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Eye care restoration roadmap for 2020/21

Implementing safe and effective eye care pathways and processes

Version x, x January 2021

Contents

Summary

This document sets out what systems can do now to scale up the restoration of eye care services safely and minimise irreversible sight loss for patients. COVID-19 has led to the suspension of many eye care services and delayed appointments.

Subsequent social distancing and infection prevention and control (IPC) measures have increased pressure on an ophthalmology outpatient service where face-to-face consultations are standard practice. The NHS Long Term Plan ambition to avoid unnecessary face-to-face outpatient attendances has become an urgent imperative as we restore eye care services.

Links to further information and resources on the Eye Care Hub are included throughout including Eyecare Digital Playbook which has been developed in partnership with many stakeholders.

The roadmap

The roadmap is made up of five opportunities to transform local systems, and four principles for scaling up good practice. If all elements of the roadmap are implemented nationally, there is potential to avoid more than 2.3 million traditional face-to-face hospital ophthalmology outpatient appointments.

We welcome feedback on this roadmap and all supporting resources. We encourage local systems to share successes and learning opportunities on the Eye Care Hub. Register at https://future.nhs.uk/ecdc/joingroup.

See table 1 below for a breakdown of how the actions in this roadmap may help avoid unnecessary referrals:

Table 1: Roadmap actions, results and timescales

Roadmap actions	Estimated changes to referrals[1]	Implementation timescales
Implement integrated eye care pathways across primary, secondary and community care	**Cataract:** Up to 85% of all cataract surgery suitable for follow up in the community and potential for a 20% reduction in referrals for those not suitable for surgery.	Medium-term, approx 3-9 months *(If transformation resource is scarce focus on one or more sub-specialties initially)*
	Glaucoma: Up to 50% of all glaucoma follow up patients and 30% avoidance of false positive new patient referrals.	
	Medical Retina: Up to 50% of all AMD & DMO follow up patients and 30% avoidance of false positive new patient referrals.	
	Urgent care: Up to 50% of all urgent referrals managed in community.	
Implement risk stratification and failsafe processes to reduce harm	Risk stratification on its own will not reduce face-to-face appointments. It enables services to direct patients to the most appropriate care within safe timescales.	Short term, approx 1-3 months
Implement remote consultations for all appointments where possible and safe	Remote consultations are a fundamental part of the eye care pathways. This could replace up to: 50% in Accident and Emergency; and 30% of face-to-face activity when combined with diagnostic clinics in other areas.	
Implement diagnostic clinics for all appointments where possible and safe	At least 30% of follow up medical retinal and glaucoma outpatient ophthalmology activity suitable for diagnostic only care, significantly more if combined with remote consultations.	
Implement patient-initiated follow up (PIFU) care	As PIFU is relatively new in ophthalmology we will share data from rapid adopters as soon as it is available.	

[1] Calculations based on evidence from NHS Digital ophthalmic annual outpatient activity; GIRFT report; NSC; Case studies from High Impact Interventions, Eyes Wise;

Opportunities and principles

Five opportunities to transform local systems:

1. Implement integrated care pathways across primary,[2] secondary and community[3] eye care.
2. Implement risk stratification and failsafe processes to reduce harm.
3. Implement remote consultations for all appointments where appropriate, possible and safe.
4. Implement diagnostic clinics for all appointments where appropriate, possible and safe.
5. Implement patient-initiated follow up (PIFU) care.

To support and optimise these five opportunities, collaborative working between regional and local operational and transformation leads will be crucial. Working across local systems and through national networks, leads should tailor the implementation of these five opportunities to local needs while minimising unwarranted variation.

Support is available from the Eye Care Restoration and Transformation Project team and via the Eye Care hub on the FutureNHS community of practice.

Four key principles to scale up good practice:

1. Work collaboratively across local systems, working with patients, primary and secondary care providers, clinicians, local eye health networks (LEHNs) and commissioners to implement change.
2. Use existing commissioning levers.
3. Continue to use digital enablers at scale.

[2] Primary care services provide the first point of contact in the healthcare system, acting as the 'front door' of the NHS. Primary care includes general practice, community pharmacy, dental, and optometry eye health services.
[3] In this document, community eye care is distinct from primary and refers to multidisciplinary outpatient and day case care delivered in community settings. This covers both community eye services as defined by the Clinical Council for Eye Health Commissioning (CCEHC) and hospital eye services delivered in a non-acute hospital community setting, such as a community hospital, clinical or hub.

