This document explains how systems should plan local eye care transformation in line with the requirements of the planning letter including:

1. the overall asks for all health care services, including high impact elective service models, outpatient transformation among others, which are relevant to eye care
2. the specific requirement for eye care improvements stated in the letter as:

To reduce variation in access and outcomes, systems are expected to implement whole pathway transformations and thereby improve performance in three specialties: Cardiac, Musculoskeletal (MSK) and Eye Care with support via the National Pathway Improvement Programme (2021/22 priorities and operational planning guidance).

For eye care this can be summarised as:

- **Improve equity of access within and between ICSs and reduce the backlog of cases by:**

  ○ establishing a visible elective patient tracking list (PTL), with enough detail to understand resource requirement and risk, ensuring mutual aid for the treatment of P1 and P2 patients and greater coordination of capacity to address inequity

  ○ setting up high volume low complexity (HVLC) surgical pathways and high flow clinics, concentrating provision in hubs if required, ensuring health inequalities are not created as a result of high flow services

- **Implement standardised integrated care pathways across cataracts, urgent eye care, medical retina and glaucoma pathways including:**

  ○ primary, secondary, community and independent sector eye care services – with primary care optometrists as first contact practitioners and managing low risk patients in the community

- **Risk stratification for new and follow-up patients, failsafe processes & regular recording of delays to follow up patients (earliest clinically appropriate date or ECAD) to reduce harm**

- **Embed digitally enabled system transformation including:**

- implementation of electronic eye care referrals (EeRS) where procured to send referrals and large image files between primary care optometry and hospital eye services and to overcome the barriers to the consistent commissioning of extended primary eye care services

- implementation of digitally supported services such as video consultations and virtually reported diagnostics only assessments

- implementing or accessing a digital diagnostic hub that provides a range of services across eye care pathways and referrals

- developing plans for longer term integrated digital diagnostic and care capabilities, such as a digital diagnostic hub that provides a range of services across eye care pathways and referrals

The Eye Care Hub on the Future NHS Collaboration Platform provides toolkits and many resources to support delivery. Additional guidance providing digital tools that support the delivery of patient pathways can be found here.

Delivery structures:
Work to date has identified that the key conditions for effective specialty change are:

- Accountability which sits clearly at the appropriate level, with the assumption that leadership for each element sits at the most local level unless there is a clear case for devolution to a higher body

- Clinical leadership team with protected time and project management support, linked with a network of system clinical leaders, commissioners and operational teams to cascade information, co-develop change, improve performance and solve barriers at all levels

- Senior regional sponsorship

To deliver this, it is important that eye care-focused groups, empowered to implement the required changes, are formed at system level, with clear lines of reporting to a regional eye board which will be accountable for delivering regional eye care plans. Existing structures may need to be repurposed or supported to fulfil the new requirements.

NHSE/I regional teams are asked to:

- Set up strategic Eye Care Board or equivalent and an Eye Care Improvement Programme with appointed regional senior responsible officer (SRO), clinical leads from both ophthalmology and primary care optometry, provider management representation and project management support from the

regional improvement hubs, within a clear governance and escalation framework within the region
- Send representation to the national Eye Care Board once established, and provide evidence for shared learning with other regions

ICSs are asked to:

- set up an Eye Care Delivery Group that has visibility of all available system eye health and care data (including trust, extended primary eye care and independent sector NHS care)
- where a programme for eye care improvement does not already exist, establish an Eye Care Improvement Programme with clinical leads from both ophthalmology and primary care optometry, provider management representation and project management support, within a clear governance and escalation framework within the ICS and region including reporting to the regional eye care board. This may require repurposing or incorporating existing structures such as local eye health networks (LEHNs) or ophthalmology alliances
- have a clearly defined bi-directional network of communication, engagement and involvement for all key stakeholders especially providers (optometry and ophthalmology, multidisciplinary clinical, operational, and executive including financial)

Key milestones - expected timelines for change:

Q1 April - June 2021
Governance Regional eye care board or equivalent established.
Outpatients/integrated pathways All trusts to have in place a Standard Operating Procedure for the risk stratification of all patients on an OP waiting list (as per RCOphth guidance), appropriate harm review processes and recording processes of this information (where possible on a PAS/EPR). Failsafe processes with failsafe staff resource in place, with particular focus on AMD, DR, glaucoma & other high risk areas (eg lid cancers). Standardised eye care risk stratification and prioritisation tools used to plan the clinically safe timing of appointments and direct to the most appropriate care model (eg F2F, remote consultation, virtual diagnostic assessment, PIFU) and care setting (eg primary care, community hub or hospital).

