New Pathways to Drive Elective Recovery and Better Care…*insights from the last 12 months in England*

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National Eyecare Recovery and Transformation

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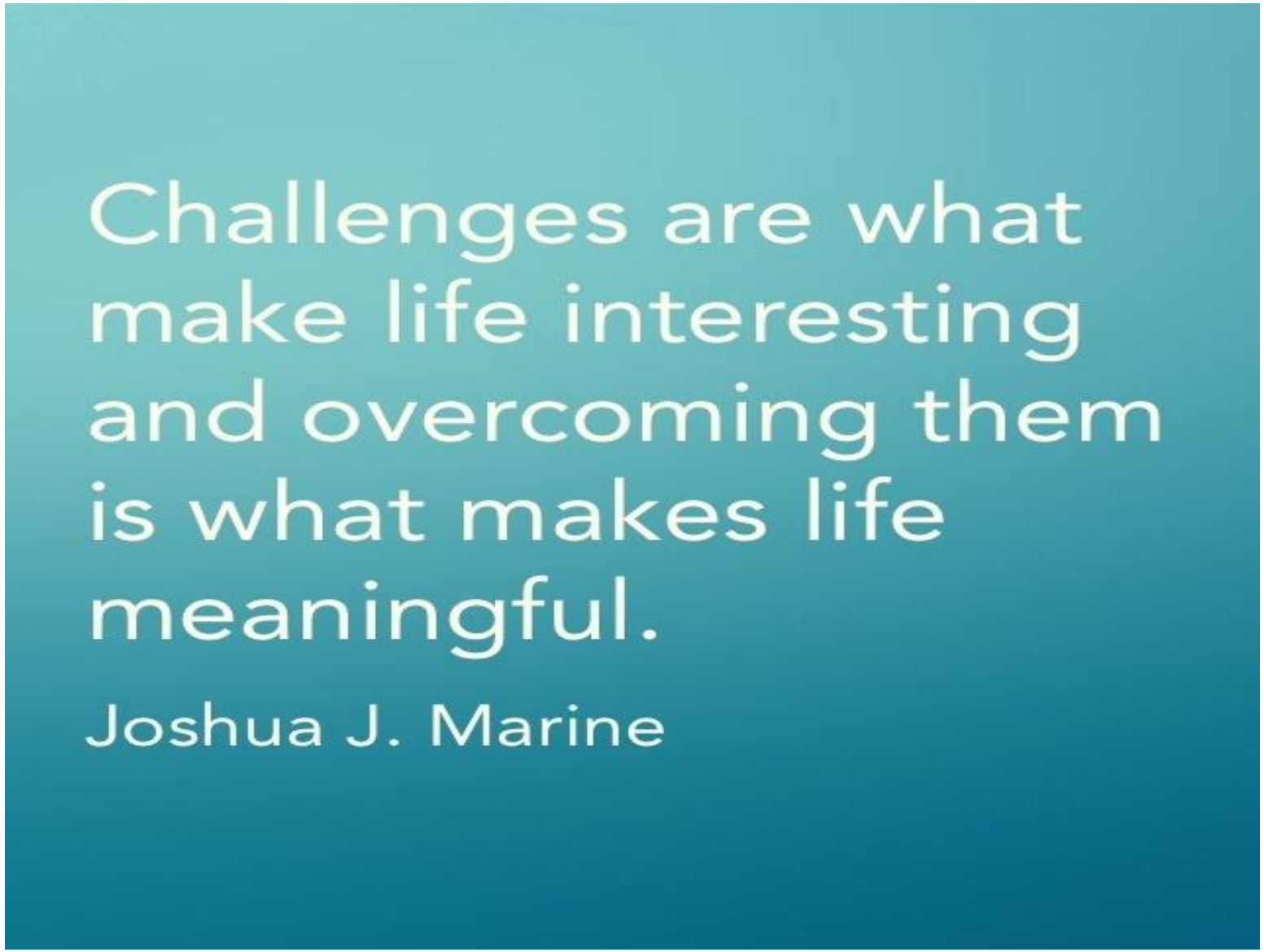


The Context

- Reduced Elective Capacity through Covid (and beyond)
- Growing waiting times and lists
- Workforce issues
- Huge variation in delivery and practice
- Growing Political expectation

The Hypothesis or Approach

- *Improve capacity (and outcomes) through removal of variation*

How

- Use of clinically led Pathways
- High Volume low complexity conditions
- Support implementation
- Monitor progress and variation

