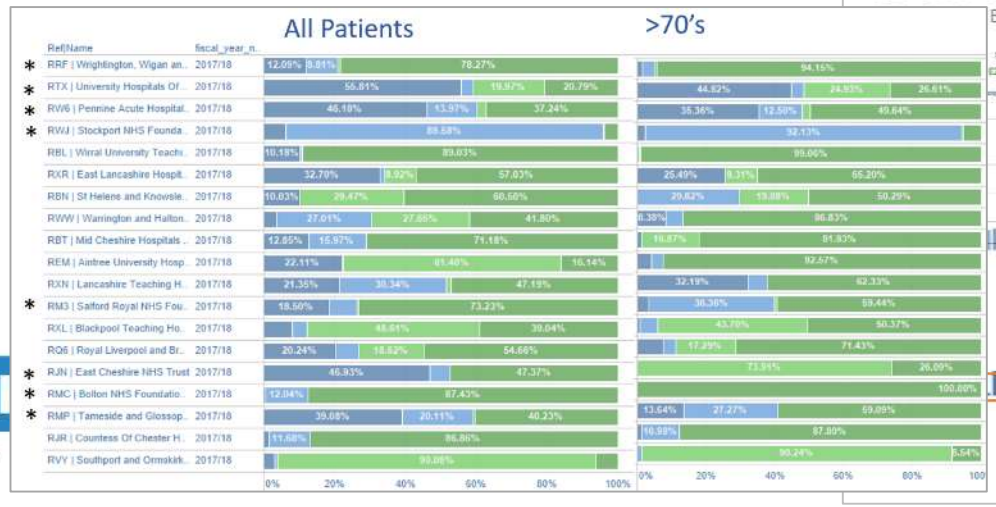
32 providers Spent over £1.1M treating around 900 patients with a device which was double the price of the established, proven stents, and even after warning signs were published by the US FDA they continued in usage into late 2017. The scenario is described below;

*'The Absorb stent was originally hailed as a major advance forward in coronary stent technology when it received regulatory approval for commercial sales in Europe in 2011 and the United States in July 2016. However, as use of the stent expanded and new trial data revealed, it was found the scaffold has several limitations compared to metallic stents. These include delivery issues due to the thicker struts, stent recoil, the limited ability to over-expand without breaking struts, the need for very precise sizing, and poor outcomes if the Absorb is used in coronary vessels 2.5 mm or smaller. Perhaps the biggest barrier to wider adoption was the much higher price tag for Absorb over traditional metallic' DES. Sept 2017*

https://www.dicardiology.com/article/abbott-will-end-sales-absorb-bioresorbable-stent



## Evidence & Diffusion of Innovation ?



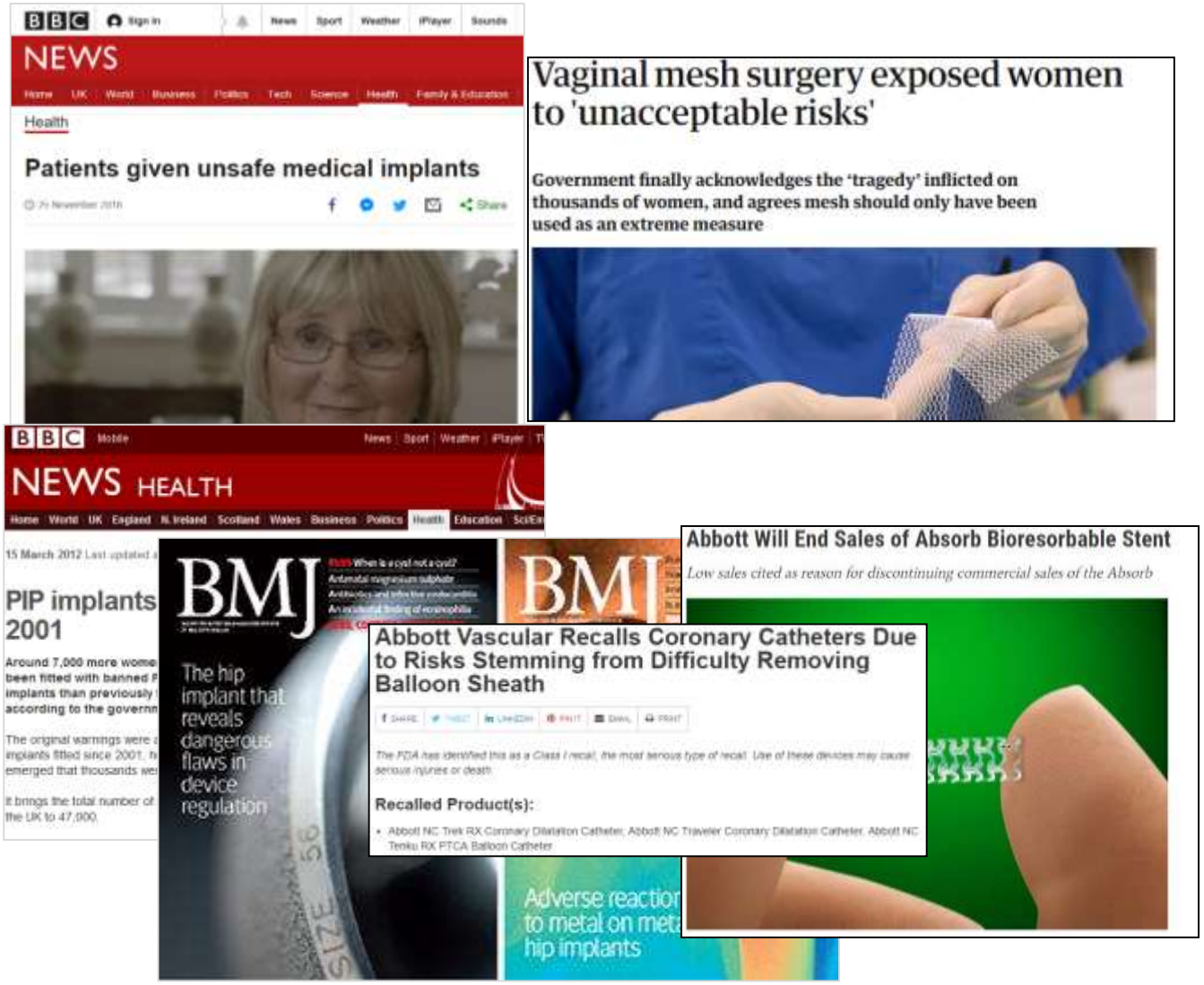

Balloon Catheters: Price and Volume Range by Trust


Across every specialty new technologies and devices are being released into the NHS constantly. CE Mark, assures product safety not not efficacy and enables product to gain early market access, often without evidence.