4. Work with patients to give them more control and choice over how and when they access care.

Equality impact assessment

This roadmap sets out two key changes for NHS eye care systems to adopt: more eye care in primary care and community settings; and more outpatient appointments supported by technology. Local systems need to adapt this roadmap to meet the needs of their population ensuring that they:

- engage and co-design changes with users, patients and the public
- ensure services are as inclusive as possible and meet the needs of all sections of the population.

NHS Digital has developed resources to support health and social care teams develop digitally inclusive services. Local systems should complete an equality impact assessment to inform local implementation plans.

Implement integrated eye care pathways across primary, secondary and community care

Five integrated eye care pathways and supporting resources have been developed by national stakeholders. The pathways, national specification and example protocols, together with the existing COVID-19 urgent eye care service (CUES) pathway, provide a template that local systems should exploit to use capacity differently. Where successful integrated eye care pathways already exist, local systems should build on these to deliver a whole-system integrated eye care service which utilises all six opportunities to meet the needs of their patients.

Full implementation of end-to-end pathways will take significant local commitment and resource, but this will reap the maximum benefit. If resource is limited, start by implementation for a single sub-specialty or commissioning CUES in the first instance.

CUES pathway

The CUES pathway supports safe, local, urgent eye care in the context of COVID-19. It reduces the need for patients to attend their GP surgery, A&E or hospital eye departments by using existing primary care optometry resources. This is helping providers to maintain and restore capacity in England.[4] By the end of July 2020, 73% of CCGs had commissioned an urgent eye care service from primary care optical practices.

Effective communication and collaborative leadership are driving the implementation of CUES. Supporting resources have been developed for CCGs to commission, implement and spread the service. Early results have been positive: initial impact data collected in Greater Manchester have shown that >80% of urgent eye care patients were able to be treated within the CUES and avoided a hospital appointment or contact with the GP.

[4] Desai P, Parkins D & Richmond Z. A catalyst for change. Eye 2020. https://doi.org/10.1038/s41433-020-01176-4

Cataract, medical retina and glaucoma pathways

Together with CUES and the minor eye conditions service (MECS), the cataract, medical retina and glaucoma pathways deliver a robust and integrated whole eye care system, sharing care across primary and secondary eye care professionals, at integrated care system (ICS) level. They follow The College of Optometrists and Royal College of Ophthalmologists (RCOphth) Joint Vision 2020, and incorporate national guidelines – eg NICE, existing Local optical committee support unit (LOCSU) care pathways and the System and Assurance Framework for Eye Health and Care (SAFE) from the Clinical Council for Eye Health Commissioning (CCEHC).

The National outpatient transformation programme (NOTP) eye care restoration (ECR) service specification is designed to underpin implementation of the pathways. The specification supports eye care systems to agree plans that incorporate:

- referral filtering and co-management
- advice and guidance delivered by ophthalmologists and specialist non-medical clinicians including higher qualification optometrists
- triage to the most appropriate clinician / setting
- remote consultation and diagnostic clinics
- risk stratification and patient prioritisation.

Why implement the cataract, medical retina and glaucoma pathways?

Full implementation of these pathways could result in >2.3 million appointments (>25% of ophthalmology outpatient activity) being conducted by means other than traditional face-to-face attendances in hospital settings.[5]

The pathways increase opportunities for integrated and collaborative services across primary care optical providers, community diagnostic and treatment hubs and hospital eye services. They free up hospital capacity and enable the whole eye care system to reduce the volume of the ophthalmology backlogs and unsafe

[5] Calculations based on evidence from NHS Digital ophthalmic annual outpatient activity; GIRFT report; case studies from High Impact Interventions, Eyes Wise; published scientific papers; established integrated eye care pathways; and expert clinical consensus. See Eye Care Hub for more details on evidence base for eye care opportunities.

delays. They use the established primary care workforce in optical practices to provide the first line response for people presenting with eyecare needs.

Patients can have a consultation and receive treatment or advice without the need to be seen in the hospital eye service. Patients who do need a referral can attend the most appropriate service, thereby reducing duplication of appointments. People requiring long-term, low-complexity care can have an alternative to the hospital, either in primary care optical practices or through high volume diagnostic clinics and non-medically led pathways in community diagnostic and treatment hubs.

