The NHS Eyecare Pathway Pilots

Eyecare Services Team
NHS Eyecare Pathway Pilots

• Part of NHS Improvement Plan:
  – To meet the changing needs of the population
  – To reduce waiting lists
  – To make better use of resources available
  – To provide a high quality patient centred service
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• Eyecare changes include:
  – Patient centred services with patient involvement
  – Reduced waiting times
  – Increased accessibility such provision within community settings
  – Increased choice
  – Better and more flexible use of resources such as utilising skills within primary care
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Some Reasons for change

• Population growth indicates that there will be increasing demands on the service:
  – 10% of the population is over 65, predicted to increase to 12.8% by 2025
  – highest incidence of eye disease is in this age group
  – number of people with visual impairment expected to double in the next 20 years
    (Taylor and Keefe, BJO, 2001)
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Some Reasons for change

- Increased demand on hospital Eyecare services
- Increased demand for refraction and refractive correction
- Increased demand on low vision and rehabilitation services
- Increased number of treatments available
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Some Reasons for change

- To remove barriers to eyecare
- To provide services where and when they can be easily accessed
- To increase awareness of the importance of eyecare
- To make better use of professionals
- To develop innovative partnerships, for example with the voluntary sector
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working with the voluntary sector

- Expertise in specific areas
- Understanding of patient’s needs
- Good source of patient information
- Able to work across traditional barriers
- Provision of advice and supporting services
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The National Eyecare Steering Group

• Set up by the Department of Health in 2002, with representatives of:
  – ophthalmologists
  – optometrists and dispensing opticians
  – orthoptists
  – ophthalmic nurses
  – patient organisations
  – policy organisations
  – social care
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The National Eyecare Steering Group

• Remit:
  – To develop proposals for improved eye care services
  – To develop model pathways for:
    • cataract
    • glaucoma
    • low vision
    • age related macular degeneration
  – Published report April 2004
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The National Eyecare Steering Group

• As part of £77m investment by the Government in the modernisation of eye care, £4m was dedicated to test the implementation of pathways for:
  – glaucoma
  – low vision
  – age related macular degeneration

• All pilots to be PCT led
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Pathway design principles

- Develop a patient-centred service, making better use of all resources
- Reduce the number of patient steps
- Increase and improve patient choice
- Demonstrate high standards of care
- Provide an evidence base to facilitate spread of good practice
- Commitment by PCT to sustain service
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Pathway objectives

• To provide services that meet the changing needs of the population
• To develop patients involvement
• To utilise of the skills available at community level - health, social care and the voluntary sector
• To provide a high quality patient centred service
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The pilot sites for glaucoma

• East Devon
• North Birmingham
• Peterborough
• Waltham Forest
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Glaucoma - some reasons for change:

• To reduce waiting for initial and follow-up appointments
• To release secondary care time to manage more complex glaucomas and other eye conditions
• To increase accessibility of services for patients - both times and location
• Reduce number of “false” referrals to secondary care
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Glaucoma pathway

**Proposed Glaucoma Pathway**

1. Patient attends community optometrist (CO)
   - Sight test, IOP over 21 (applanation tonometry) and/or visual field defect and/or excavated discs
   - Patient/optometrist makes appointment with optometrist with special interest in glaucoma (OSI) or OMP

2. Patient attends OSI or OMP
   - Full history and assessment carried out according to protocol
   - Decision taken as to whether patient has ocular hypertension (OSI/OMP reviews) or can be discharged (return to CO) or has glaucoma (treat or refer to HES)
   - Patient advised, given information etc and further appropriate appointments made if needed

3. OSI/OMP relays data to HES
   - HES reviews data, advises OSI/OMP regarding management and sets up review at HES if needed

4. OSI/OMP manages patient in community setting
   - Regular reviews set in place
   - OSI/OMP relay data to hospital if significant progression for HES review if needed

Start
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The pilot sites for AMD

- Brighton and Hove
- Waltham Forest
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AMD pathway - some reasons for change:

• Too many delays in the pathway
• For many patients, the community setting can give an improved service
• Rapid and accurate referral is needed for neovascular AMD
• Over referral can “clog” the system
• More patient support is needed
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AMD pathway

Proposed AMD Pathway

Start

1. Patient attends optometrist with special interest (OSI)
   - Differential diagnostic assessment, including full history, clinical examination, biomicroscopy and macular function
   - Patient has non-neovascular AMD
   - Patient has neovascular AMD - OSI refers directly to HES

2. Patient attends HES
   - Outpatient appointment with ophthalmologist*
   - AMD untreatable
   - AMD treatable
   (* fluorescien angiography and further investigation)

3. Patient attends HES
   - Access to treatment
   - Advice and information etc for patient

4. Fast access to integrated low vision services
   - Optical low vision services
   - Advice and information
   - Counselling
   - Social service support
   - Rehabilitation
   - Possible certification (CVI)