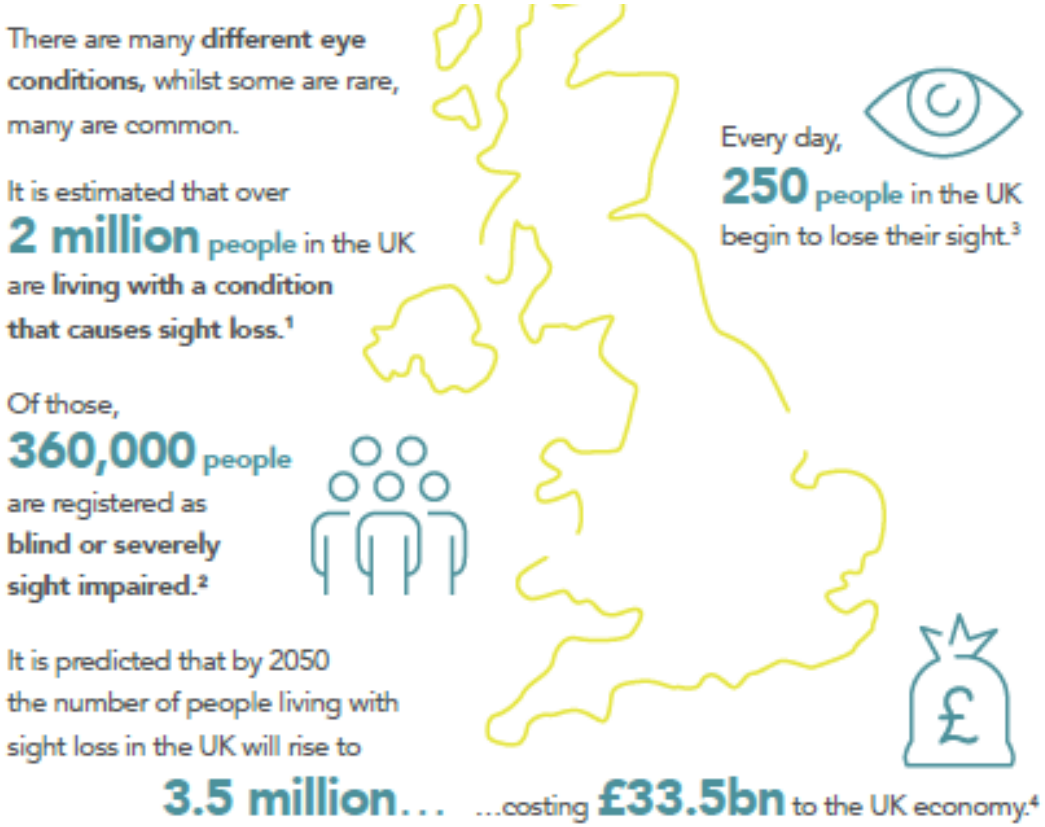
National Eye Care Recovery and Transformation Programme

John Ashcroft, Director of Pathway Improvement and Transformation

NHS England and NHS Improvement

Contents

Eyecare context



Eyecare:

- Is the highest volume outpatient specialty with 8m appointments in 2019/20.
- Has also the single highest volume surgical procedure in the NHS - cataracts; based on the latest available data approximately 540k cataracts will be performed over the next year (55% NHS, 45% IS).
- Costs are growing above NHS budget spend. In 2017/18 the NHS spent circa £2.65bn on eyecare services which rose to around £2.8bn (5.7% growth) in 2018/19.
- Underlying annual demand growth for eyecare services is approximately 2.5-3.8% and attendances are rising by 2.2% per year.

Objectives

Objective	How will we know it's working
Deliver already identified productivity benefits and activities needed to restore service and reduce backlog/waiting lists	▪ We have a measurable in-year impact on the key programme metrics, in particular the productivity and operational efficiencies
Create and deliver more radically transformed clinical eye care pathways enabled by digital and tech	▪ We have piloted and evaluated transformational changes in at least three, different ICSs ▪ We have received positive feedback from regions and ICSs that we've worked with in terms of the value add of the national team
Pilot a delivery /change model that ensures 30+ ICSs have implemented new clinical pathways and realised benefits **▪ Identify structural issues (e.g., commissioning models) and work with the relevant NHSEI policy leads to develop strategic solutions.**	▪ All ICSs have adopted the interventions outlined in the recovery planning letter ▪ A large proportion (30+) of ICSs have also adopted the more transformational models e.g., digital hubs, home care ▪ There is clarity around the role of national v regional v ICS in design and delivery of eye care transformation
Develop new ways of operating that combine the user centered iterative multi-disciplinary "digital/agile" way of working with the discipline of large programme management	▪ The senior leadership team feel they have sufficient grip of the programme and are able to be held accountable for delivery ▪ We view ourselves as one team and no longer discuss teams as 'X' and 'EI' ▪ We view our budgets & people resources as one, and no longer refer to 'X' and 'Improvement' budgets and people

