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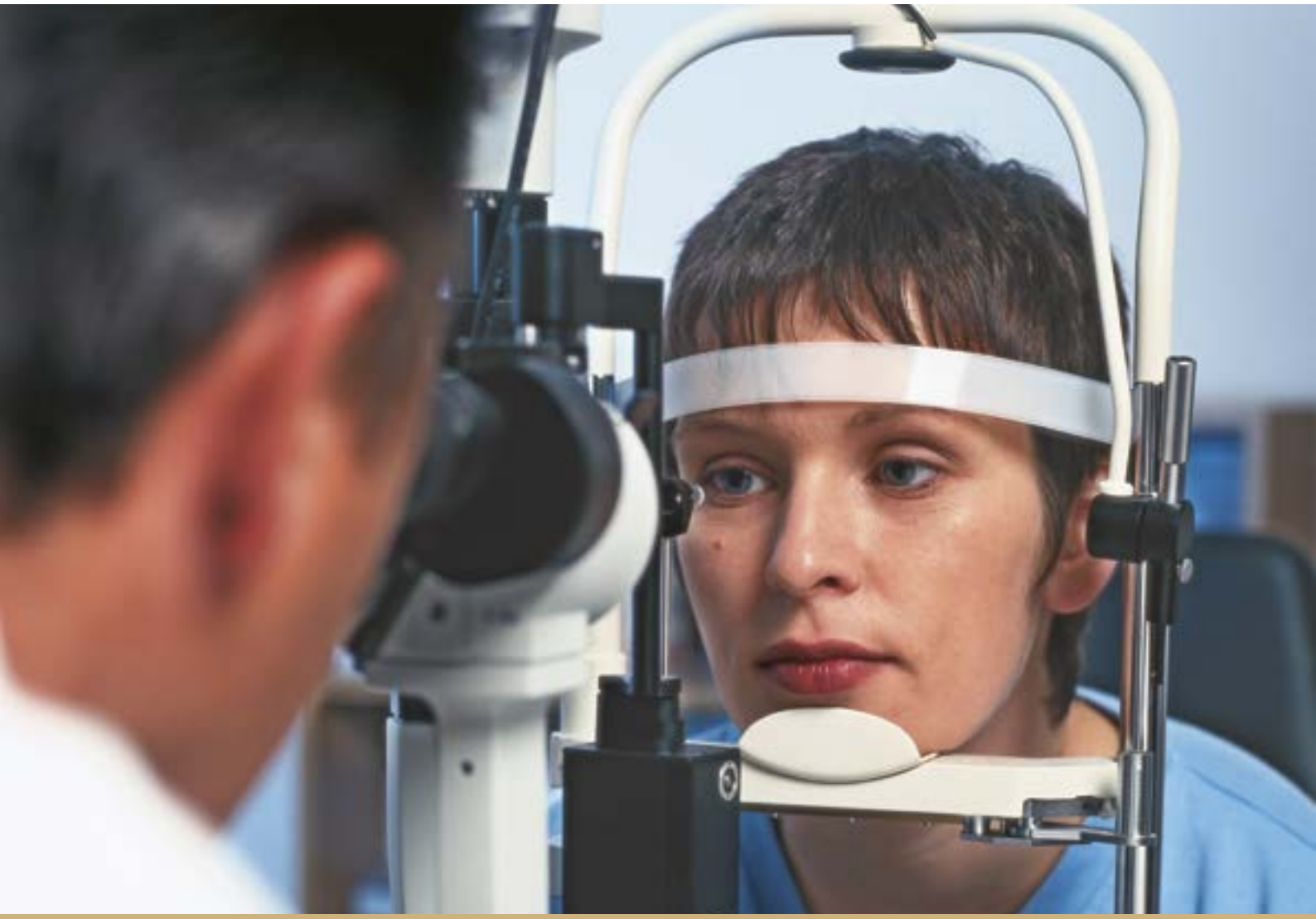
National Ophthalmic Implementation Plan 2015



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1 Summary

The purpose of the National Ophthalmic Implementation Plan is to improve patient experience and deliver sustainable services. The plan builds on a series of developments in Wales to provide a balanced service change for implementation by health boards across Wales.

The plan requires health boards to understand and measure **demand and capacity** for the main subspecialties in ophthalmology

The three primary drivers will be:

- **Clinical Value Prioritisation, CVP** (making sure that only the right patients are managed in secondary care).
- **Integrated Care, IC** (strengthening eye care groups and empowering patients).
- **Best in Class, BIC** (measuring value for money and benchmarking against top performing organisations).

The **key actions** (or secondary drivers) will be;

CVP

- Produce a response to a report on “do not do” procedures.
- Active management of thresholds for integrating primary care optometry.
- Urgent management of wet age-related macular degeneration (AMD).
- Delivering an antismoking service for selected patients.

