NHSEI National Eye Care Recovery & Transformation Programme

Reducing Frequent and Unnecessary Follow-ups

GUIDANCE

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Version Control - 1

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Contents

Executive Summary

In response to rising national eye care capacity constraints exacerbated by the impact of Covid and in line with national priorities for outpatient transformation supporting elective recovery, this guidance aims to help direct limited outpatient capacity to those patients most in need.

The intention is to rapidly increase eye care capacity to see patients with urgent, complex or sight-threatening disease and prevent permanent visual loss in delayed patients. By reducing or personalising the frequency of appointments where appropriate, and eliminating those that are unnecessary, patients can receive an improved outpatient experience and providers can release significant outpatient capacity for re-allocation to delayed or higher risk patients.

This guidance represents the first phase of support, providing information on best practice. Further resources are planned to include exemplars, case studies and local documents and to identify and work with areas needing support to overcome challenges. We are keen to hear from providers who have discharge policies with eye content, any risk-based or triage follow up guidance or who have implemented ophthalmology patient-initiated follow-up (PIFU).

The NHS England and Improvement National Eye Care Recovery and Transformation Programme (NECRTP) recommend the adoption of this new guidance and look forward to working with systems, providers and professionals to learn from good practice and support improvement.

Background and context

It is recognised the pandemic has led to record numbers of patients with delayed ophthalmology outpatient (OP) appointments and surgery, putting large numbers of patients at real risk of avoidable sight loss. With ophthalmology being the highest outpatient activity in hospitals at 8 million attendances per year, it is imperative to manage pathways differently to reduce this risk and satisfy ambitions for the Elective Recovery Strategy 2022. The NECRTP team are already supporting systems and providers around the country with development of local PIFU criteria and local workshops to implement this in local eye services. We look forward to working with more to embed robust risk-based discharge and timely follow up.

Purpose of the guidance

To help and support systems and providers develop eye care pathways, processes and systems that lead to: -

1. Reduced unnecessary follow-ups through better discharge

2. Reduced frequency of follow-ups, where clinically safe and appropriate, through better triage and risk stratification

3. Increased PIFU

Modeling and adoption in action

The response to Covid and the recovery of elective care has accelerated and embedded many changes in line with the NHS Long Term Plan. The cultural and behavioural shifts recently experienced at an operational level by providers and patients exemplifies transformational models of care that are adaptable to meet the needs of patients safely in new and innovative ways: -

Many specialties beyond eyes have been introducing these approaches to better manage the demand and pressures for outpatient appointments with expectations of up to 40-80% capacity release: Cancer services, cardiology, dermatology, gynaecology, musculoskeletal, respiratory, rheumatology and urology

Many of the processes in other specialties can be easily adapted or built on for eye care, and providers should look to do this so that eye care OP transformation can be introduced more rapidly.

Why and benefits

The following are headlines for key aspects of the rationale and benefits for reducing unnecessary and over-frequent follow-up appointments in eye care.

National priority 2021/24

- 8M eyecare outpatient appointments, busiest OP area
- Pressures for wait lists exacerbated by Covid
- Long waits risk permanent harm and vision loss
- Release 2.4M OP capacity over 3 years
  - OP reduction – 25%
  - PIFU – 2% - Mar 22 / 5% Mar 23
- **An additional 30,000 OP appointments could be released in year

Elective recovery

- Optimal impact to elective recovery ambitions
- Reduce operational and workforce costs associated with additional lists
- Efficacy and benefits realised
- Realease OP capacity

Patient experience

- Appropriate care - Right time, right place
- Appointments that benefit treatment and care plan
- Improved wait times
- Empowering: independence and self-management
- Timely and safe follow-ups
- Only patients who need an appointment are seen
- Care is better suited to a patient's individual needs and preferences
- Better outcomes
- Patients in control of their follow-up care
  - Patients can arrange their follow up appointment as and when required, for example a change in symptoms or circumstance
- Follow-up care through monitoring
  - Clinical teams can arrange an appointment as required based on the need to monitor or treat the patient's condition
- Timed follow-up
  - Timing on a patient's next appointment will be based on each individual's need

Tools and enablers for change

In essence we are establishing how best we can:

- ✓ Take the decision right for the patient AND for all the other patients/whole service
- ✓ Get senior clinical input or oversight without consultants seeing all the patients
- ✓ Start to move to prospective decisions not retrospective endless notes review
- ✓ Change the mindset that the desired outcome is not holding on and frequently reviewing the patient.