Existing national programmes of work:

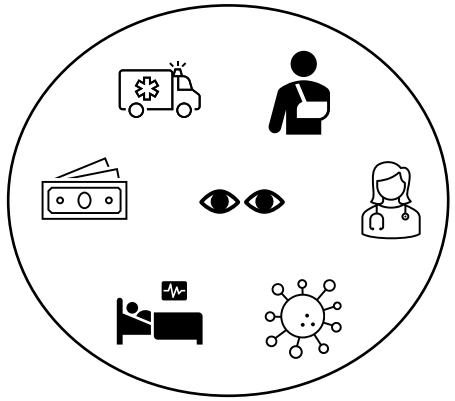
- National Outpatient Transformation Programme
- Getting It Right First Time (GIRFT)
- Digital projects (Optometry, Electronic Referral Service)

Different methodologies – waterfall + agile

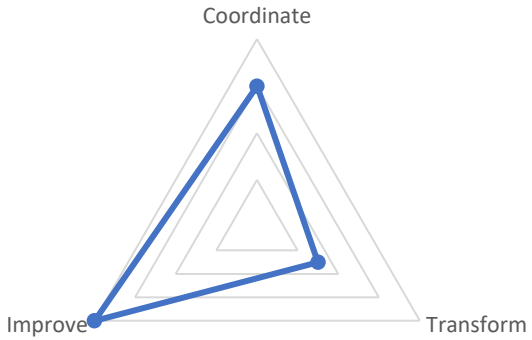
c.20 wte from improvement, digital and clinical backgrounds pulled into a single team

However

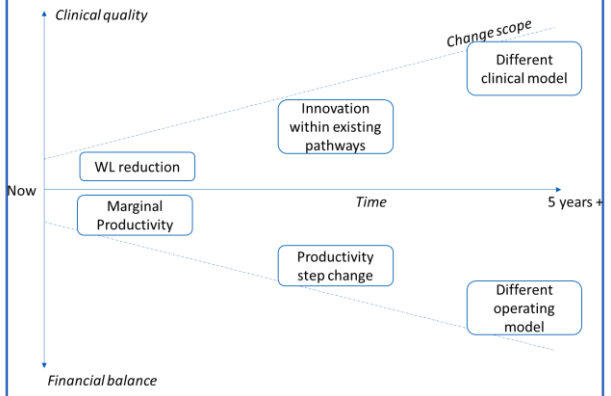
Competing organisation and system priorities



