Southend University Hospital NHS
NHS Foundation Trust

Board of Directors Meeting Report – 5 December 2017

Agenda item 90/17

Title	Position Statement - Ophthalmology
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Purpose	To provide assurance and update on the provision of Ophthalmology services

Executive Summary

This report provides an update to the backlog position statement reported in June 2017. At that time the validated position of patients 1 day or more past their due date was 6879. As at 27/11/17 the review backlog is 5796.

This report outlines actions that have been taken by the Ophthalmology service from the Ophthalmology review list action plan and the backlog action plan.

Capacity for 1000 cataract and primary care first appointments and subsequent treatment patients was agreed and arranged with the BMI. To-date, 606 of that capacity has been utilised and is increasing on a weekly basis. There is concern that the BMI are unable to manage backlog referrals as there are currently 130 patients that have been identified by clinicians as suitable, but that have yet to be sent due to lack of assurance that they can be treated quickly.

Aspen Healthcare are able to undertake a review of the overdue stable glaucoma patients, providing the patients are able to travel to Chelmsford which historically has been an issue. It is envisaged that this will commence late December/early January and complete by March 2018.

4 insource companies have provided quotes to utilise SUHFT's facilities for cornea, primary care, glaucoma and cataract patients. It is envisaged that this will commence in January.

A summit between Southend and Mid Essex Hospitals took place on 07/09/17 where the model of care delivery for ophthalmology was agreed. This model had been developed through the Essex Ophthalmology Network.

The October Portfolio group will consider the options appraisal which sets out a phased approach to transformation given finite transformation resources.

Related Trust Objective	Excellent Patient Outcomes Excellent Patient Experience Engaged and Valued Staff Financial and Operational Sustainability
Related Risk	Risk 1 - Failure to provide adequate patient safety , quality of care and patient experience due to capacity, demand and external agency stakeholder engagement

Essex Success Regime	Does this proposal have any implications for the other Trusts within the Essex Success Regime (BTUH and MEHT) or for the Mid and South Essex health economy as a whole? Yes, there may be a realignment of services across the Essex Success Regime which will impact the services discussed in this paper. As yet no decisions have been made. The impact will be monitored closely as plans are agreed.
Legal implications / regulatory requirements	Actual harm resulting from a delay in care could result in legal claims
Equality impact assessment	Not applicable
Recommendations: The Board is asked to note the content of the report and receive assurance therefrom.	

Introduction/Background

1.0 Purpose

The purpose of this report is to provide an update on progress in relation to the current backlog position for non-admitted patients and the model of care delivery for Mid and South Essex.

2.0 Current Backlog

The current backlog as at 27/11/17 on Medway is broken down as follows:

Type	**Past**	**Future**
Adnexal	139	50
Adult squint	63	70
Anterior segment	143	63
Cataract	519	277
Cornea	302	235
ERM/FTMH	71	48
Glaucoma stable	1477	2478
Glaucoma unstable	0	664
NAD	81	39
Neuro	295	97
Ocular surface	174	60
Paeds Amblyopia	4	83
Paeds Other	28	501
Paeds Squint	18	253
Retina ARMD	172	144
Retina detachment	57	64
Retina diabetic	643	415
Retina vascular	227	139
Uveitis	79	47
VR other	279	208
No diagnosis	1026	600
TOTAL	**5798**	**6535**

3.0 Ophthalmology Recovery Plans

3.1 Outsourcing of First Appointments

BMI are providing capacity for 1000 cataract and primary care patients once they have been triaged as suitable for the private sector. To-date, 606 patients have been sent, increasing weekly. There is concern that the BMI are unable to manage backlog referrals as there are currently 130 patients that have been identified by clinicians as suitable, but that have yet to be sent due to lack of assurance that they can be treated quickly.

3.2 Diversion of 400 Patients per month

The CCG have negotiated with both the BMI and Aspen Healthcare to take between them 400 patients per month and are communicating with their Opticians to send directly. This will save the need for the patients to be triaged. Aspen Healthcare capacity utilisation is dependent on patients' willingness to travel.

3.3 Outsourcing of Overdue Stable Glaucoma Follow Up patients

Aspen Healthcare will carry out the review and, where appropriate, determine whether the patient is suitable to move across to the community monitoring service or be retained by SUHFT. Discussions are on-going regarding the methodology of booking the patients and sharing the notes, visual fields and photos. It is planned to start in either late December/early January and complete the first cohort by March 2018.