How to support implementation

ICS leads should:

- Review the CCEHC SAFE frameworks to understand service structure for organisation and delivery of integrated eye care services at system level.
- Review the ECR service specification and share the pathways, specification and protocols with local stakeholders.
- Complete a gap analysis of current services to identify early opportunities for change.
- Bring together commissioners and patients/users, providers and professionals from primary and secondary care, local optical committees (LOCs) and LEHNs to steer change. The Transforming Elective Care Services: Ophthalmology handbook is a useful resource.
- Use the Joint Vision 2020 to set up effective local clinical leadership that is multidisciplinary, collaborative, and includes a focus on clinical governance, risk management and clinical audit.
- Assess workforce needs and current capabilities and build a local eye care workforce development plan based on this assessment.
- Assess current digital connectivity to see whether there is the capability to communicate and share clinical information between providers and professionals in primary and secondary eye care and develop a local digital connectivity development plan based on this assessment.
- Develop a funding and commissioning plan to implement change.

Primary, community and secondary care providers should:

- Review the CCEHC SAFE frameworks to understand service structure for organisation and delivery of integrated eye care services at system level.
- Engage with local system leaders such as NHS commissioners, LEHNs and LOCs as well as patients and the public, and support clinical leaders to implement the pathways with local leads.
- Work with ICS leads on digital connectivity, making the internal changes required to support connectivity across the eye care system.
- Review the NOTP ECR service specification and adopt and adapt where necessary.
- Consider how senior and specialist clinicians from all eye care professions can offer support for upskilling, peer support and learning, training and advice and guidance to the multi-disciplinary secondary and primary eye care teams.
- Establish a rapid, reliable and accessible route for advice and guidance from senior optometric, other non-medical specialist clinician, ophthalmic and consultant staff, incorporated into job plans.
- Develop robust feedback mechanisms between hospital providers and referring primary care clinicians including optometrists.

Implement risk stratification and failsafe processes to reduce harm

COVID-19 IPC measures, combined with pre-existing and lockdown-related backlogs in hospitals, has resulted in significant delays for care at all levels of the system.

Risk stratification ensures that systems review the backlog of patients to agree when and how to follow up each patient. A simple risk stratification process enables patients and patient populations to be categorised into high, medium and low risk of harm groups. Failsafe processes including failsafe officers ensure specific actions are taken to prevent and reduce avoidable harm to individual patients and patient groups.

Clinical teams should:

- Identify patients at highest risk of losing their sight and plan capacity to allocate a clinically appropriate follow up date and modality (eg remote, diagnostic, shared care, etc).
- Assess whether the lowest risk patients are appropriate to discharge to primary care.
- Keep patients informed about their individual level of risk and plans for care, including ensuring care modality is suitable, safe and appropriate for that patient's needs. Ensure there are communication channels for patients to discuss this with clinicians as required.

Systems should identify the risk level of patients at each care point (as risks change over time), record the decision in patient records and administration systems and have mechanisms to keep each patient informed.

The Risk Stratification and Prioritisation Toolkit for eye care services supports implementation of risk stratification processes.

Assessing risk management and safety

Each local system should use the following questions to assess whether their eye care risk management and failsafe processes are robust and consistent. Where gaps are identified, local systems should develop a co-ordinated, system-wide plan to reduce harm for all patients with ophthalmic conditions, starting with the highest clinical risk categories.

Key questions:

1. Is there an agreed clinical risk stratification system (based on RCOphth guidance) used to classify and record patients as low, medium and high risk, and to direct patients to the suitable care model within a clinically acceptable time scale?

2. Is there an agreed, straightforward local tool used to prioritise cataract surgery risks and benefits against COVID-19 risks (based on RCOphth guidance)?

3. Is the service using consistent grading recommended by the RCOphth (1-4, with 4 being the most complex or time-consuming) for all cataract surgery patients?

4. Is the service using GLAUC-STRAT-FAST to rate and record risk and complexity in all patients with glaucoma and glaucoma-related conditions?

5. Is there an urgent eye care/CUES risk assessment tool for referral and triage?

6. Is there a written eye care failsafe policy or protocol applicable to all providers/across the system for high risk patients?

7. Are there failsafe officers for glaucoma, retina conditions and other high-risk conditions in all relevant providers and integrated across the system?

8. Is there a high level of direct consultant supervision and input into clinical decision-making to support risk stratification, prioritisation and discharge?