Examples exist in every specialty but in cardiology specifically the example of Drug Eluting Balloon catheters ( an alterative to drug eluting stents) further fragments the supply chain, creates inflationary cost pressures without proof of efficacy against Drug Eluting Stents.

The highlighted sections show both very low volume usage (often 10-20 per year) with no known structured contribution to evidence. It also shows sporadic 'pathfinder' trust, who without any evidence base are using the new devices at scale significantly replacing stented angioplasty.

# Consequences: safety




Alongside the growing number of product and brands, across Medical devices, there has a been a growth in safety notices and recalls. The public profile of these recalls has been steadily growing as the number of patient effected increases.

In response there has been an increase in calls for transparency* and clinically led evidence base evaluation of current and new devices.

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* https://www.sciencedirect.com/science/article/pii/S0140673618312704
https://www.tctmd.com/news/high-risk-medical-device-approval-process-europe-inches-towards-transparency

# What did the GIRFT Clinical Team find?

- A very confused picture
- Variability in procurement
  - Equipment bought with and without service contracts
  - Phaco machines bought with and with out lens or disposable deals
- Variability in price for everything


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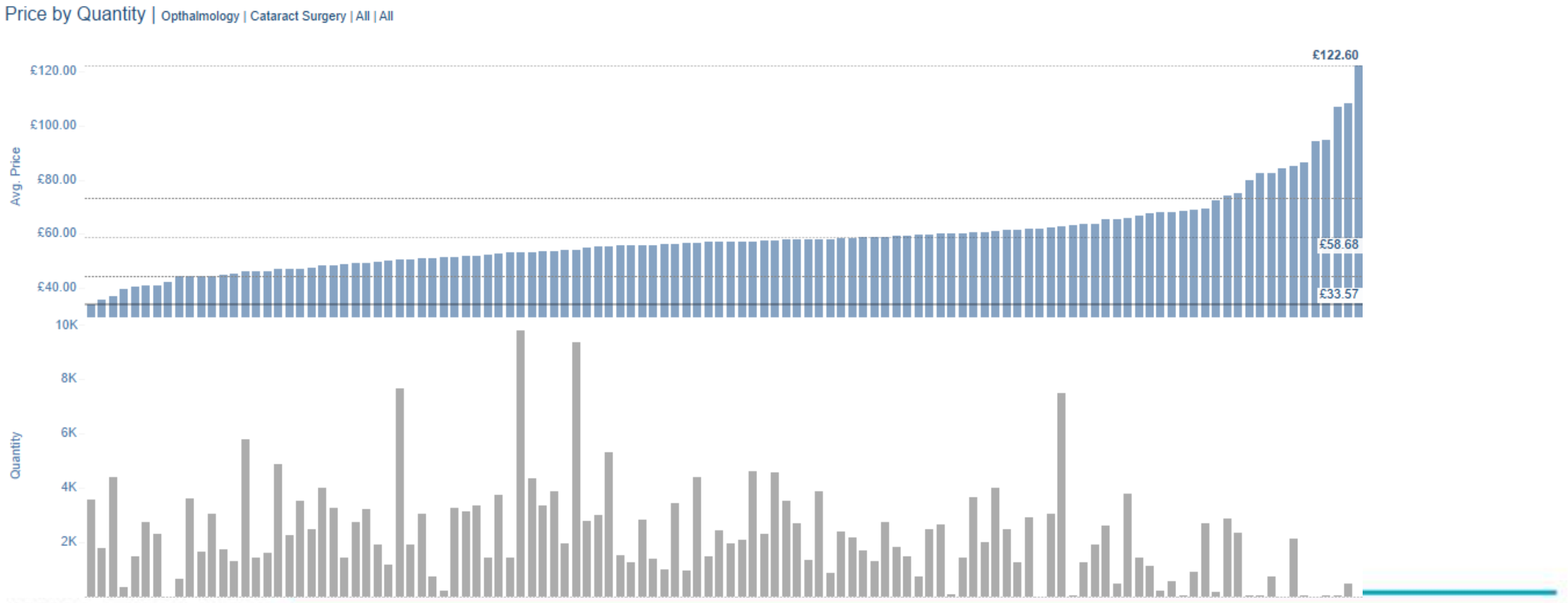
# Example: IOLs

PPIB reveals significant variation in brands and prices IOLs. NHS spent c£18m in 2017-18 covering full range of aspheric, toric, accommodating, multifocal, mono-vision, and pre-loaded. c45 different brands were bought from 16 companies with some trusts using as many as 12 brands! This level of fragmentation leads to higher prices and more costly supply chains as inventories must be held for the brands (caveat linked deals)



# Why does this matter?

## GIRFT Clinical Team are asking questions:

- Does this impact on patient safety?
- Does this impact on patient outcomes?
- We need better data to find out e.g. NOD

- Even allowing for the caveats such as underlying linked deals to equipment, this suggests there is an opportunity to save up to £1.5m on the £14.5m (6.9%)
- Does not even consider the efficiencies that could be gained by rationalising the number of products and brands used across the NHS
- Currently only around 30% of lenses are contracted through NHS Supply Chain

What can we do?

- Take an interest as a clinician and plan a change
- What data could we collect to look at patient safety and/ or outcomes?
- How could this support a cost improvement plan?
- Work with GIRFT and UKOA

# Emerging recommendations: General

- Create a **single national dataset** for medical devices, evaluation, surveillance and cost, with clear and transparent links to clinical outcome registries.
- Systematic reviews of data by national **CTAPs**, to root out safety concerns, encourage greater focus on what works well, speed up and manage the adoption of new technologies, and highlight value opportunities.
- Trusts should undertake **regular surveillance of medical devices used by their trusts**, reviewing them for safety, outcomes, innovation and value.
- Trusts and STPs, supported by GIRFT and Category Towers, to undertake **annual reviews of value of medical devices and establish opportunities for improvement**, embedding them into their annual trust Cost Improvement Plans
- STP clinical specialty groups to assess trust-level CIPs and **explore opportunities to aggregate spend** – working with local procurement and category towers to develop annual STP-level Clinical Technology Optimisation Plans

# Emerging recommendations: Ophthalmology

Improve procurement through cost and pricing transparency, aggregation and consolidation, and the spreading of best practice:

1. work closely with sources of data such as PPIB and relevant clinical data to identify value for money procurement choices, considering safety, outcomes and cost/price
2. identify short and long-term opportunities for improved value for money, including the development of benchmarks and specifications, and locate sources of best practice and procurement excellence, identifying factors that lead to the most favourable terms
3. Trusts and STPs to work with GIRFT and the new Category Towers, to benchmark and evaluate their products and seek to rationalise and aggregate demand with other trusts to secure lower prices and supply chain costs
4. GIRFT, UKOA and Category Towers to develop standard specifications for procedure packs to enable cost comparison, building on the work already commenced by UKOA
5. GIRFT to work with the Royal College of Ophthalmology and the UKOA to develop and collect outcome measures to better inform procurement of intraocular lenses

# National Clinical Technology Advisory Panels (NCTAPs)

*Improved structured clinical review of evidence and variation, to improve safety, outcomes, Innovation and Value.*

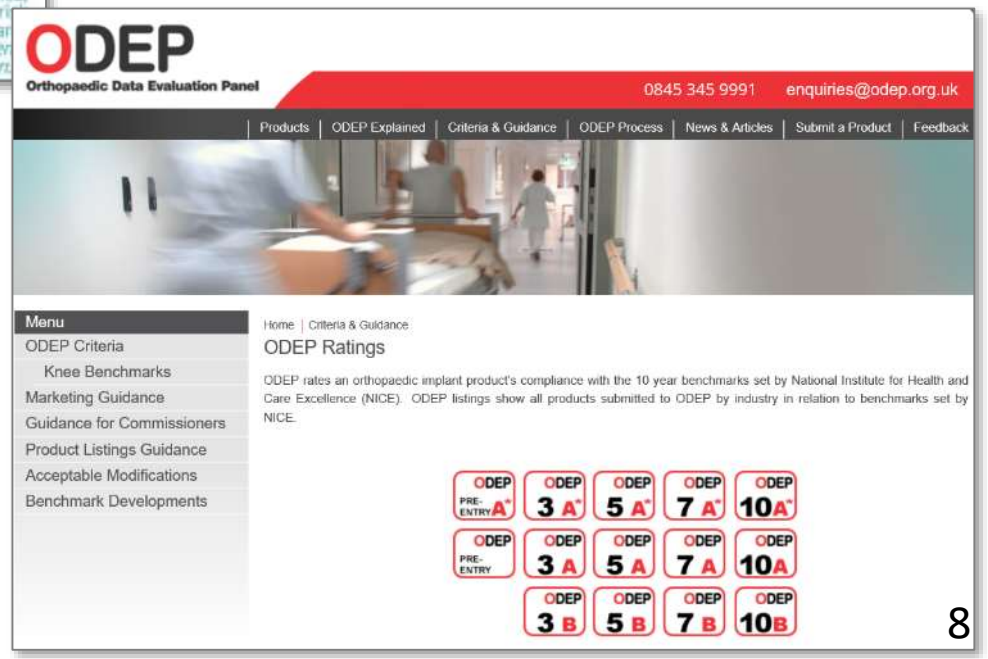
| | |
|---|---|
| **Safety** (based on ODEP methodology)<br>▪ Quarterly Clinical Technology Evaluation Panel (CTEP) rating meeting<br>▪ Monthly Webinar review of Progress with Clinical Advisors<br>▪ Collection of evidence and registry submissions from Companies<br>▪ Collection of device product data and development/validation of segmentation classifications | **Innovation** (based on Beyond Comp methodology)<br>▪ Prioritization of new device / technology submissions<br>▪ Evaluation of new device / technology evidence and potential impact<br>▪ Work alongside HCTED DWG's but focus on non-HCTED devices<br>▪ Company meeting and review<br>▪ Canvas wider clinical expert feedback<br>▪ Published GIRFT NCTAP review to companies and NHS Trusts. |
| **Outcomes**<br>▪ Work to improve collection and specifications of device level outcome registry data<br>▪ Registry analysis, interpretation, implementation team action plans and Trust feedback.<br>▪ Evaluate compliance, publish and report findings.<br>▪ Development of Best Practice tariffs to stimulate compliance | **Value** (based on working with SCCL and Towers)<br>▪ Review PPIB device variety and price variability analysis<br>▪ Validate PPIB data classification of brand and device groupings<br>▪ Evaluate Category Tower opportunity assessments<br>▪ Publish recommendations for improved value and savings<br>▪ Review trust 5 year plans for improved supply chain aggregation and integration |

# We already have a successful model to build on…


www.beyondcompliance.org.uk

*"The CE mark is compliance, Beyond Compliance takes risk analysis and vigilance forward. It is about protecting patients whilst supporting innovation"*

www.odep.org.uk




***"What it means for surgeons***

*It should be remembered that at present that if you are not using a 10A prostheses the prostheses is deemed as being part of an ongoing clinical trial (NICE2002). This is a bit far-fetched and anyhow ODEP is a service evaluation and not a trial but the point must be made that the performance of an implant where there is less than 10 years data must be tracked. YOU HAVE A RESPONSIBILITY TO FACILITATE DATA COLLECTION Thus if a product you are using does not carry a 10A* rating the manufacturer will be tracking it through a registry (NJR) and maybe through an in house trial.*

*If you are using a product that is not registered with ODEP at all or has only Pre-entry status it will not be a positive count on your own ODEP rating. You will remember that your percentage use of ODEP rated products counts on your annual (personal) NJR profile. This is part of the GIRFT project"*

# Prioritisation

Specialty Workstreams have been categorised into 3 distinct categories:

## 1. High-impact workstreams

Where trusts spend considerable sums on medical devices that have a significant impact on safety, outcomes and value for money, and where there are active GIRFT Clinical Leads prepared to set up NCTAPs address variation

**Wave 1:**

- NCTAPs are being established
- Trust/STP level datasets will be available through BIMs
- IMs will be trained to influence clinicians and coordinate local implementation
- Intensive hands-on support from National CTOP team)
- Light-touch support from Clinical Leads and Ambassadors

## 2. Medium-impact workstreams

Where trusts still spend considerable sums on devices, but the impact is less than for those in Category 1 above but variation still needs to be addressed

**Wave 2:**

- Category Towers will manage data but through NHSI/Digital
- Trust/STP level datasets will be available through BIMs
- Building on learning from Wave 1 Cllinical Leads and IMs will work directly with Category Towers on analysis and implementation
- Light-touch support from National CTOP team)

## 3. Low-impact streams

Where spend on devices is low and impact is equally low

- Category Towers will take full responsibility working directly with Clinical Leads
- GIRFT IMs will provide support as required