Of the different ways and tools that will enable sustainable change and transformation, we are focusing on 3 interactions: -

1. Discharge

Discharging patients from the hospital eye service (HES) should be the target and the natural default when undertaking treatment and care. Patients not discharged should only be those who need continued active treatment and care which can only be delivered through the HES. For example, low risk/routine cataract post-operative patients should be discharged to optometrists for sight tests.

The learning from Covid measures to maintain delivery of elective care and transform eye outpatients shows how much capacity could be released when discharge is undertaken well. Where long wait lists have prevented patients from being seen, an enhanced validation and review of notes of waiting patients for potential harm and deterioration can lead to more than 40% increased discharges.

Characteristics of safe discharge

- Patients' active secondary care episode has ended
- Further secondary care appointment requires a new referral
- No further follow-up appointment will occur
- Responsibility for patient care is back with primary care
- Information flow, provided to the patients, copied to the GP and Primary care Optometrist

The NECRTP Discharge and PIFU toolkit provides more detailed guidance and illustration of many examples for safe discharge for eye conditions in key subspecialties such as glaucoma, cataracts, cornea and ocular surface, age related macular degeneration and diabetic macular oedema etc. An updated more detailed version of these examples will be shared soon.

The following are necessary components for robust and efficacious discharge in providers:

How to 

1. **Dedicated time for clinical review of patient notes**

During the early waves of the pandemic, Rotherham designated its clinic time for ophthalmologists to review patient notes and identified 40% could be discharged from wait lists. As services were reinstated and an EPR was implemented, this time could be significantly reduced. Through the development of these processes, a system is in place where OP lists are now monitored with a targeted level of discharge per list.

2. **Enhanced validation of wait lists**

University Hospitals Dorset undertook enhanced validation across specialities where all patients were contacted via the use of SMS messaging giving access to a digital portal and hard copy letters. The trust were able to receive an update from patients and parents of paediatric patients of their need/want for remaining on service wait lists, any deterioration noticed, readiness for hospital attendance if required and those now being treated in the independent sector.

For ENT, the level of increased discharge was 10%, following a clinical review of notes and/or virtual appointment with patients.

3. **Pathway re-design**

Through innovative redesign and adoption of NECRTP priorities, there is great opportunity and national support to improve eyecare pathways enabling increased safe discharge. When looking at the journey of a patient and capacity constraints, operational changes to timing, workforce in attendance, use of digitalisation and change of location can further optimise

our elective recovery ambitions. Necessary actions for change include: - reducing pre-op appointments to one for local anaesthetic cataract surgery using one-stop services, multidisciplinary clinics, efficient eye injections in OPs as opposed to theatres, community diagnostic centres, shared decision making tools, embedding a culture to discharge as default e.g. cataract post-operative patients and adopting the optometry first model which better utilises optometrists.

2. Timely follow-ups

Covid has made us think and act differently to maintain elective services and we need to maintain that momentum and not slip back into old habits to ensure every part of our limited capacity is used well. Where discharge is not appropriate, we need professionals and providers to look innovatively at removing unnecessarily frequent appointments that add no value clinically to patients in terms of treatment and a favourable experience.

We need to encapsulate the same triage and risk stratification elements used in decision making for discharge to refresh the timeliness of follow-ups. We also need to shift culturally from the traditional long-term relationships of recurring appointments between consultant teams and patients which do not reflect the true clinical and patient need.

How to

The previously mentioned approaches of; -

- ✓ Dedicated time for clinical review of patient notes
- ✓ Enhanced validation of wait lists
- ✓ Pathway re-design

are applicable when it comes to reducing the frequency of follow-ups as well as:

1. Competence and skill mix of decision makers

Junior doctors and less experienced team members can be risk averse and subsequently request further unnecessary appointments. Consultant oversight and support to these decisions is key to embedding a unified approach using local guidance tools to reduce variations for follow-ups.