How to support implementation

ICS leads should:

- Develop system-wide plans to make optimal use of all eye care resources at the system level. This process should involve commissioners, LEHNs, NHS hospital providers, LOCs, community ophthalmology services, community diagnostic and treatment hubs and the independent sector.
- Implement an agreed risk stratification process across the system based on national guidance (RCOphth). This should apply to every patient at each interaction, as risks change over time. Ensure providers develop processes and policies to review, record and act on the results of risk stratification and prioritisation.
- Ensure a written eye care failsafe policy or protocol for all secondary care providers. Develop a written eye care failsafe policy or protocol for the whole integrated eye care pathway with all stakeholders, incorporating integrated failsafe officer functions for the system.
- Ensure that all hospital eye services can report compliance with the RCOphth/Portfolio of Indicators for Eye Health and Care data on delays and risk as set out in the NHS Operational Planning and Contracting Guidance 2020/21 (page 15).
- Ensure all relevant providers have eye clinical liaison officers with easy access to patient advice and counselling services throughout the pathway.

Primary, community and secondary care providers should:

- Record patients' risk (low medium, high), the diagnosis or subspecialty (if possible) and prioritisation, and any decisions to delay (with reasons) in patient records and on patient administration systems, and keep patients informed.
- Risk stratify individual patients based on referrals, clinical records for those already receiving care (especially delayed patients, ie a backlog of follow ups), and after every clinical interaction to inform decisions on:
  - discharge or need for ongoing care/intervention
  - timing
  - professional
  - setting
  - modality/suitability for new models of care.

- Record the clinically desired/safe follow up date (for hospital providers using the earliest clinically appropriate date [ECAD] field on PAS) and use to calculate compliance with the RCOphth/Portfolio of Indicators for Eye Health and Care 25% delay indicator. Use for failsafe processes and to report safety performance internally and at system level.
- Have failsafe officers and processes, integrated with the system-wide failsafe process.
- Provide eye clinic liaison officers (ECLOs) and easy access to patient advice and counselling services throughout the pathway.

Implement remote consultations for all patients where appropriate, possible and safe

Remote consultations can take place via telephone, video (via smartphone, tablet or webcam) or electronic chat/messaging/email function. Medications can also be prescribed remotely. This allows patients seen remotely to obtain their medications, especially if a change in medication (or new medication) is required.

Remote prescribing also allows ophthalmologists and independent prescriber optometrists to support non-prescribing healthcare professionals in providing a wider range of care in their practice or community settings as part of CUES and other integrated eye care pathways. Refer to the Remote Consultation Toolkit for further guidance on implementation.

When to use remote consultations?

Eye care providers should use remote consultations where possible. They are particularly suitable for:

- Urgent, children's and adnexal (eyelid, tear system and orbital) conditions.
- Conditions or situations which do not require an ophthalmic examination or where the necessary clinical data are already available.

- Non-clinical interactions (eg counselling and support services).
- Patients who have travelling or access difficulties, and for those who are at higher risk of, or have active, COVID-19 infection.

There are situations where eye care patients will need a face-to-face appointment. Where this is the case, eye care providers should use remote consultation for triage prior to a face-to-face appointment, or after a diagnostic (investigation-only) appointment.

Situations where patients require a face-to-face appointment include:

- Patients with very urgent high-risk sight or life-threatening condition.
- Patients who need a detailed examination or an internal examination, eg intraocular pressure or fundus examination.
- Patients who require a physical intervention, eg removal of suture or injection of ocular medication.
- When data is required from an investigation, eg optical coherence tomography (OCT), or examination by a non-medical clinician, eg orthoptist. In such cases, a remote consultation can follow to review the data and agree the management plan.

How to support implementation

ICS leads should:

- Ensure that video, telephone or online remote consultation is part of the wider system of eye care triage, prioritisation and care delivery, and use it when there is low risk of impact to patient safety and outcomes.
- Support development of consistent system-wide criteria and risk assessment processes to direct suitable individual patients and patient cohorts to remote consultations.
- Support the planning of, and access to, appropriate technology for eye care providers.
- Develop and implement plans to address digital exclusion, accessibility and safeguarding issues to ensure equality of access to care.

- Lead a system-wide patient communication and engagement strategy to reassure patients about the effectiveness and desirability of remote eye care consultations.
- Ensure that patients undergoing remote consultations have access to patient support, counselling, assessments on medication use and sight loss issues, and health promotion.