3.4 Insourcing of Cornea, Primary Care and Glaucoma

The administrative set up of access to SUHFT'S systems (including Scribetech) and an induction will need to be completed once the Clinical Lead has spoken to the Clinical Lead of the insourcing company. All bookings will then be made to optimise the rooms available at the weekend at both Orsett or Southend as required based on 34 patients per day per consultant.

4.0 Standardisation of Clinical Practice

Service pathways will be standardised in line with the Southend and Mid Essex model of care for ophthalmology which was agreed at the Summit meeting between the two Trusts on 07/09/17 and with commissioners.

5.0 Clinical Governance

Serious Incidents are monitored by both the Directorate and the Trust as per the standard policy.

Due to the high volume of patients awaiting review, it is not possible to risk assess each on an individual basis. The clinicians have confirmed that the highest risk patients should be prioritised are those with unstable and stable glaucoma. The backlog review list for unstable glaucoma has now been cleared (see table in Section 2.0) and a process is in place to ensure all patients in this clinical category are allocated an appointment within a maximum of 2 weeks of their due date to ensure backlog does not re-occur. Stable glaucoma patients are now being allocated into any

available appointment slots released from the outsourcing of first appointments to the BMI that are not required for unstable patients.

RTT – due to the high volume of patients awaiting new appointments, it is not possible to risk assess each on an individual basis. However, all new referrals are prioritised on receipt by consultants and identified as 'urgent, soon or routine' and are processed in chronological order. The numbers of patients awaiting appointments are reviewed at the weekly capacity meeting with the lead clinician and manpower resource is allocated according to clinical priority.

Harm review process is the same process as for Cancer.

6.0 Workforce

There is a national shortage of consultants. Mid Essex are also recruiting and Southend's vacancy update is as below:

Job Title	**Comments**
Specialty Doctor x 3 WTE	1 x offered – awaiting confirmation of start date. 4 applications – awaiting interview date. Convert 1 post to Optometrist – needs to go to VRCP
Consultant with Specialist Interest x 2 WTE	1 appointed – starting in March 2018 No suitable candidates to shortlist for the 2nd post most recent advert
Paediatric Fellow x 1 WTE	3 candidates shortlisted – interview booked for 07/12/17

The Essex Plan for Ophthalmology

It was recognised last year that responsive changes were unsustainable and that fundamental changes were required to systemically transform the way ophthalmic care is delivered in Essex.

In 2016, a clinical summit was held with all acute providers of ophthalmology in Essex and the CCGs to discuss a way forward. The Essex Plan for Ophthalmology begun to emerge as a new systemic model of care.

The Essex Plan supports the STP plan and is in keeping with the recommendations within 'The Way Forward' from the Royal College of Ophthalmologists.

The Plan describes a fundamental shift of activity from hospital settings along with the need to transform service delivery. The intention is to work as a health system to use the resources available. Additional investment will be needed to ensure continued sustainability of quality services. This will need fully scoping to understand the need.

A key element of the Essex Plan is the development of community eye care services for Essex that will see enhanced service optometrists accepting referrals directly from GPs and optometrists for more minor conditions.

A new model of care will also incorporate consultant-led triage to ensure appropriate direction of activity referred into ophthalmology services. Re-direction to these enhanced community optometrists via Tier 1 primary care or via Tier 2, intermediate care services, would also be possible following triage.

The establishment of community services will significantly reduce the number of referrals to the hospitals eye services. The financial impact needs to be determined according to proposed pathways.

Disinvestment from hospital into primary care services would enable the hospitals to focus on more complex cases and reduce waiting times.

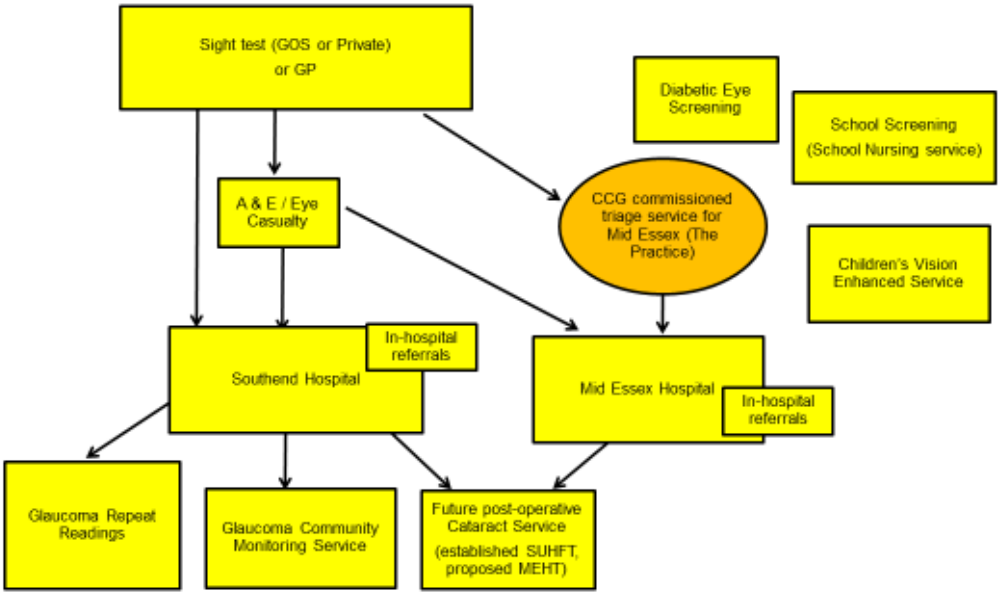
The new model of delivery will support the 'Care Closer to Home' strategy by utilising the skills and knowledge of optometrists, enabling a convenient and accessible service for patients and ensuring patients are seen by the most appropriate healthcare professional in the most suitable setting.