# Categorisation for NCTAPs

| Category | Specialty workstream |
|---|---|
| Category 1 | • Orthopaedic Surgery<br>• Orthopaedic Trauma Surgery<br>• Orthopaedics Spinal<br>• Cranial Neurosurgery<br>• Neurology<br>• Cardiology<br>• Vascular Surgery<br>• Vascular Interventional Radiology<br>• Breast Surgery |
| Category 2 | • ENT Surgery<br>• General Surgery<br>• Obstetrics & Gynaecology<br>• Cardiothoracic Surgery<br>• Ophthalmology<br>• Paediatric Surgery<br>• Urology surgery<br>• Plastic Surgery and Burns<br>• Gastroenterology<br>• Diabetes<br>• Renal Medicine<br>• Respiratory |
| Category 3 | • Oral & Maxillofacial<br>• Acute & General Medicine<br>• Anaesthesia & Perioperative Medicine<br>• Dermatology<br>• Emergency Medicine<br>• Endocrinology<br>• Geriatric Medicine<br>• Hospital Dentistry<br>• Mental Health<br>• Neonatology<br>• Paediatric Critical Care<br>• Rheumatology<br>• Stroke |

- NCTAPs will be established for Category 1 specialties in this calendar year
- Intend to follow a more light-touch approach for category 2 specialties
- We don't anticipate setting up anything for Category 3 specialties, but we do expect GIRFT Clinical Leads to work with Category Towers on reducing variation

# So what happens next?

## From a GIRFT perspective:

- Complete the dataset
- Set up Ophthalmology CTAP to review data for safety, outcomes, innovation and value – and start filling the data gap
- Publish GIRFT National Ophthalmology Report (due end of this month)
- Issue data-packs via GIRFT implementation network – with supporting insight from CTAP

## From a UKOA perspective

- We can help to pull a UKOA-wide dataset together so you can see the variation and think about what you want to do to reduce it
- Once you are clear what you want to do, the Category Tower should be engaged to deliver your expectations
- UKOA has already begun to set out these expectations e.g. procedure packs, but you need a clear plan from the Tower so you can track delivery
- At all times we think this should be clinically-led rather than procurement-led

# David Haider Ophthalmic Device Video

https://youtu.be/ahcaxjD7fUc

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# Miranda Middleton-Howard

Newcastle NHS Trust

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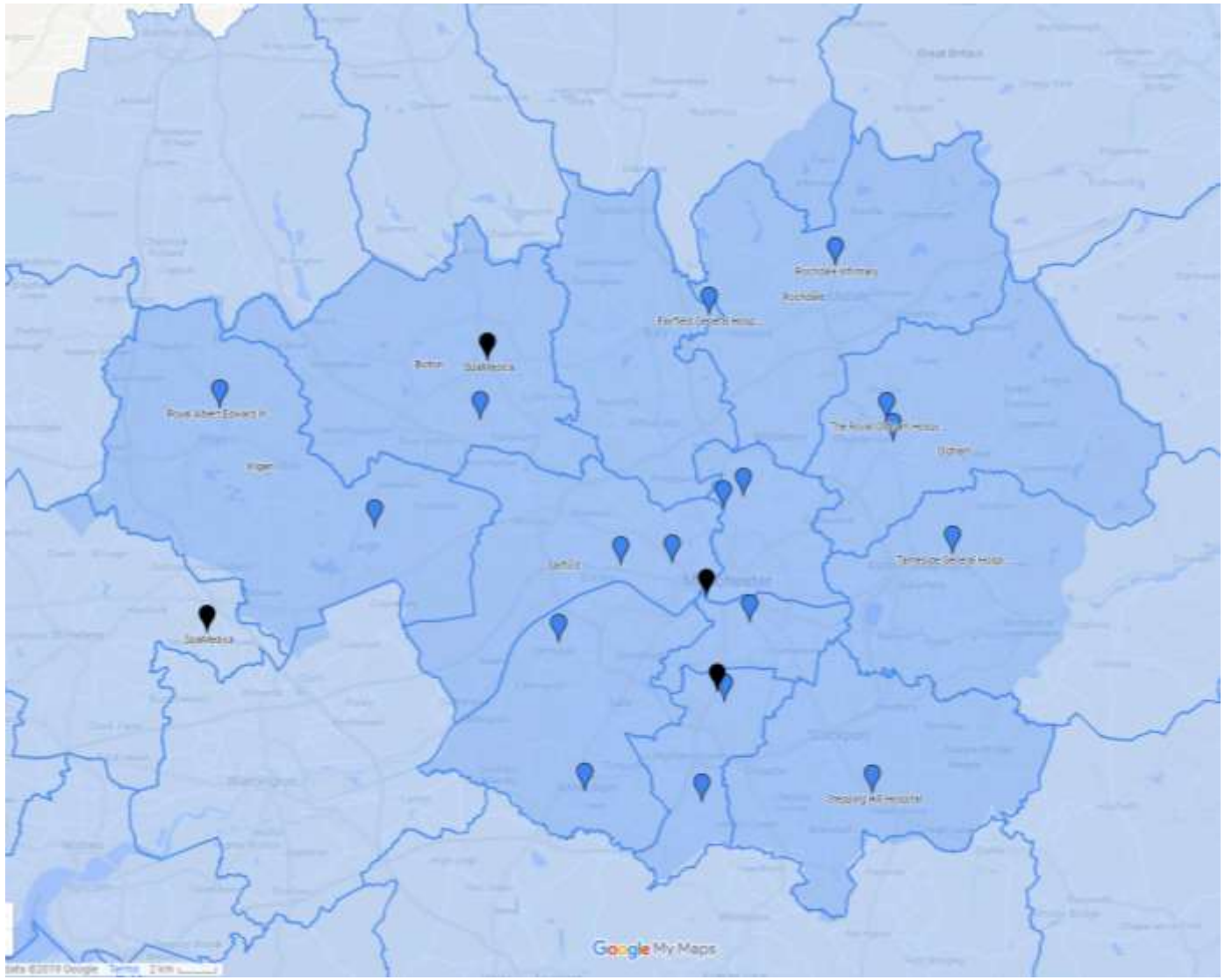
# Greater Manchester's Ophthalmology EPR Project

Glyn Wood
Strategy Manager, Manchester Royal Eye Hospita

**UKOA Quarterly Meeting June 2019**

# Providers in Greater Manchester




| Provider | Market Share | |
|---|---|---|
| Manchester | 34% | 34% |
| Pennine Care | 22% | 56% |
| Bolton | 12% | 68% |
| Wigan | 7% | 75% |
| Stockport | 6% | 80% |
| SpaMedica | 6% | 86% |
| East Cheshire | 5% | 91% |
| Optegra | 3% | 94% |
| CareUK | 2% | 96% |
| Tameside & Glossop | 1% | 97% |