Primary, community and secondary care providers should:

- Implement risk-based processes to ensure 'remote first' for all suitable eye care patients.
- Ensure all secondary care patients, including new referrals and those already receiving ophthalmic care, have a regular records review by a senior clinician supported by administrative validation processes, to determine risk and priority for next appointment and suitability for video or telephone consultation prior to or instead of a face-to-face appointment.
- Develop and share workforce plans to ensure sustainable remote care delivery:
  - Job plans to include rostering for remote care sessions.
  - Consider establishing a specific staff focus and shared training in this area, including doctors and the wider workforce of specialist and advanced practice nurses, optometrists and orthoptists, dispensing opticians and contact lens opticians.
  - Deploy higher-risk or shielding staff groups and recently returning retired staff to deliver remote consultation care from outside the provider settings.
- Ensure there is a robust method to provide patient information, support, counselling and assessments (eg for drop compliance or medication issues or sight loss support) for patients on a remote consultation pathway including access to ECLO services.

Implement diagnostic clinics for all appointments where appropriate, possible and safe

In ophthalmology, a diagnostic clinic is defined as one in which the face-to-face clinician consultation is removed but the face-to-face diagnostic test still occurs. Trained technicians or non-medical healthcare professionals undertake the diagnostic tests. Data and/or images are then reviewed either synchronously (same time) or asynchronously (another time) by a clinician decision-maker.

Data transfer enables virtual working across primary and secondary care locations, and across a range of functions such as advice and guidance, referral refinement, monitoring and shared care.

Refer to the Diagnostic Clinic Toolkit for further guidance on implementation.

Why implement diagnostic clinics?

Diagnostic clinics have been successfully implemented in ophthalmology prior to COVID-19. Increasing the use of diagnostic clinics helps reduce unsafe delays and provide more sustainable eye care services.

Clinical diagnostic assessments can take place in 'green' COVID-19 low-risk settings, and patient journey times can be reduced, protecting patients and staff from COVID-19 exposure. Patients with glaucoma and retinal conditions in particular are highly suitable for diagnostic clinics (GIRFT, The Way Forward Medical Retina, RCOphth virtual glaucoma clinics).

How to support implementation

ICS leads should:

- Ensure that diagnostic clinics are part of the wider system of eye care triage, prioritisation and care delivery, and use them when there is low risk to patient safety and outcomes.

- Support agreement of consistent system-wide criteria and risk assessment processes to decide whether a diagnostic clinic is suitable for individual patients and patient cohorts, and which patients will benefit most. That is, consider the cohorts of patients most likely to be fully managed remotely against patients who may require a remote attendance followed by a face-to-face appointment which could increase the number of attendances.
- Support identification or development of appropriate diagnostic clinic locations, including in primary care optical practices, or in community hub settings, which are suitably configured to allow efficient flow and reduced waiting times.
- Support the planning of, and access to, appropriate connected technology, electronic patient record and admin systems and diagnostic equipment for providers.
- Support system-wide protocols and guidelines for diagnostic clinics including eye care diagnostic bundles and diagnostic quality criteria.
- Ensure that care delivers an equitable service and meets accessibility requirements.
- Lead a system-wide public and patient communication and engagement strategy about the safety and desirability of diagnostic clinics.
- Support workforce planning for delivery across the system.
- Ensure that patients undergoing diagnostic clinic have access to patient support, counselling, assessments on medication use and sight loss issues, and health promotion.

Primary, community and secondary care providers should:

- Identify accessible sites in primary care, and in suitably configured (for efficient high flow) hospital and community sites, equipped with appropriate diagnostic equipment and networked to deliver diagnostic clinics.
- Ensure that appropriate IT systems such as electronic patient records and admin systems can integrate or communicate data across the system as required.
- Implement risk-based processes to ensure remote first for all suitable eye care patients; consider supplementing with a video consultation if discussion or consultation is required after the diagnostic appointment.

- Ensure all secondary care patients, including new referrals and those already receiving ophthalmic care, have a regular records review by a senior clinician supported by administrative validation processes to determine risk and priority for next appointment and consider diagnostic triage or diagnostic assessment prior to any face-to-face appointment.
- Map, develop and share workforce plans for sustainable diagnostic clinic care delivery:
  - Job plans to include rostered sessions for diagnostic clinics and reporting for clinical decision-makers including, where relevant, for advice and guidance and urgent assessments.
  - Consider establishing a specific staff focus and joint training in this area, including doctors and the wider workforce including specialist or advanced practice nurses, optometrists and orthoptists as clinical decision makers.
  - Ensure sufficient support staff and appropriately skilled professionals to achieve high quality diagnostic data and imaging collection.
  - Deploy higher-risk or shielding staff groups and recently returning retired staff to deliver diagnostic clinics from outside provider settings.
- Ensure routes for rapid access to senior decision-maker opinions for urgent and higher risk conditions.
- Ensure appropriate detail on the outcomes/decisions from the clinic (including discharge summaries and letters) are provided to primary care optometrists, GPs and other relevant professionals and to patients.
- Ensure there is a robust method to provide patient information, support, counselling and assessments (eg for drop compliance or medication issues or sight loss support) for patients on a diagnostic clinic pathway including access to ECLO services.