IC

- Establishing national terms of reference for eye care groups.
- Delivering measures to empower patients including the development of a glaucoma school

BIC

- Measuring the “cost” of cataract surgery.
- Measuring “quality” from outcomes after cataract surgery, time to outpatient and treatment in wet AMD and delayed glaucoma follow up rates.
- Benchmarking “value” within Wales and against top performing units in the UK.

2 Background

2.1 National planned care programme brief

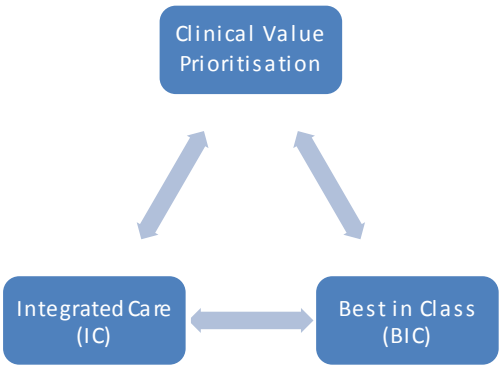
The purpose of the national planned care programme is:

1) To provide “sustainable” planned care services
2) To optimise the patient experience of using planned care services.

2.2 How will change be achieved?

The planned care programme requires measurement and management of demand and capacity in each of the major subspecialties.

The programme will employ a balanced service change approach based on the three primary drivers of clinical value prioritisation, integrated care and best in class.



Clinical value prioritisation (or CVP) will include

- Identification and management of NICE “do not do” and interventions “not normally undertaken”.
- Evidencing management of agreed pathways of care.
- Agreeing urgent and priority patient groups.
- Taking a holistic approach to patient care including life style modification.

Integrated care (or IC) will include:

- Establishing structures in health boards bringing together primary and secondary care clinicians with management support and patient input (C2CMP) with agreed terms of reference to ensure that the "right patient is in the right place at the right time".
- Providing patient empowered entry into the planned care system incorporating information, decision making aids and a supportive environment for decision making and a range of treatment options.

Best in class (or BIC) will include

- Establishing outcome measures for each planned care service.
- Measuring the cost of providing services using a range of tools including time directed activity based costing.

The national care programme will be delivered according to the principles of "managing successful programmes" and will be monitored by a national programme board. Each national service plan will be delivered by individual health boards and reported through national specialty boards.

The programme will be supported by expert reference groups and will rely heavily on patient involvement.

2.3 Changes in ophthalmic services

Our planned care system is facing challenges and there is a need for significant and urgent change.

In ophthalmic services, there are many new pressures, including demographic changes, leading to an increasingly elderly population with associated eye conditions and new treatment possibilities such as lucentis in AMD.

Currently there are more than 300,000 out-patient attendances each year for hospital eye services (more than 10% of all hospital outpatient visits in Wales) and there is insufficient capacity to meet the current demand.

Recent developments in eye care in Wales have enabled optometrists to monitor many more patients.

Certain patients with suspect glaucoma or ocular hypertension (OHT), who have been assessed as being at low risk, may be discharged to primary care for ongoing monitoring by Eye Health Examination Wales (EHEW) accredited optometrists and other patients at "medium risk" may be managed in an ophthalmic diagnostic and treatment centre (ODTC) where optometrists or nurse practitioners monitor patients

in a variety of settings under consultant supervision (in accordance with NICE guidance). However patients with glaucoma or OHT and classed as high risk can not be discharged to an EHEW accredited optometrists and will require ongoing treatment in hospital eye services.

Work that started in 2014 will connect all parts of the eye services via information technology (IT) enabling improved integration, and access to information.

In “Together for Health: the Eye Care Delivery Plan for Wales”, access to high quality, integrated eye care services is a priority.

The national ophthalmic implementation plan is intended to build on the considerable amount of progress that has been achieved in recent years through the Wales eye care initiative and the focus on ophthalmology clinical pathways project.

3. The national ophthalmic implementation plan

3.1 Measuring the outcomes of the national ophthalmic implementation plan

Patient experience will be measured using PREMS.

Demand and capacity measures will be established for each of the following pathways:

- Cataract
- Glaucoma
- AMD
- Diabetic retinopathy

Relating to the high level process points:

- First ("new patient") appointment
- Commencement of treatment
- Follow up appointment in accordance with the evidence-based schedule

Action1: Health boards will put in place systems to measure patient experience.

Action 2: Health boards will put in place systems to measure and report "capacity and demand" according to an agreed set of national (all Wales) parameters for each of the pathways above.

3.2 Clinical value prioritisation

3.2.1 Do not dos

Prudent healthcare principals encourage clinicians to do no harm. The list includes NICE do not do's, interventions not normally undertaken and health board decisions on procedures that should not be undertaken. This will include.