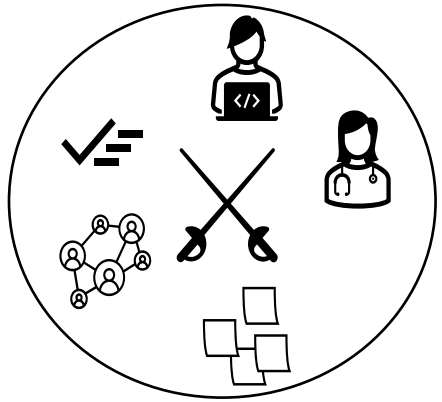
Lack of clear purpose and balance



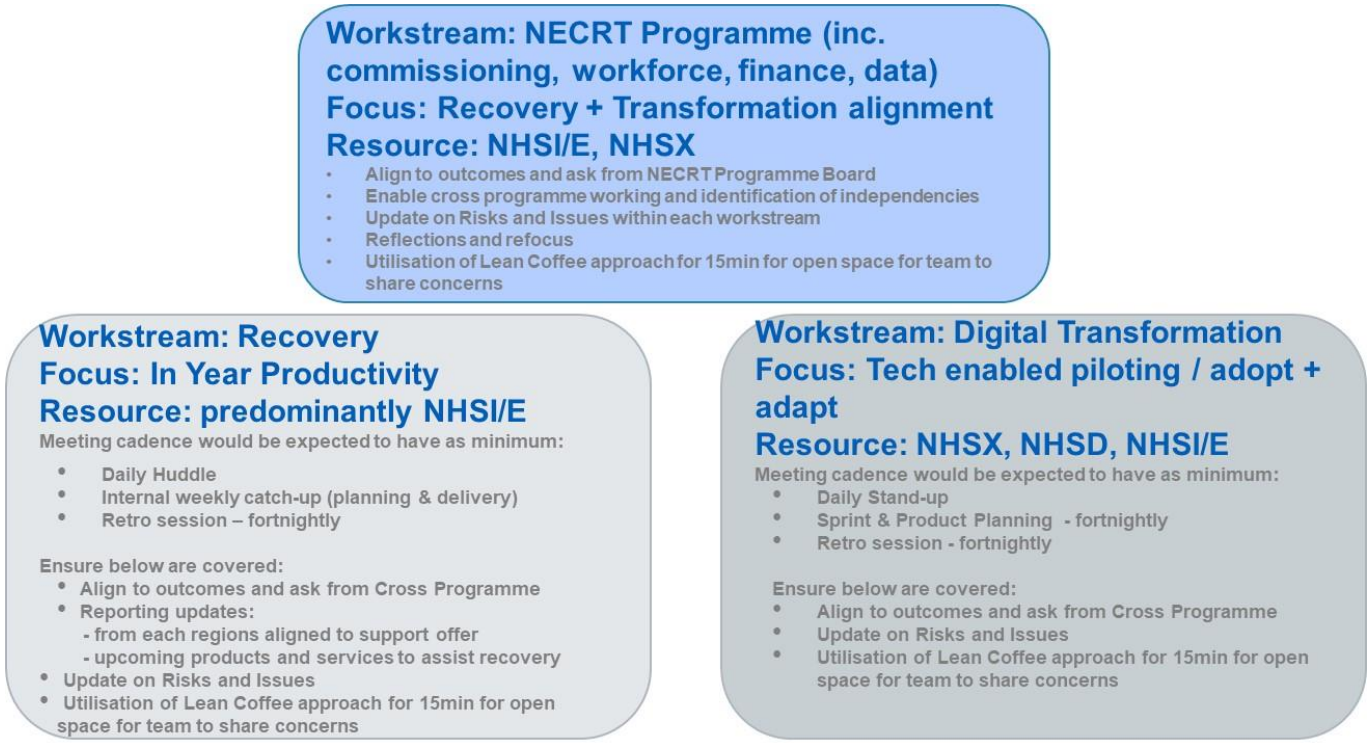
Trying to do too many different things



Clashing theories, styles and cultures



How we organised ourselves



Separated activities into three areas:

1. Programme Management Office
- Programme co-ordination
- Simplified reporting

2. Recovery
- Short term pathway improvement
- Rapid interventions with short pay-offs
- Support, guidance and tools

3. Transformation
- Longer term delivery
- Digitally centred transformation
- User centred design, agile delivery

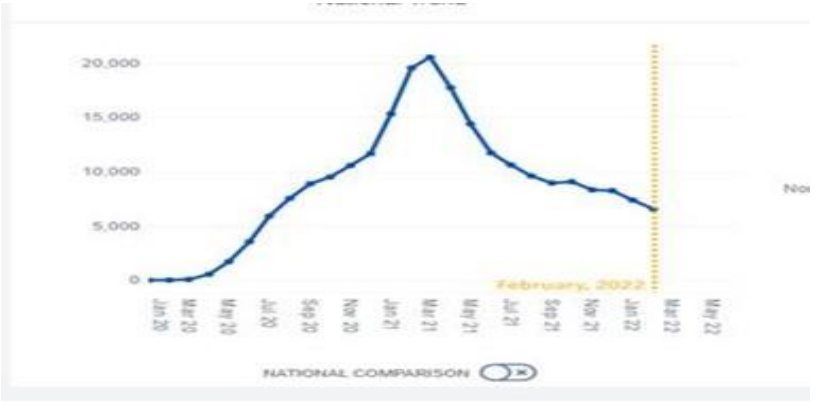
Recovery

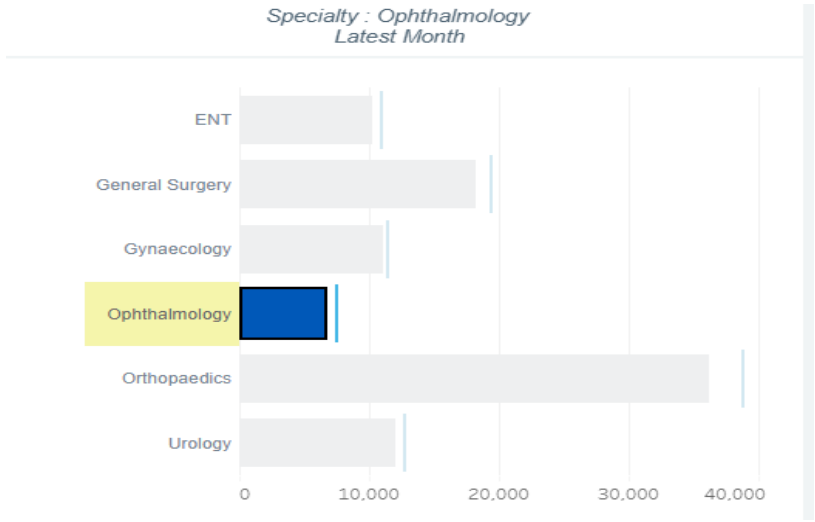
Universal eye care pathways support offers:
Sub-specialty specific

Specialty	Pre-hospital	In hospital	Post-hospital
Glaucoma 'How to' Guidance for Glaucoma 2021/22 Glaucoma Recovery & Transformational Opportunities	• Minimum requirements for all glaucoma referrals • Key steps to establish glaucoma referral filtering in primary care	• Glaucoma triage and efficient booking of clinics • Minimise risk • Workforce optimisation • Virtual clinics • Remote consultations • Patient support and information	• Discharge • Optometry long term care
DMO (Diabetic Macular Oedema) Pathway 'How to' Guidance for DMO 2021/22 DMO Recovery & Transformational Opportunities	• OCT referral refinement	• Triage and efficient booking • Workforce optimisation • Minimise risk • Productivity • High volume virtual clinics • Remote consultations • Patient support and information	• Discharge • Follow up in community / primary care

- Defined best practice clinically, defined opportunities, produced 'how to guides' and defined support offer
- Cataract pathways
  - Clinical buy in to simplify the pathway
  - Publish pathway data
  - Standardise the independent sector contract
- Standard pathways for Medical Retina and Glaucoma
- Competency based frameworks for eyecare professionals
- Optimising Primary care contracts

Recovery: What has been achieved to date 1/3





Decrease in number of people awaiting surgery from c.21k in Feb ’21 down to c.6k in Mar ’22 and continuing to decrease.

Ophthalmology has had largest decrease in volume of any specialty with long waiting patients.

This was achieved by:

- resumption of cataract surgery within the NHS trusts
- improved productivity
- use of independent sector

Recovery: What has been achieved to date 2/3

Specialties which need to do the greatest activity:

- T&O, ENT, gynae and general surgery
- 40% potential 78+ week cohort

Specialties at greatest risk of breaching 78+ week waits:

- ENT, dermatology, gastro and urology
- 47% total predicted cohort
- These specialties would be a particular focus for a partnering support offer

High Low

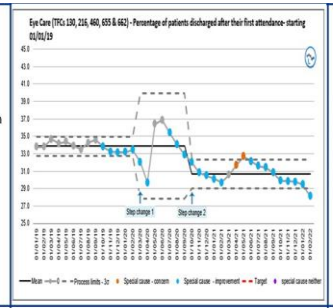
Treatment Function	Feb-22 Actuals (Monthly RTT)			78+ ww Cohort Modelling (based on PTL up to we 24 Apr 22)			
	78+ww (Feb-22)	% 78+ ww with a Decision to admit	Proportion of 78+ww (Feb-22)	Potential 78+ww cohort Mar-23	Proportion of Potential 78+ww cohort Mar-23	31st Mar-23 projection*	Proportion of Potential 31st Mar-23 projection*
Ear Nose and Throat Service	8,629	49%	13%	139,362	11%	10,968	20%
Dermatology Service	922	25%	1%	67,284	5%	4,989	9%
Gastroenterology Service	1,173	26%	2%	68,595	5%	4,759	9%
Urology Service	6,030	61%	9%	81,304	6%	4,738	9%
Oral Surgery Service	3,978	58%	6%	60,900	5%	3,801	7%
Gynaecology Service	4,608	68%	7%	111,194	9%	3,597	7%
Rheumatology Service	51	31%	0%	17,703	1%	2,608	5%
General Surgery Service	8,010	68%	12%	107,020	8%	2,547	5%
Trauma and Orthopaedic Service	15,663	73%	23%	160,863	12%	2,532	5%
Neurology Service	608	13%	1%	37,995	3%	2,479	5%
Ophthalmology Service	3,508	37%	5%	117,125	9%	1,766	3%
Cardiology Service	370	68%	1%	40,983	3%	1,672	3%
Neurosurgical Service	1,015	63%	1%	14,547	1%	682	1%
Respiratory Medicine Service	187	6%	0%	19,440	1%	488	1%
Plastic Surgery Service	2,195	84%	3%	24,292	2%	479	1%
General Internal Medicine Service	204	12%	0%	6,004	0%	320	1%
Elderly Medicine Service	3	0%	0%	1,190	0%	141	0%
Cardiothoracic Surgery Service	96	91%	0%	2,182	0%	38	0%
Other - Medical Services	975	55%	1%	218 K	17%	5,140	10%
Other - Mental Health Services	11	27%	0%				
Other - Paediatric Services	2,519	72%	4%				
Other - Surgical Services	6,314	59%	9%				
Other - Other Services	1,424	12%	2%				
Total	68,493	60%	100%	1,296,143	100%	53,743	100%