Implement patient-initiated follow up care

Patient-initiated follow up (PIFU) in isolation is not suitable for chronic ophthalmic conditions where symptoms are not enough for patients to detect change or deterioration, such as glaucoma or active retinal conditions, but may have a role for these conditions if used in conjunction with timed follow ups.

PIFU as part of the wider suite of interventions in this roadmap should support providers to manage demand and allow patients (or their carers) to initiate a follow up appointment when they need it without the need for automatic recall. PIFU is an important tool to support the personalised care agenda and supported self-management. Further resources on PIFU can be found on the PIFU FutureNHS page.

We know there are a small number of providers who have experience of implementing PIFU in ophthalmology. We will share examples of best practice on the Eye Care Hub as we work with providers to rapidly implement PIFU and share locally developed resources to support its adoption.

Many eye hospitals already offer PIFU-like access for their urgent care patients and long-term patients who experience flare-ups in their condition. Formally identifying and recording these patients as on a PIFU pathway in admin systems will increase the evidence base to support the role of PIFU in eye care.

Table 2: Conditions where PIFU in isolation could be appropriate (not exhaustive)

Refractive change following a sight test	Patients who wear spectacles or contact lens should be encouraged to re-present if they notice any change in vision.
Conditions that flare up intermittently. Patients are seen when needed rather than at an arbitrary time:	Blepharitis, dry eye, allergic eye disease, inflammatory external eye disease and recurrent iritis (anterior uveitis). In the paediatric population chalazion and acute conjunctivitis.

Conditions which are not currently sight threatening but may develop a symptomatic problem in the future (normally an urgent appointment):	Posterior vitreous detachment, dry or treated and stable wet macular degeneration and post-operatively after cataract, oculoplastic or squint surgery.
Conditions which are stable or slowly progressive and the patient does not currently want treatment:	Epiphora (watery eye), ectropion (out turned eyelid), cataract, squint and genetic eye conditions.

A wider range of conditions may be manageable with PIFU in conjunction with a minimum frequency of booked appointments. For all patients on a PIFU pathway it is important that clinical professionals define and record in patient administration and clinical record systems:

- how long a patient should remain on PIFU
- any minimum frequency of booked appointments
- what happens at the end of the PIFU pathway eg clinical review appointment or discharge
- take into account any vulnerabilities of the patient and address potential risks of health inequalities arising from this.

How to support implementation

ICS leads should:

- Ensure PIFU is part of the wider system of eye care triage, risk assessment, prioritisation and care delivery, and use it when it is suitable and there is low risk to patient safety and outcomes.
- Support implementation of consistent system-wide eye care criteria and risk assessment processes to decide whether PIFU is suitable for individual patients and patient cohorts.
- Support system-wide availability of eye care patient information, support and self-management resources.
- Support plans to ensure PIFU does not affect equality or accessibility.
- Lead a system-wide eye care patient communication and engagement strategy around the safety and benefits of PIFU in eye care.

- Ensure patients undergoing PIFU have access to patient support, counselling, assessments on medication use and sight loss issues, access to ECLO services and health promotion.

Primary, community and secondary care providers should:

- Develop and agree local eye care guidance, criteria and protocols which set out when to use PIFU and when not; including non-ophthalmic criteria, eg low health literacy or poor access to technology. Some general guidance is given in the phase 3 implementation document.
- Ensure choice of PIFU is supported by risk stratification, and implement safety nets for patients, including failsafe mechanisms for those needing further appointments.
- Consider supporting with home monitoring tools and the ability to obtain virtual opinion on results.
- Consider combining PIFU with booked remote or face-to-face consultations in primary care, community or hospital to expand suitability for more patients.
- Develop, in conjunction with the system, excellent patient information, support and self-management resources.
- Ensure patients have information on how to book a follow up directly with the service, and how long this will apply for with a simple and accessible system to book an appointment eg a patient portal.
- Ensure simple and accessible access to clinician advice and support.
- Agree mechanisms to record and flag (including to primary care) that a patient is on a PIFU pathway, and to record the length of time for the PIFU and the action at the end of the PIFU pathway; eg a discharge or further appointment at the end of the defined follow up time period.
- Audit patients on a PIFU pathway to understand what prompts a further appointment, so as to continually improve the pathway.
- Develop mechanisms for capturing patient feedback on PIFU.
- Monitor clinical outcomes for patients on PIFU pathways.
- Monitor the proportion of service caseload for patients moved to PIFU, the proportion who initiate an appointment and the reduction in total appointments PIFU leads to.