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# Starting Point

| Provider | Market Share | | Current EPR Journey |
|---|---|---|---|
| Manchester | 34% | 34% | No acute EPR (in procurement)<br>Medisoft used in main cataract and macular units |
| Pennine Care | 22% | 56% | Various acute EPR solutions (scanning, forms, system)<br>Medisoft licence but not used |
| Bolton | 12% | 68% | All Scripts EPR<br>OpenEyes EPR |
| Wigan | 7% | 75% | No acute EPR<br>No ophthalmic EPR |
| Stockport | 6% | 80% | No acute EPR<br>Medisoft licence but not used |

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# Guidance

- Royal College Guidelines

Electronic Medical Records – Standards for UK Ophthalmology Services

The Royal College of Ophthalmologists champions excellence in eye care. In order to provide the best care for patients, and to generate improvements in care, it is important to be able to measure the quality of clinical and supporting services provided and ensure minimum quality standards are met. Electronic Medical records (EMRs)[1] are increasingly helping clinical teams to not only record clinical care in a legible and standardised manner but also to measure the quality of the services they provide (e.g. through more automated clinical audit) but their use is not without well documented risks.[1]

This document, based on published evidence and consensus expert opinion, is designed to indicate how EMRs can be expected to best support the aims of the Royal College and its members in providing high quality ophthalmic care. They are standards which specifically address, or are considered particularly pertinent to, ophthalmic care and do not attempt to cover generic ground which has been comprehensively described or laid out in separate standards elsewhere. [2] Instead they aim to focus on a small number of key areas. It is not expected that most EMR vendors will comply with all the standards but the minimum standards are indicated by a "must".

We welcome feedback on the standards and how they might be improved and updated going forward.

Please send feedback on the standards and how you have used it to Beth Barnes, Head of Professional Support beth.barnes@rcophth.ac.uk.

- GIRFT

GETTING IT RIGHT FIRST TIME

National Ophthalmic Database (NOD)
British and Eire Association of Vitreoretinal Surgeons (BEAVRS)
GM level HII

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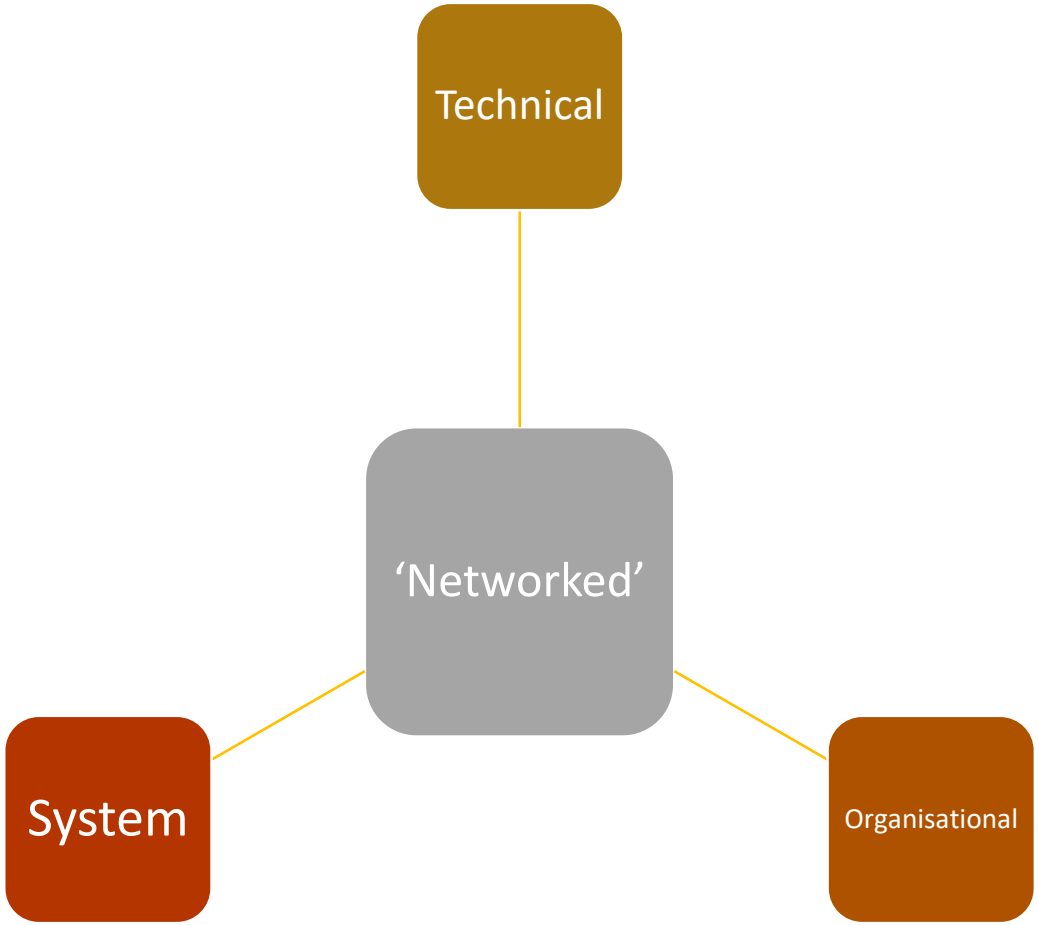
# ‘Networked’




**Organisational**
The EPR must allow minimal levels of information between providers:

- Primary (optometric) to secondary
- Primary (orthoptic) to secondary
- Secondary to secondary
- Secondary to tertiary

**System**
The EPR must have connectivity to other software packages:

- Order comms
- Scheduling systems
- Patient administration systems (PAS)

**Technical**
The EPR must connect:

- Relevant computers, mobile devices
- On site and off site, NHS and non-NHS, home
- Ophthalmic imaging devices (nod to ODMS)
- Biometry machines

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# The Master Plan

**Our Digital Vision**

**It is the vision of GMOC to integrate care records between the top 5 ophthalmology providers across Greater Manchester to provide a key strategic enabler to shared care protocols, MDT working across organisational boundaries and pathway integration. In so doing, each Trust will improve its ability to meet the substantial demographic challenges facing modern ophthalmology services.**

**Our Digital Strategy**

It is therefore a strategy of GMOC to procure a fit for purpose electronic patient record that can:

- make detailed recordings required for ophthalmology services in a standardised way and using standardised workflow
- ensure parity of access to patient records, regardless of provider, so each can review entries made in the ophthalmology care record

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# The Master Plan

- Single EPR

- Pros
  - Likely significantly reduced costs (capital and revenue)
  - 80% of ‘organisational network’ has **full** information sharing

- Cons
  - Agreements needed on the single solution
  - Complex project planning to deploy