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The pilot sites for low vision

- Barking and Dagenham and Havering
- Gateshead
- Sutton and Merton with Wandsworth
- Waltham Forest
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Low Vision pathway sites

• Associate Sites:
  – Brighton and Hove
  – Hartlepool
  – Lincoln South and West
  – Northumberland

• Plus commissioning of RNIB to identify plant and nurture a further 5 sites to utilise, adapt and apply learning from other sites and have the ability to become associates
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Low vision - some reasons for change:

• Wide variation re access and quality
• Usually current referral is to secondary care for the service, often via GP
• Uni-disciplinary
• Lack of information and signposting
• Long waiting times
• Low Vision only after ophthalmological assessment
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Low vision pathway

Proposed Low Vision Pathway

Start

1. Patient referred to Low Vision Service (LVS)
   • Referral may be from secondary care, GP, social worker, rehabilitation officer, community nurse, OT etc or may be self-referral
   • Patient may have an LVL, RVI or CVI
   • All patients are contacted by LVS within 10 working days

2. Patient attends LVS
   • Service is seamless across health, social care and the voluntary sector
   • A full sight test forms part of assessment
   • Patient is given information on eye condition, entitlements etc as well as local services
   • Counselling/support available and advice on employment or education
   • Spectacles, LV aids, advice (esp. lighting, contrast and size) and home adaptations are discussed and made available as appropriate
   • Referral to other areas of health and social care as needed, including certification

3. Patient has follow up visits as needed
   • Visits may take place in the patient’s home or elsewhere
   • Visit will be by appropriate member of the LV team

Finish or service enables re-access

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Pathway implementation

• Pilots following the PRINCE 2 project management methodology to ensure that project objectives are fulfilled
• Pilots report progress on a regular basis
• Project managers work together
• Both internal and external evaluation has been established
• Fees/commercial issues resolved locally
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Initial actions by pilots:

• To appoint a project manager, project board and team

• To develop project plans including:
  – business
  – finance
  – risk log
  – lessons learnt log
  – establish measures
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Initial actions by pilots:

• Establish baseline measures
• Define current pathways, using techniques such as process mapping
• Engage service users
• Engage other key stakeholders e.g. local optometric committees, local voluntary support groups
• Define/review new pathway and targets
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Initial actions may also include:

- Seeking sites convenient to the community
- Scoping exercise to define need
- Establish clinical protocols
- Order equipment
- Keep everyone on board
- Establish audit/governance procedures
- Document everything
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Initial actions for training:

• Arrange training to agreed standards
• Engage local ophthalmologists in the training programme for optometrists and standards of skills to be achieved
• Ensure that training is inclusive:
  – multi-disciplinary approach
  – training is a “must” for all pilot participants
  – needs to be on-going
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Current pilot status:

• All pilots now seeing patients
  – first started as from December 2004
• Current stages
  – reflection and review of progress
  – on-going service improvement and modification
  – external evaluation under way
  – mainstreaming of services
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Lessons learnt to date:

• Ensure engagement of all stakeholders
• Identify a local champion
• Appoint a dedicated project manager
• Be familiar with finance arrangements of contracting bodies
• Allow additional time for building work
• Order equipment at an early stage
• Put training in place at an early stage
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Lessons learnt to date:

• Have contingency plans for high risk areas:
  – if it can go wrong, it will go wrong!
• Establish a good communication plan and be ready to promote the service
• Primary care providers, both dispensing opticians and optometrists have been keen to take part
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Lessons learnt to date:

• Expect scheme participants to need varying amounts of training
• Secondary care commitment essential
• Ensure that there is clear information available about the scheme to meet the needs of the people using the service
• IT always causes a problem! Be prepared to look for alternative solutions
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The future

• Emerging findings being shared from spring 2005 and the new eyecare pathways promoted
• Pilot stage will end in summer of 2006
• Full evaluation will be completed by autumn 2006, with conference in June
• This will be used to influence delivery of sustainable local services
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• Principles of modernisation:

  Review, revision, reflection and recognition:
  • Utilising NHS modernisation tools and techniques to review progress and amend accordingly
  • Ensure continued engagement in period of further structural change within NHS
  • Ongoing recognition, of the skills of the full range of professional groups
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• Sharing and promoting
  – National Programme facilitating process to share with national and local bodies - but sometimes access is difficult – any ideas welcome!
  – Contributed to the RNIB Glaucoma Roadshows
  – Communities of Practice database
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• Sharing and promoting
  – National conference 7 & 8 June 2006
  – Seeking opportunities to meet with and share outcomes, learning and implementation ideas with:
    • Health, Social Care, Voluntary Sector organisations
    • Professional groups/organisations
  – Emerging findings, local highlight reports to be posted on our new website:
    www.eyecare.nhs.uk
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