Annex 1: Key benefits of implementation

Benefit Measure	Pathways	Risk	Remote	DC	PIFU
Patients					
Improved patient convenience.	✓		✓	✓	✓
Improved personalised care (including shared decision-making and self-management).	✓	✓	✓	✓	✓
Identifies those who need failsafe processes or immediate direct action	✓	✓			
Minimises face-to-face exposure between the patient and healthcare worker to protect patients, public and staff including vulnerable patients who are self-isolating or shielding	✓		✓	✓	✓
Avoids long waits for care	✓		✓	✓	✓
Reduces carbon emissions and travel time and expense for the patient	✓		✓		✓
Reduces patients' time spent in healthcare settings and utilises low COVID settings	✓		✓	✓	✓
Access to diagnostics and management closer to home in community and primary care	✓		✓	✓	
Improves patient experience and satisfaction	✓		✓	✓	✓
Strengthens trust between patient and professionals	✓	✓			✓
Frees up patient's time and reduces unnecessary travel	✓		✓		✓
Allows clinicians and patients to agree 'what if' scenarios and plan accordingly	✓	✓	✓		✓
Empowers patients to take more control of their care (including self-management) and book an appointment when they need it	✓	✓			✓
Eye Care System					
Improved collaborative working, clinical relationships and system. effectiveness.	✓	✓			
Optimal use of resources and available capacity	✓	✓	✓	✓	✓
Safe, high quality service with reduction in unwarranted variation	✓	✓			
Better use of the primary care optometric and optical workforce, equipment and estate	✓	✓		✓	✓
Better use of technical staff and wider workforce	✓	✓	✓	✓	
Reduced number of eye-related GP appointments	✓				
Improved referral quality and referral appropriateness with a reduction in inappropriate referrals and first appointment discharge rates	✓	✓			
Release hospital workforce and resources for more complex ophthalmic care	✓	✓	✓	✓	✓
Improved information sharing including feedback to the referrer in all cases	✓				
Build an evidence base at local and national level for long term transformation and cost effectiveness	✓	✓	✓	✓	✓
Provides data to support planning of delivery	✓	✓	✓	✓	✓
Allows regional teams to identify weak points in the system which need additional support and resources	✓	✓			
Operational Performance					
Reduced ophthalmology new patient waiting times	✓	✓	✓	✓	✓
Reduced number of ophthalmology hospital outpatient attendances	✓	✓	✓		✓
Reduced number of face-to-face hospital ophthalmology appointments	✓	✓	✓	✓	✓
Reduced ophthalmology follow up delays	✓	✓	✓	✓	✓
Protects patients from harm	✓	✓			
Identifies high-risk patients who need earlier appointments, face-to-face appointments, senior clinical reviews, or require more support	✓	✓			
Identifies lower risk patients who need less urgent care, can receive their care through remote or video assessments, and/or in the community, primary care or be discharged	✓	✓	✓	✓	✓

Benefit Measure	Pathways	Risk	Remote	DC	PIFU
Increases capacity for high risk patients who need face-to-face assessment	✓	✓	✓	✓	✓
Allows staff who are at COVID risk, self-isolating or shielding to continue to deliver care from non-clinical areas or home	✓		✓		
Greater flexibility in scheduling appointment times	✓		✓	✓	✓
Improves use of in-hospital space and resources, and more use of primary and community space and resources, to increase eye care capacity	✓	✓	✓	✓	✓
Flexibility in job planning, with clinicians able to deliver care from non-clinical areas	✓		✓	✓	
Reduces did not attend (DNA) rates	✓		✓	✓	✓
Maximises the use of clinical capacity to follow up patients with chronic eye conditions	✓	✓	✓	✓	✓
Maximises the use of clinical capacity to follow up patients with chronic eye conditions	✓	✓	✓	✓	✓
Quality of Care					
Improved outcomes of care through timely appointments	✓	✓	✓	✓	✓
Reduced duplication of care	✓				
Reduced ophthalmology associated harm events	✓	✓	✓	✓	
Easy access to advice and guidance and second opinion for quality assurance	✓			✓	
Use of standardised electronic clinical data and images supports longer-term eye care service transformation through automation and AI	✓		✓	✓	