- Multiple EPR Estate

- Pros
  - Potentially quicker deployment that then integrates

- Cons
  - Depth of record sharing is poor – current vendors export summaries
  - Likely more expensive

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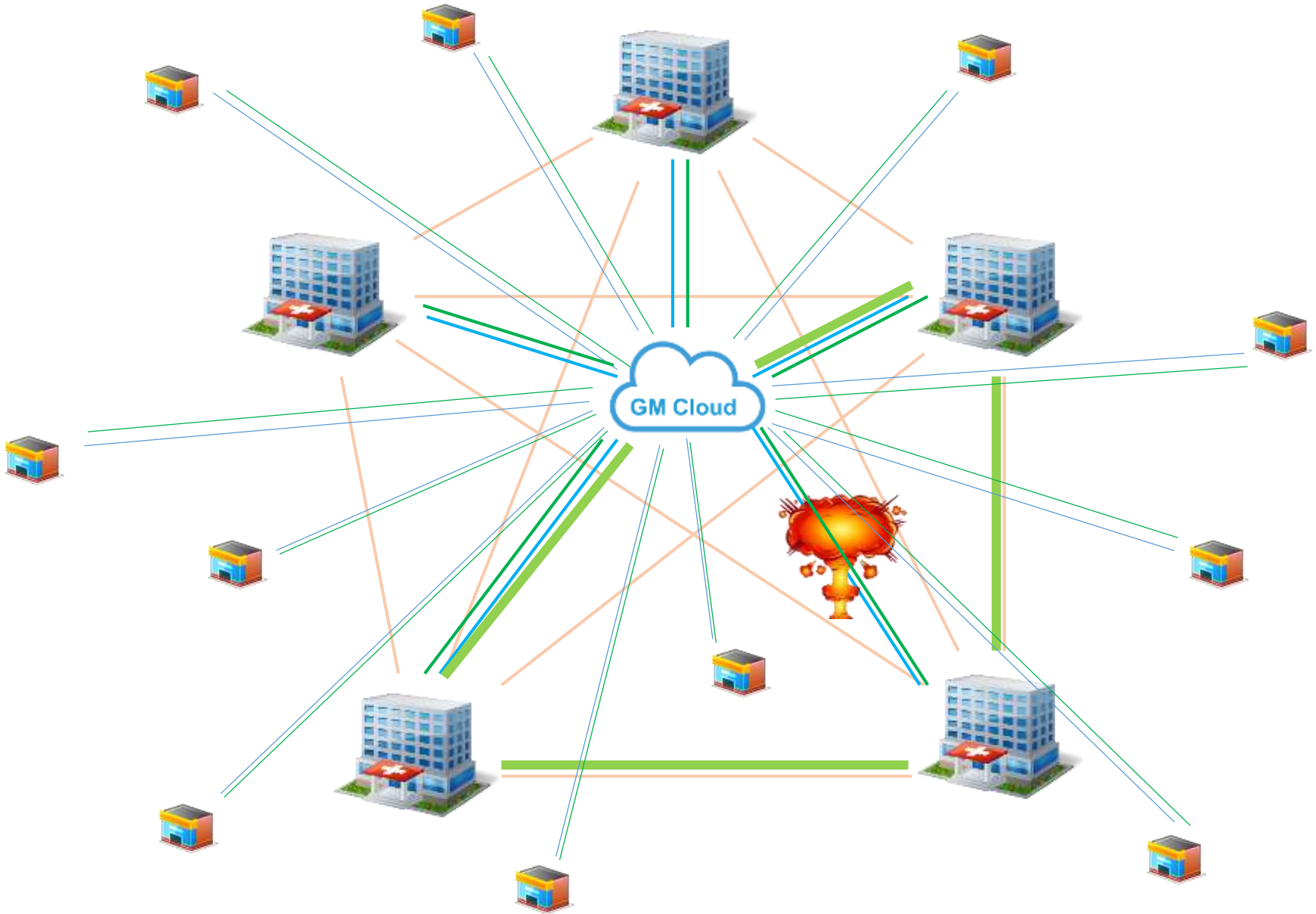
# The Master Plan