**Based on average volume reduction per working day over the last 4 weeks.*
The 78+ ww cohort cannot be accurately modelled by with/without a decision to admit (DTA). Patients without a DTA includes patients without a DTA yet. Some of these patients will change to "with a decision to admit" over time.

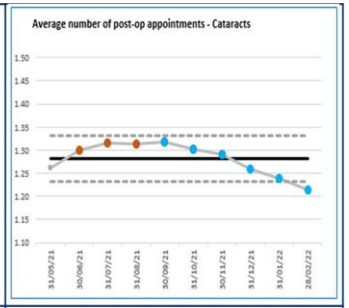
Recovery: What has been achieved to date 3/3

No	NECRTP Priority	Metric	Latest	SPC / RAG rating
1	Enabling Optometry	Reduction in the percentage of people who are discharged after a single OPFA Percentage of patients placed on waiting list for cataract surgery at or shortly after their first attendance	28.1% (mean) February 2022 85% (median from 61 Trusts) Q3 2021/22	SPC: Special Cause Improvement Increased from 81.6% in Q2. This is a different set of trusts in latest quarter.
2	Reduce multiple acute cataract pre-ops	Reduction in average number of pre-op Outpatient attendances for cataract surgery in 12 months prior to surgery	1.70 attendances Latest data: cataract surgery to February 2022 (so outpatient appointments date back to Feb 2021)	SPC: Special Cause Improvement
3	Post procedure discharge for cataracts	Reduction in average number of post-op Outpatient attendances for cataract surgery in 3 months following surgery	1.21 attendances Latest data to February 2022 (so cataract surgery from Sept to Nov 2021)	SPC: Special Cause Improvement
4	Reduction of over frequent or unnecessary follow-up	Reduction in ratio of First to Follow-up Outpatient attendances Plus PIFU metric TBC	3.07 Q3 2021/22	SPC to be incorporated in future iterations.

1. Enabling Optometry: Reduction in the percentage of people who are discharged after a single OPFA



3. Reduction in average number of post-op Outpatient attendances for cataract surgery in 3 months following surgery



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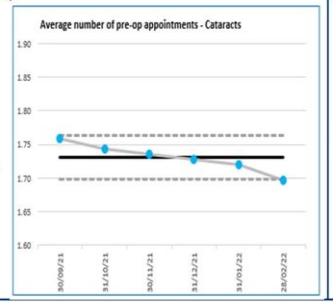
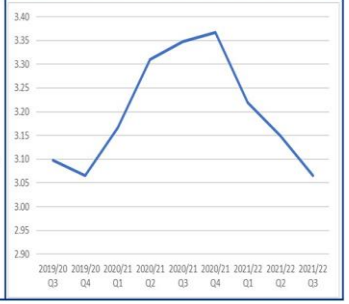