Where procured, an EeRS system deployment for the transfer of clinical information and images between primary and secondary care.
Each ICS completes a scoping exercise to understand current provision and performance for locally commissioned extended primary care services across the ICS geography.

To include as a minimum:
Glaucoma referral.
Cataract referral and post-operative care.
Urgent eyecare (MECS, PEARS and CUES).
Medical retina referral filtering (AMD and diabetic macular oedema).
Identify variation and coverage.

Should also include all other provision, typically:
Glaucoma long term monitoring / management, children's eye services, low vision, medical retina long term monitoring.

Elective
All trusts to have in place a Standard Operating Procedure for the risk stratification of all patients on an IP waiting list (as per RCOphth guidance), appropriate harm review processes, and recording of this information (where possible on a PAS/EPR).

Each ICS to have a visible elective PTL to assess equity between/within ICSs and to plan co-ordinated support (must include both NHS and IS providers for NHS patients). This must include mutual aid processes in place to ensure the treatment of P1/P2 patients, in the event that a trust does not have capacity to treat as clinically indicated, and processes to standardise waiting times for P3/P4 patients between providers to reduce inequity across the ICS.

Q2 July - September 2021

Governance
ICS delivery boards or equivalent established and reporting to regional board
Regular recording of the earliest clinically appropriate date (ECAD) 90% patients recorded in every trust.

Outpatients/integrated pathways
Patient-initiated follow-up (PIFU) eye care – with adequate safeguards and patient support - commenced for suitable patients and conditions.

Virtual /digitally reported diagnostic data assessments commenced for appropriate appointments.

Remote (telephone and video) consultations commenced for appropriate appointments in key areas eg urgent care.

Optometrist referrals not redirected via GPs routinely (direct referral permitted) and hospital letter copied routinely to referring optometrist.

All systems to have a direct referral pathway from primary care optometry to the hospital eye service for urgent wet age related macular degeneration.

Where there are existing extended primary care services, demonstrate an increase in number of extended primary care episodes with a corresponding reduction in traditional hospital appointments.

Undertake gap analysis for national primary care optometry and diabetic macular oedema monitoring pathways for low risk patients and identify suitable patients.

Elective
ICS elective patient tracking list (PTL) being used to reduce inequities through coordinated/mutual support.

HVLC pathway agreed for low risk cataracts and piloted in some providers (note some areas this may be already delivered in IS).

Q3 October - December 2021

Outpatients/integrated pathways
Complete local roll-out plans of the EeRS solutions procured with NHSX 2020/21 funding.

Implementation of remote (telephone and video) consultations for all appointments where appropriate, possible, and safe.

ICSs have a timeline for introducing eyecare specific EPRs within their digital strategies.

All optometrists with IP quals who are working within an urgent eyecare service (MECS or CUES) to have access to FP10.

Elective
Improved theatre productivity for cataracts through use of HVLC pathway (as per RCOphth/GIRFT guidance).

Q4 January 2022 - March 2022
Outpatients/integrated pathways Virtual/digitally reported diagnostic data assessments established for all appropriate appointments. Scoping, planning and mobilisation of ophthalmology high flow hubs (improved use of existing eye facilities or new build) for high flow diagnostic data capture +/- high flow treatment. Complete benefits realisation analysis of the EeRS solutions procured with NHSX 2020/21 funding. Implementation of patient-initiated follow-up (PIFU) care in suitable patients – roll-out more widely with adequate safeguards and patient support. All systems to have an integrated cataract referral and post-op pathway and report a decrease in post-op cataract appointments delivered in hospital (aim for 50% cataract post-op across each system) and achievement top decile cataract first appointment conversion rate (85%). All systems to have an urgent eye care provision in primary care optometry with optometry first approach for all urgent (non-emergency) eye care. All systems to have glaucoma referral filtering pathways which can reduce avoidable hospital face-to-face consultations. All systems to have medical retina referral filtering pathways which can reduce hospital face-to-face consultations. If long term condition pathways in primary care optometry (glaucoma, medical retina) or diabetic eye screening (OCT monitoring) already exist, demonstrate an increase in activity with a linked reduction in hospital face to face consultations. Where they do not exist, develop a plan to implement these. All systems to have developed a plan for an optimal optometry first FCP service for eye care.
Elective

Establishment of HVLC pathways/hubs where required (unless IS provision means not required).