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# GM ODMSs

| Trust | Device category | Category (other) | Local Identifier | Location | Manufacturer | Model | Connectivity Score (1-4) | Safety Score (A-C) |
|---|---|---|---|---|---|---|---|---|
| RBH | Field analyser | | HFA1 | | | | 4 | C |
| RBH | Field analyser | | HFA2 | | | | 4 | C |
| RBH | Field analyser | | HFA3 | | | | 4 | C |
| RBH | Field analyser | | HFA4 | | | | 4 | C |
| RBH | Field analyser | | HFA5 | | | | 4 | C |
| RBH | Field analyser | | HFA6 | | | | 4 | C |
| RBH | OCT | | OCT01 | | Zeiss | Cirrus | 4 | C |
| RBH | OCT | | OCT02 | | Zeiss | Cirrus | 4 | C |
| RBH | OCT | | OCT03 | | Zeiss | Cirrus | 4 | C |
| RBH | OCT | | OCT04 | | Zeiss | Cirrus | 4 | C |
| RBH | OCT | | OCT05 | | Zeiss | Cirrus | 4 | C |
| RBH | OCT | | OCT06 | | Heidelberg | Spectralis | 4 | C |
| RBH | A-Scan | | AScan1 | | Acutome | | 4 | C |
| RBH | B-Scan | | BScan1 | | | | 1 | A |
| RBH | Topographer | | Pentacam1 | | | | 4 | C |
| RBH | Other | Old Topcon ant seg cam | Cam1 | | | | 1 | A |
| RBH | Fundus camera | Stereo cam 1 | Kowa01 | | Kowa | | 4 | C |
| RBH | Fundus camera | Stereo cam 2 | Kowa02 | | Kowa | | 4 | C |
| RBH | Fundus camera | Fundus cam 1 | Kowa03 | | Kowa | | 4 | C |
| RBH | Fundus camera | | Optos1 | | | | 4 | C |
| | | | | | | | | |
| PA | B-Scan | | | RI Eye Unit | | | 1 | A |
| PA | Biometry machine | | | RI Eye Unit | | | 1 | A |
| PA | Biometry machine | | | RI Eye Unit | | | 1 | A |
| PA | A-Scan | | | RI Eye Unit | | | 1 | A |
| PA | Other | Autorefractor | | RI Eye Unit | | | 1 | A |
| PA | Topographer | | | RI Eye Unit | | | 1 | A |
| PA | OCT | | | RI Eye Unit | | | 1 | A |
| PA | Field analyser | | | RI Eye Unit | | | 1 | A |
| PA | Fundus camera | | | RI Eye Unit | | | 3 | B |
| PA | OCT | | | OICC | Canon | | 3 | A |
| PA | Topographer | | | OICC | | | 3 | C |
| PA | Field analyser | | | OICC | | | 3 | C |
| PA | Field analyser | | | OICC | | | 3 | C |
| PA | Field analyser | | | OICC | | | 3 | C |
| PA | OCT | | | OICC | Heidelberg | | 3 | B |
| PA | B-Scan | | Old | OICC | | | 1 | A |
| PA | B-Scan | | New | OICC | | | 1 | A |
| PA | Biometry machine | | | OICC | | | 1 | A |
| PA | Biometry machine | | | OICC | | | 1 | A |
| PA | Other | Autorefractor | | OICC | | | 1 | A |
| PA | Field analyser | | | FGH | | | 1 | A |
| | | | | | | | | |
| SHH | A-Scan | | 114B | | Quantel Medical | | 1 | A |
| SHH | Biometry machine | | 45971 | | Zeiss | IOLMaster 500 | 1 | A |
| SHH | Field analyser | | x1108 | | Zeiss | HFA | 1 | A |
| SHH | Field analyser | | 48522 | | Zeiss | HFA | 1 | A |
| SHH | Field analyser | | | Buxton | Zeiss | HFA | 1 | A |
| SHH | B-Scan | LX | x563 | | | | 1 | A |
| SHH | Other | Topcon Camera | 48794 | | | | 2 | A |
| SHH | OCT | | 45969 | | Heidelberg | | 2 | A |
| SHH | Fundus camera | | 10827 | | | | 2 | A |
| SHH | Other | OPTOS | 47466 | | | | 2 | A |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| WWL | OCT | | HEUK00282 | | Heidelberg | Spectralis | 3 | C |
| WWL | Other | | HEUK00294 | | Heidelberg | Spectralis | 3 | C |
| WWL | Field analyser | | 40360 | | Zeiss | | 3 | C |
| WWL | Field analyser | | 40337 | | Zeiss | | 3 | C |
| WWL | Field analyser | | 9266 | | Zeiss | | 3 | C |
| WWL | Biometry machine | | 1130270 | | Zeiss | | 3 | C |
| WWL | Fundus camera | | 859744 | | Zeiss | | 3 | C |
| WWL | B-Scan | | 459 | | Quantel Medical | | 1 | A |
| WWL | Topographer | | 5446 | | Tomey | | 1 | A |
| WWL | Other | | 4870156 | | Topcon | | 1 | A |
| | | | | | | | | |
| MREH | Fundus camera | Mydriatic Fundus Camera (Retinal) | 947874 | Central | Topcon Corporation | TRC 50DX | | |
| MREH | Fundus camera | Mydriatic Fundus Camera (Retinal) | 948975 | Central | Topcon | TRC 50DX | | |
| MREH | Fundus camera | Mydriatic Fundus Camera (Retinal) | 948020 | Central | Topcon | TRC 50DX | | |
| MREH | Fundus camera | Mydriatic Fundus Camera (Retinal) | 948974 | Central | Topcon | TRC 50DX | | |
| MREH | Fundus camera | Non-Mydriatic Fundus Camera (Retinal) | 2881570 | Central | Topcon | TRC NW6S | | |
| MREH | Other | Widefield Camera (Retinal) | 51535 | Central | Optos | California P200DTx (Cali 1) | | |
| MREH | Other | Widefield Camera (Retinal) | 51536 | Central | Optos | California P200DTx (Cali 2) | | |
| MREH | Field analyser | | 720I-5407 | Central | Zeiss | HFA 720 | | |
| MREH | Other | PC for Clinical Studio Photography | 8JH9P4J | Central | Topcon | Optiplex 380 | | |
| MREH | Other | Slit lamp Camera | Z101119 | Central | Topcon | SL-D701 + DC4 LED light | | |
| MREH | OCT | | 703105 | Central | Topcon | 3D OCT 2000 FA+ | | |
| MREH | OCT | | 683340 | Central | Topcon | 3D OCT 2000 | | |
| MREH | OCT | | 683009 | Central | Topcon | 3D OCT 2000 | | |
| MREH | OCT | | 980546 | Central | Topcon | DRI Triton | | |
| MREH | OCT | | 980548 | Central | Topcon | DRI Triton | | |
| MREH | OCT | | 684215 | MTCJ | Topcon | 3D OCT 2000 | | |
| MREH | Other | Multi Scanning Imaging Camera | HEUK00251 | Central | Heidelberg | Spectralis HRA OCT | | |
| MREH | Other | Multi Scanning Imaging Camera | HEUK01133 | Central | Heidelberg | Spectralis HRA OCT-A | | |
| MREH | Field analyser | | 720i-40443 | Central | Zeiss | HFA 720 | | |
| MREH | Field analyser | | 720i-40440 | Central | Zeiss | HFA 720 | | |
| MREH | Field analyser | | 720i-8640** | Central | Zeiss | HFA 720 | | |
| MREH | Field analyser | | 720i-5407/5408** | Central | Zeiss | HFA 720 | | |
| MREH | Field analyser | | 720i-8654** | Central | Zeiss | HFA 720 | | |
| MREH | Field analyser | | 720i-8626** | Central | Zeiss | HFA 720 | | |
| MREH | Field analyser | | 720i-8701** | Central | Zeiss | HFA 720 | | |
| MREH | Field analyser | | 720i-8620** | Central | Zeiss | HFA 720 | | |
| MREH | Field analyser | | 740i-17980** | Central | Zeiss | HFA 740 | | |
| MREH | Other | Focimeter (Automatic) | 812208 | Central | Rodenstock | Auto Lensmeter AL4600 | | |
| MREH | Other | Focimeter (Automatic) | 812108 | Central | Rodenstock | Auto Lensmeter AL4600 | | |
| MREH | Other | Focimeter (Automatic) | 802105 | Central | Rodenstock | Auto Lensmeter AL4600 | | |
| MREH | Other | Focimeter (Automatic) | 801905 | Central | Rodenstock | Auto Lensmeter AL4600 | | |
| MREH | Field analyser | | 720i-50207 | MTCN | Zeiss | HFA 720 | | |
| MREH | Field analyser | | 720i-50209 | Altrincham | Zeiss | HFA 720 | | |
| MREH | Field analyser | | 720i-50213 | Altrincham | Zeiss | HFA 720 | | |
| MREH | Field analyser | | 720i-50215 | Altrincham | Zeiss | HFA 720 | | |
| MREH | OCT | | 684149 | Altrincham | Topcon | 3D OCT 2000 | | |
| MREH | Fundus camera | Non-Mydriatic (Retinal) | 87201 | Altrincham | Topcon | NW8 | | |
| MREH | Fundus camera | Widefield Camera (Retinal) | 51381 | Altrincham | Optos | California P200DTx (Cali 3) | | |
| MREH | Fundus camera | Truecolor Confocal Scanner | 26 | Altrincham | CenterVue | Eidon AF (Retia) | | |
| MREH | Other | Focimeter (Automatic) | 1509306 | Altrincham | Rodenstock | Auto Lensmeter AL300 | | |
| MREH | Other | Focimeter (Automatic) | 1509406 | Altrincham | Rodenstock | Auto Lensmeter AL300 | | |
| MREH | OCT | | 684357 | Trafford | Topcon | 3D OCT 2000 | | |
| MREH | OCT | | 980624 | MTCN | Topcon | DRI Triton | | |
| MREH | OCT | | 980536 | MTCS | Topcon | DRI Triton | | |