Annex 2: Key metrics to measure performance, quality and safety by provider and across the whole system

Metric	Pathways	Risk	Remote	DC	PIFU
Quantitative outcome measures					
Reduction in the number of face-to-face appointments	✓	✓	✓	✓	✓
Reduction in eye related GP appointments	✓	✓	✓	✓	✓
% follow up face-to-face appointments for non-face-to-face care within 1 month	✓	✓	✓	✓	✓
% potential duplication of care (eg seen by optometrist and later need to attend hospital)	✓	✓	✓	✓	✓
False positive rate at HES (% patients discharged after first hospital attendance)	✓	✓	✓	✓	✓
Reduction in ophthalmology new patient waiting times (to attendance, first treatment, procedure)	✓	✓	✓	✓	✓
Number of new patients delayed (new backlog)	✓	✓	✓	✓	✓
Outcome of Diagnostic Clinic review (eg discharge to community/referred to follow up)				✓	
Quality assurance audit of images eg how many Diagnostic Clinic assessments not successful due to poor quality images				✓	
Quantitative process measures					
Numbers and % of patients seen (activity), total and broken down into: • Face-to-face • Diagnostic Clinic • Remote • PIFU • Optometry commissioned	✓	✓	✓	✓	✓
Numbers of referrals	✓	✓	✓	✓	✓
Numbers of Advice and Guidance	✓	✓	✓	✓	✓
100% feedback on referrals to primary care optometrists	✓	✓	✓	✓	✓
100% letter and outcome information to patients after every interaction	✓	✓	✓	✓	✓
Outcome of all attendances and clinical interactions (treatment /referral/discharge/follow up) recorded total and broken down into: • Face-to-face • Diagnostic Clinic • Remote • PIFU • Optometry commissioned	✓	✓	✓	✓	✓
Do not attend (DNA) rates	✓	✓	✓	✓	✓
Number and % patients with ophthalmic risk (high, medium, low) recorded		✓			
Number and % patients with diagnosis/subspecialty code recorded		✓			
Number and % completion of patient data on clinically desired follow up date for follow up patients (ECAD field submitted to NHS Digital if hospital provider)		✓			
Number and % completion of patient data on compliance with Portfolio of Eye Health Indicators 25% delay target		✓			
Number / % of advice and guidance supported by diagnostic assessment				✓	
Number of patients reviewed per diagnostic clinic session (& comparison with traditional face-to-face session)				✓	
Time spent reviewing diagnostic clinic results by specialist clinician				✓	
Number of practices/other community settings involved in diagnostic clinics				✓	
Costs of delivery vs traditional hospital face-to-face care	✓		✓	✓	✓

Metric	Pathways	Risk	Remote	DC	PIFU
Number and % cataract surgery referrals and assessments with COVID-19 prioritisation tool or risk factor data completed		✓			
Number and % cataract surgery operations where grading 1-4 completed		✓			
Number and % cataract operations at each grade		✓			
Number and % glaucoma interactions with GLAUC-STRAT FAST risk grading completed		✓			
Safety					
Incidents of inappropriate care	✓	✓	✓	✓	✓
Serious incidents	✓	✓	✓	✓	✓
False negatives ie cases missed later detected	✓	✓	✓	✓	✓
Incidents of missed pathology or inappropriate care specifically due to non-face-to-face modality			✓	✓	✓
Ophthalmology follow up delays (Portfolio of Eye Health Indicators 25% indicator): • numbers overdue (follow up backlog) • % compliance	✓	✓	✓	✓	✓
Numbers lost to follow up	✓	✓	✓	✓	✓
Evidence of adherence to key national guidance eg NICE, RCOphth	✓	✓	✓	✓	✓
Adherence to local clinical protocols	✓	✓	✓	✓	✓
Patient and staff focus					
Friends and family test	✓	✓	✓	✓	✓
Patient feedback	✓	✓	✓	✓	✓
Complaints	✓	✓	✓	✓	✓
Patient information and support provision as per NICE guidelines	✓	✓	✓	✓	✓
Staff feedback	✓	✓	✓	✓	✓
National NHS staff survey	✓	✓	✓	✓	✓
Numbers/% for patients failing to successfully access remote consultation			✓		
How many patients needed or asked for a face-to-face appointment instead of remote			✓		
How many patients needed or asked for a face-to-face appointment instead of a diagnostic clinic appointment				✓	

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