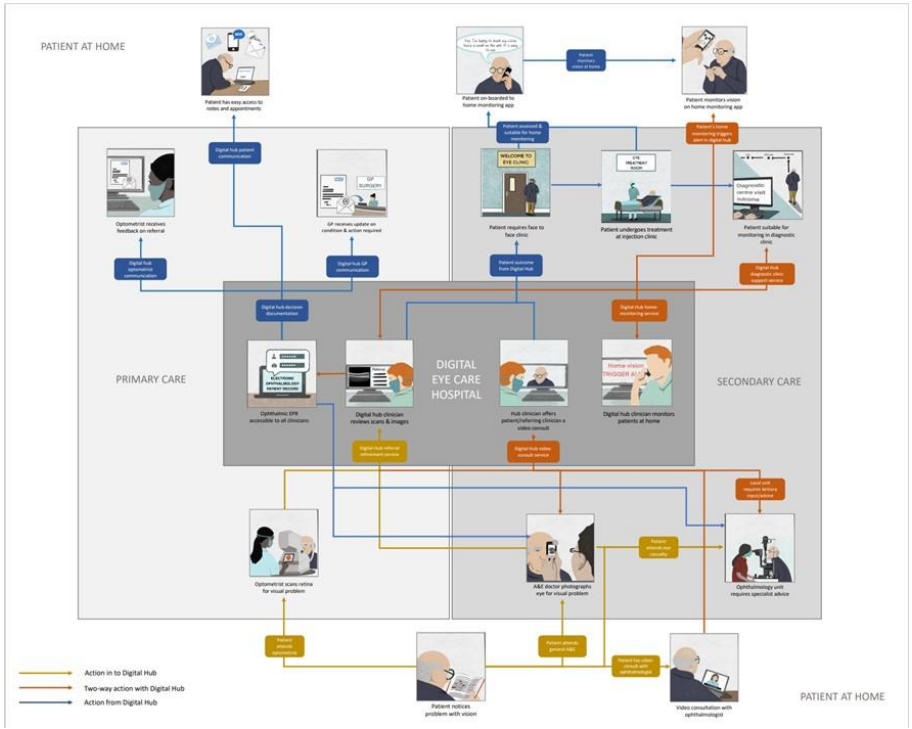
4. Reduction in ratio of First to Follow-up Outpatient attendances



Quantified delivery of efficiency to date:

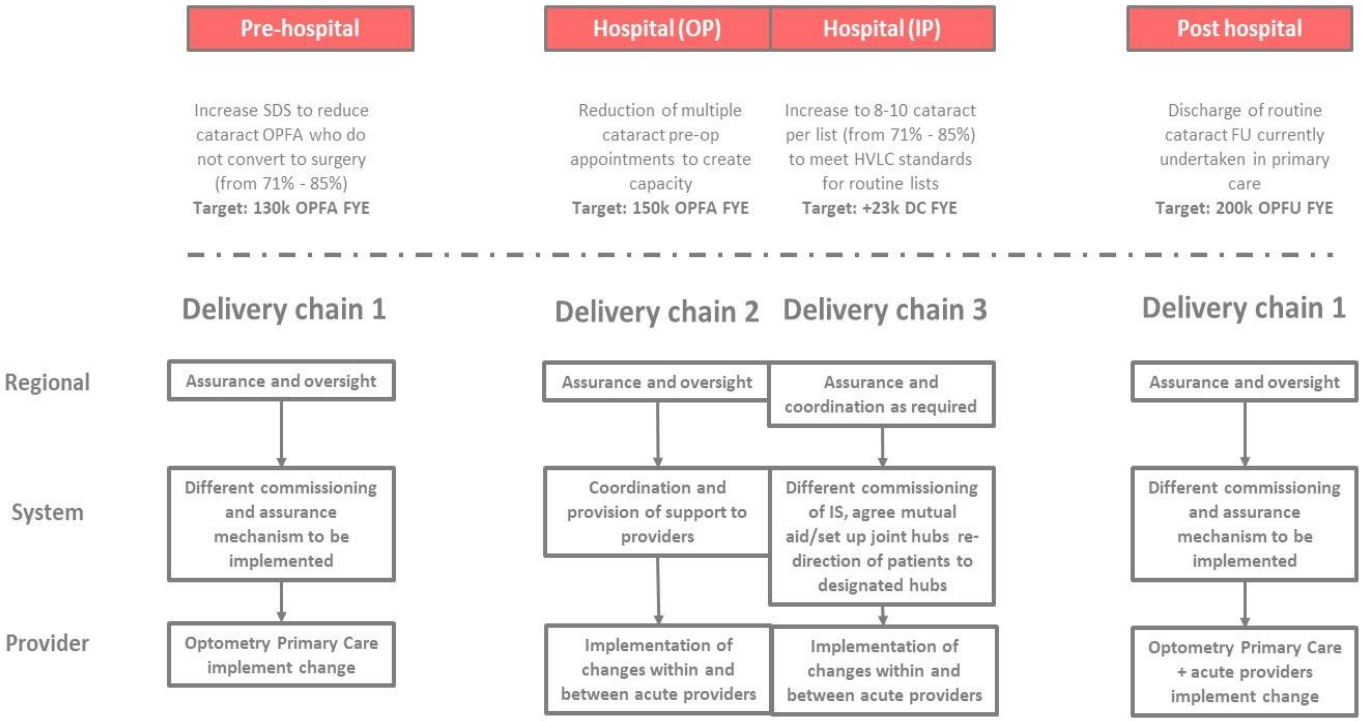
- in Q3+Q4 FY2021/2022 38,000 OPFU appointments for routine cataract surgery have been avoided with patients discharged straight to an optometrist sight test;
- there has been a decrease in the average number of pre-operative outpatient appointments before cataract surgery from 1.76 (Sept 2021) to 1.70 (Feb 2022);
- there has been a decrease in the average number of post-operative outpatient attendances following routine cataract surgery from 1.30 (May 2021) to 1.21 (Feb 2022); and
- there has been a decrease from 35% (April 2019) to 28% (Feb 2022) in the number of patients discharged after an outpatient first appointment.