2. Reviewing DNAs with clinicians to see if patients should be discharged and checking with patients as this may be flagging opportunities for discharge.

3. Level of open pathways on wait lists

Robust management and review of open OP attendances and wait lists cohorts will facilitate and enable targeted efforts for review, action and improvement.

The table below highlights what capacity can be released where the frequency of follow-ups is changed. This sort of knowledge can be shared with clinical teams to help think differently.

Wait list scenario for 1000 patients	Outpatient capacity release
If patients are scheduled every 3 months = 4000 appointments	0
If patients are scheduled every 4 months = 3000 appointments	1000
If patients are scheduled every 6 months = 2000 appointments	2000
If patients are scheduled every 12 months = 1000 appointments	3000

Details on how to measure risk and risk-based triage tools are available in the Risk Toolkit.

NECRTP have also adapted Moorfields ophthalmic global trigger tool audit to develop a Discharge and follow-up ophthalmology trigger tool (OTT) audit as an enabler.

3. Patient Initiated Follow-Up (PIFU)

This is a key priority for Covid recovery in the NHS England planning guidance 2021-2022 and in the planning guidance annexe for eye care from the National Eye Care Recovery and Transformation Programme. Several providers have become early adopters for implementing a PIFU pathway in eye. With national targets of 2% in year 2021/22 and 5%

target for March 2023, patient episodes need to be transferred to PIFU as part of the elective recovery ambitions enabling OP capacity release and become an embedded practice moving forwards.

PIFU explained

- Is when a patient (or their carer) can initiate their follow-up appointments as and when required, e.g. when symptoms or circumstances change, within a defined timescale
- For some patients who are unable to book their appointments directly, administrative staff at their GP surgery or care home may be able to help
- Does not replace discharging patients who should be discharged at the end of their treatment or care
- Further secondary care appointment does not require a referral within the defined timescale
- Flexible, determined by the patient, may not be any further appointment
- Responsibility for care remains with secondary care
- Operationally, patients are
  - discharged and placed on a PIFU pathway or
  - set as an outpatient PIFU with an intended discharge date

How to

As with all service changes, providers should seek to establish working groups with key stakeholders from teams e.g. clinicians, operational, IT/PAS, patients, comms etc.

PIFU components

- Guideline with criteria
- Admin processes key
- Patient info and comms
- Clinician info and comms

The NOTP PIFU SOP template provides details of how this process should be established and should be used in conjunction with the enabling tools provided and those developed locally e.g. London PIFU SOP. The NECRTP Discharge and PIFU toolkit : NECRTP discharge, follow-up and PIFU flow chart is useful to provide more details to establish PIFU across all eye care services providing steps for necessary inclusion and considerations for a robust system.

Stakeholder focus areas

The following stakeholder groups are listed with areas for your consideration in communicating, engaging, managing expectations and providing resources for successful introduction of change to increase discharges, reduce frequent and unnecessary follow-ups and to implement PIFU.

1. Patients

- Planned care and condition information
- Understanding expectations and wishes
- Move away from traditional long-term fixed-timing relationships with consultant/hospital-based teams
- Confidence in shared decision-making and self-management
- Engagement with patient groups and third sector
- Use of digitalisation as an enabler for self-management, updates, escalations, communications and support
- Pathway options
  - Discharge
  - Booked follow-up
  - Digital and virtual options
  - PIFU
  - Primary care
- Seeking support, information, understanding when symptoms mean seek help, how to re-engage with secondary care
- Support within primary care

2. Clinicians and provider team behaviour

- **Operational teams**
  - Review of services/pathways and proactively seeking opportunities
  - Highlight and share recommended best practice for an improved patient experience and clinical care by increasing discharges and PIFU
  - Modelling outpatient capacity release and reduction in unsafe waits
  - Identified triage tools and risk stratification data
  - Fail safe practices embedded
  - Discharge, PIFU and follow-up decision tools developed with clinicians
  - Supporting audit again tools and guidance
  - Use of digitalisation as an enabler for diagnostics, pathway management, escalations, interventions, communications and support
  - Developing and embedding administration processes and ensuring admin staff education
  - Learning from other specialties in the provider or local area

- Alignment with NOTP/NECRTP priorities and ambitions
- Developing data reporting tools and audit of performance
- Communicating proactively and sharing records or clinical data with primary eye care for every patient
- Embedding failsafe, ECLO and patient information and support resource.