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# The Master Plan

**Steps taken**

- Formalisation of a GMOC EPR into the GMOC workplan
- Submission of a GM Digital Technology Fund bid
- Completion of the ODMS at all five Trusts
- Development of a ‘Digital Vision’ consisting of business case headings
    - Full options appraisal
    - Benefits analysis
    - Financial analysis
- Development of a Output Business Specification

**Next steps**

- Alignment to Trust acute EPR strategies
- Secure further funding
- Confirm revenue implications
- Procure
- Deploy

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# What patients tell us about booking appointments

Helen Lee
Policy and Campaign Manager, RNIB

**UKOA Quarterly Meeting June 2019**

# All Party Parliamentary Group on Eye Health and Visual Impairment inquiry ‘See the light: Improving capacity in NHS eye care in England’

- Published June 2018
- 100 organisations contributed
- Over 550 patients gave evidence to the inquiry
- Expert group advising the inquiry including RCOphth; College of Optometrists, patients, Optical Confederation

Consensus on:

- 16 recommendations

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# For NHS Providers

- To ensure the eye care pathway is clear for those responsible for managing patient care and effectively communicated to patients.

- To review booking procedures to ensure patients who need further appointments can book their next appointment, within clinically appropriate timescales before leaving the clinic. This will benefit patients and aid capacity planning.

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Where patients can’t book follow up appointments before leaving the clinic it often causes anxiety.

Booking systems need to ensure that appointments cannot be allocated outside of clinically appropriate timescale without consultation with clinicians.

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# What patients told the inquiry

- Just over half of those had at least one appointment or treatment delayed
- Chasing appointments
- 77% felt the delay or cancellation caused them anxiety and stress
- 54% felt it had a negative impact on day to day life
- Concerns:
  - long waiting times
  - Problems securing appointments
  - A lack of continuity of care
  - Poor communication from the clinic to both patient and other professionals

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# Suggestions for improving the services

- Seen within clinically appropriate time without having to chase
- Shorter waiting times in clinics, less over crowding, more co-ordination
- More continuity of care, information about patient care to be available to the right professional at the right time
- Better emotional and practical support
- More accessible information about treatment options & time to ask questions
- Extra funding for more staff & resources

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- There were many positive comments about the experienced and supportive clinical staff, even from those people who expressed dissatisfaction with other aspects of their care (such as delays).

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# Practical aspects in the Moorfields Clinic approach

Alex Stamp
Deputy Chief Operating Officer, Moorfields Eye Hospital

**UKOA Quarterly Meeting June 2019**

# Context

Moorfields Eye Hospital operates clinics across our 30 sites within the network run by a multi-disciplinary team of consultants, nurses, optometrists and orthoptists.

Last year (2018/19) Moorfields carried out:

- 135,360 new patient episodes.
- 457,260 follow up episodes.
- 42,304 injection episodes.

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# Practical Aspects – pre-clinic

- All patient referrals are registered on the Trust's PAS system.
- The Trust complies with national Electronic Referral System standards and is now 99% slot availability for GPs to schedule into using the system.
- Patients are now scheduled via one of our five contact centres when referred.
- Information is sent out to the patient via text message and letter.

# Practical Aspects – attendance on the day

- Patients are offered to check in at a patient kiosk on the day up to 45 minutes before their appointment. Alternatively patients can register at the clinic desk with the clerk.
- Patients will then be directed to the relevant clinic area and all relevant information regarding accessibility information is captured.
- At the desk they will then be called by the nursing team into their consultation and for any relevant diagnostic tests.
- The clinical team will guide the patient through their appointment and are expected to communicate regarding waiting times.
- Announcements are made in clinic and sign posts for waiting times are clearly displayed.
- Patient outcome forms are completed by the clinical team and are then handed to the clerk and all clerks are expected to complete the check out process and where possible provide a suitable RTT outcome for the patient.
- Patients will be offered a Friends and Family Test form before leaving the clinic.

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# Practical Aspects – post-clinic

- Patient letters are generated using our Openeyes system which are usually sent to the patient and their GP.
- Any patients not provided with an RTT outcome or booked for a future appointment will be monitored and reviewed on a weekly basis. Any patient without an outcome over 5 days will be escalated to the Divisional Manager.
- Patients without an appropriate follow up are monitored and reviewed on a weekly basis with discussion with the relevant clinical team to ensure safety is managed appropriately.
- Patient journey times (length of time waiting in clinic) and Accessible Information Standards are monitored on a monthly basis and included in performance reports for the Trust Board.

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# Practical Aspects – next steps

- Implement a patient portal in the next six months to enable patients to take control of their appointment management.
- Developing a chatbot for patients which will provide patients with information on their appointment and be easily accessible as well as integrated with Alexa and Siri.
- Developing a platform for community Optometry imaging reviews.
- Meeting with suppliers to discuss possible video-consultation opportunities for some of our quaternary clinics.
- Implementing an enhanced level of monitoring for patient waiting times to monitor patients booked outside their clinically appropriate timeframe to establish gaps in capacity and risk profile in advance.
- Reviewing options to optimise our PAS system to improve patient flow within clinics.

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# Practical Aspects – Lessons Learned

Given Moorfields' experience of managing clinics both in terms of demand and capacity but also experience for both our staff and our patients, the key aspects to managing this process are:

- Put the patient first – e.g. Experience-based co-design and Patient stories.
- Utilise technology where possible.
- Develop strong data quality and monitoring tools.
- Listen to staff and engage them with improvements – e.g. rolling out demand and capacity and QSIR training.
- Encourage floor to board involvement at all levels.

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Thank you for attending our UKOA Quarterly Meeting.

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