What is happening - Transformation



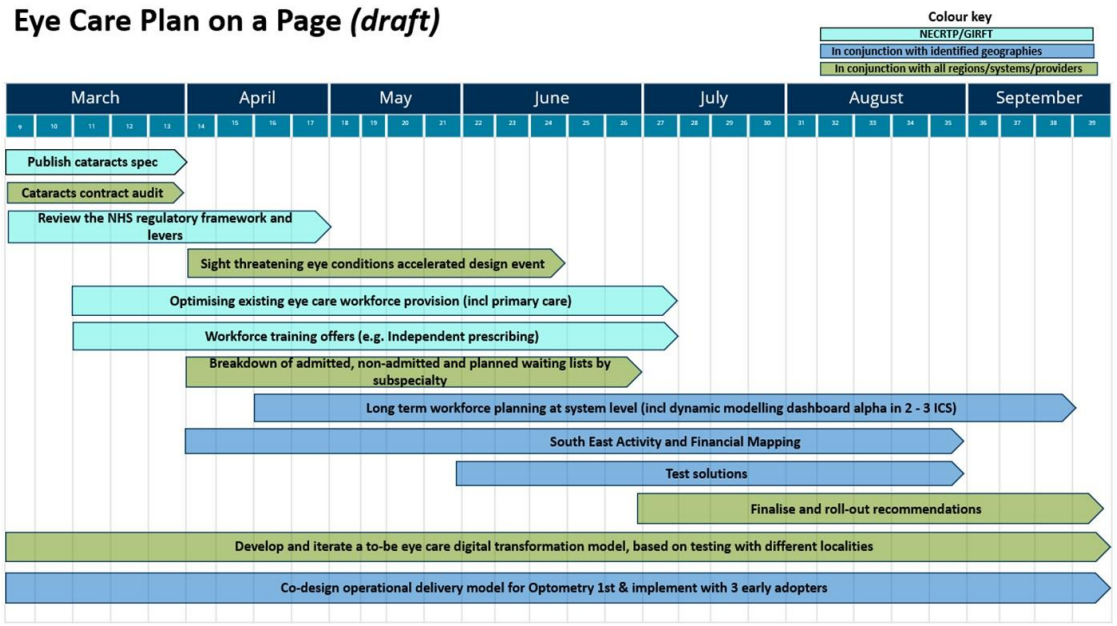
- Alpha testing of digital eyecare models to allow asynchronous review of images in a non point-to-point and provider agnostic way; formal agreements with delivery partners and systems
- Adoption of biosimilars to deliver savings
- Deep dives into local areas to understand spend and activity
- Piloting new primary care models to shift care away from hospital

Lessons learnt



- Use of data to inform objectives and understanding ‘as is’
- Clarity around objectives and metrics
- Segmenting different delivery chains across a pathway
- A core of the team need to be dedicated but secondments in bring valuable skills and experience
- Value of operational experience

Going forward



- Continue to deliver productivity and recovery initiatives
- Accelerated design event for sight threatening conditions (300+ attendees)
- Formal launch of digital eye care model
- National Clinical Director appointed
- Competency based workforce model

Now over to you….

- What are your reflections? How does this compare to the approach in your Geography?
- Are you doing anything differently to recover…we'd love to learn from your approach.
- Is there something you can take back? Is there something you can share that will help others?

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What are your reflections?

ⓘ Start presenting to display the poll results on this slide.

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Are you doing anything differently to recover? We would love to learn from you

ⓘ Start presenting to display the poll results on this slide.

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What will you be taking back to your colleagues?

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PLEASE SUBMIT YOUR FEEDBACK

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