- Blepharoplasty for cosmetic reasons.
- Excision of benign eyelid lesions for purely cosmetic reason.
- Corneal implants should not be used for the treatment of refractive error in the absence of other ocular pathology such as keratoconus.
- Follow up for unequivocally benign lesions such as typical choroidal naevi.

Action 3 : National Ophthalmic Board (previously the HES/FOO (Hospital Eye Care Services) / (Focus on Ophthalmology Group) to expand

the list of do not do's to health boards and review responses from Medical Director or Chief Executive Officer.

Action 4: Health boards will undertake a waiting list "validation" to remove patients who do not require a new or follow-up outpatient appointment.

3.2.2 Thresholds

"Together for Health: The Eye Health Care Delivery Plan for Wales" states that people should be seen within the primary and community setting, where it is clinically appropriate. The development of IT for e-referrals and electronic patient records will facilitate this.

In order to ensure that the correct referral information is recorded and referral criteria are adhered to, elective referrals (documents and electronic referrals) to the hospital eye service will be reviewed by EHEW accredited optometrists.

In addition the following thresholds for the use of optometry shall apply;

- Patients that have had routine cataract surgery and who have no ocular comorbidity requiring HES clinical review will be followed up by optometrists for refraction, vision acuity (VA) assessment, glasses and outcome feedback to ophthalmology (in accordance with the Focus on Ophthalmology (FOO) pathway for cataracts).
- Following an assessment of the risk of glaucoma progression (via an ophthalmologist led clinic or ODTC), "low risk" patients (ocular hypertension / suspect glaucoma) will be monitored by community optometrists (following an "active discharge" policy) in accordance with an individualised plan for care (drawn up between the patient and their consultant).
- "Medium risk" ocular hypertension / suspect glaucoma will be monitored in an ODTC according to local arrangements.

Action 5: Health boards will put in place systems to manage patient flows and report:

- **Visual acuities of patients referred and treated for cataract**
- **Number (and proportion) of post operative cataract patients followed up in primary care**
- **Number of new glaucoma referrals into secondary care**
- **Number (and proportion) of patients with ocular hypertension followed up in primary care**

3.2.3 Urgent and priority groups

The Minister for Health and Social Services outlined in a statement on 11 November 2014 that the referral to treatment time for patients with wet AMD must be two weeks. Patients should then be reviewed every four or eight weeks depending on the treatment used because any delay may be associated with a swift loss of sight.

Action 6: Health boards to measure and report on:

- **The proportion of patients who began treatment within two weeks of referral**
- **The proportion of patients treated within their clinician-allocated follow-up interval**

3.2.4 Holistic approach

Smoking is a risk factor for the development of cataracts and AMD. All patients with these conditions will be offered referral to a smoking cessation programme (in keeping with the teachable moment philosophy).

Action 7: Health boards to measure and report the number and proportion of smokers with cataracts and AMD who have been referred to a smoking cessation programme.

3.3 Integrated care

3.3.1 Strengthen eye care pathway groups

As a result of the “National Eye Care Delivery Plan”, eye care groups have been established in all health boards. Eye care groups will be responsible for assuring delivery of the National Ophthalmic Plan in health boards.

Action 8: Health boards to ensure that their eye care groups work to a standard national terms of reference (ToR) to include executive representation

3.3.2 Patient empowerment

Measures to improve patient empowerment are central to the “prudent health care” initiative in Wales.

Patients attending EHEW optometrists already complete a questionnaire (to enable the optometrist to decide whether or not referral is necessary) before they are referred for a cataract appointment in secondary care.

The National Planned Care Programme will build on this patient focus using patient activation and decision making support.

Action 9: Establish cataract schools in primary care prior to listing patients for cataract surgery with the aim of activating patients and using option scores

Action 10: Measure the quality of patient decision making with a Decision Quality Measure (DQM)

3.4 Best in class

There will be a national system of measuring value for money in ophthalmic services based on a standard method of costing and quality assessed against the three dimensions of clinical effectiveness, risk and patient experience.

Action 11: Health boards to measure and report the cost of a cataract pathway (based on methodology recommended by the National Reference Group)

Action 12: Health boards to measure and report quality:

- **cataract visual acuity (effectiveness)**
- **delayed glaucoma follow up (risk)**
- **wet AMD treatment > 2 weeks (risk)**
- **PROMS (patient experience – see above)**

4. Reporting and collaboration

Health board's performance against this National Ophthalmic Implementation Plan will be reported to a National Ophthalmic Board established in place of the HES / FOO group and scheduled to meet bimonthly with revised ToR.

Welsh Government will work to model the service changes and provide an indicative cost for the new ophthalmic service with a best in class reference cost.

Work will also be undertaken centrally to assess the feasibility and cost of nurse injectors (for use in the treatment of wet AMD) and advanced glaucoma practitioners (to manage medium risk glaucoma patients).