- **Primary care**
  - Assurance for appropriateness of referrals received
  - Signposting and supporting patients
  - Confidence in shared decision-making tools
  - Knowledge of and working within local HES capacity constraints
  - Highlight and share recommended best practice for an improved patient experience and clinical care that supports increased discharges and PIFU
  - Workforce modelling enabling diagnostic competences outside of consultant teams
  - Use of digitalisation as an enabler for diagnostics, communications and support
  - Alignment with NOTP/NECRTP priorities and ambitions

- **Clinical secondary care workforce**
  - Consultant leadership, oversight and audit of practice
  - Consultant input into triage and risk-based decision tools
  - Undertaking shared decision-making with patients
  - Advanced clinical decision-making competences outside of consultant body
  - Alignment to local demand and pressures for staff and numbers
  - Use of digitalisation as an enabler for diagnostics, pathway management, updates, escalations, interventions, communications and support
  - Confidence and assurance in new models of care.

3. Commissioners

- Ensuring equity in service provision
- Review existing commissioned pathways and optimise optometry services
- Optometry first model support and purchasing
- Understanding current restrictions and need to change
- Alignment with healthcare/colleges clinical recommendations and guidance
- Alignment with NOTP/NECRTP priorities and ambitions and planning guidance
- Data benchmarking and challenging provider variation
- Supporting sharing of learning and consistent tools between providers across the system.

Metrics and measures of success

The following metrics can be used to measure success

1. Increased clock stops on RTT pathways
2. Increased numbers of PIFUs (not instead of an appropriate discharge)
3. Increased patient discharges post-operatively
4. Increased release of OP capacity
5. Reduced DNAs
6. Reduced journey time for patients, families and carers attending eye care appointments
7. Reduced operational and workforce time and costs for clinical sessions
8. Reduced pre-operative OP appointments
    a. Eventual reduction in demand
9. Reduced travel and carbon footprint for patients, families and carers for eye care appointments.
10. Reduced wait list sizes
11. Reduction in unmet need and clinical risk from patients being on waiting lists for follow-up appointments
12. Reduction of numbers of follow-ups or new to follow-up ratio, especially in non-glaucoma and medical retina subspecialties.

Resources Available to Support Teams

The listed resources provide support for the implementation of recommendations and are available at Future NHS NECRTP Eye Care Hub

1. Discharge and PIFU Models

1. Cataract – clinical recommendations to discharge post-operatively - NECRTP
2. Discharge and follow-up ophthalmology trigger tool (OTT)- NECRTP
3. Discharge and PIFU toolkit - NECRTP
4. Discharge, follow-up and PIFU flow chart - NECRTP
5. Learnings from the PIFU Rapid Implementation Programme - NOTP
6. Managing clinic slots using PIFU - NOTP
7. NECRTP priorities - NECRTP
8. One-stop services/hub template -NECRTP
9. Optometry first - NECRTP
10. PIFU campaign toolkits - NOTP
11. PIFU implementation plan and pre-implementation checklist - NOTP
12. PIFU SOP - London regional eye care team
13. PIFU SOP template - NOTP
14. Rotherham discharge - TBC
15. System EROC guidance - NOTP
16. Shared decision making – NOTP
17. University Hospitals Dorset - TBC

2. Webinars

1. Outpatient efficiencies – NECRTP
2. Shared decision making - Clinicians –– London regional eyecare team
3. Shared decision making – Operational managers – London regional eyecare team

3. Patient support information:

1. Diabetes PIFU patient leaflet – York
2. MSK PIFU patient information leaflet - NOTP
3. Paediatric PIFU – Sheffield
4. Patient information leaflets – Moorfields
5. Patient information leaflet template – RNIB / NECRTP

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