Community providers represented by the Local Optometry Committee (LOC) have been involved and engaged in discussions with the CCG and the hospitals to date. They realise there is much work that needs to be done around mapping pathways into potential community services and identifying training needs for community providers.

Despite the Plan starting to emerge late last year, there has been little progress, hence an ophthalmology summit for clinicians from Southend and Mid Essex hospitals was held early September 2017 in a bid to move forward.

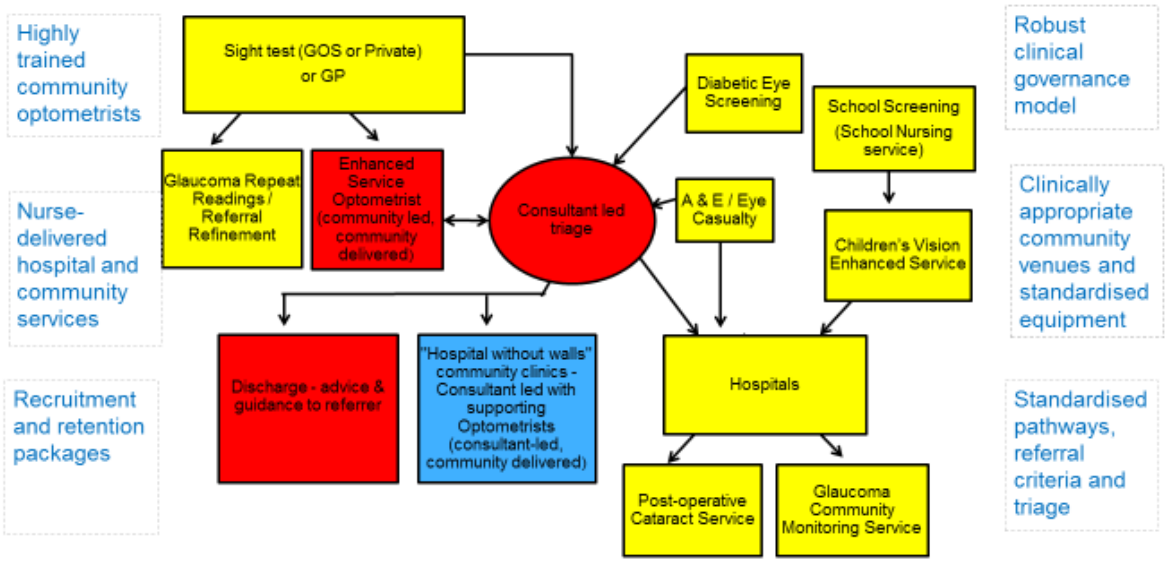
The diagrams overleaf set out the current ophthalmology service model and the ideal future service model:

Current ophthalmology service model



3

Ideal future service model



Aims of Service Transformation

To build a sustainable ophthalmology integrated care service across mid and south Essex.

Primary drivers

- Move clinically appropriate activity out of hospital to improve quality of care, reduce RTT and backlog of review patients
- Build an effective and efficient workforce
- Ensure services are safe, of the highest quality and improve patients' experience
- Provide care closer to home
- Ensure services are financially sustainable

Benefits:

There are significant expected benefits from realising a new model of care:

- Significant reduction of activity and demand on hospital eye services, so appropriate patients can be seen in a timely way in a primary care setting
- Reduced backlog and improved compliance with RTT targets and NICE guidance
- Patients directed to the right level of care, right first time (appropriate referrals)
- Ability to utilise nurses and AHPs in hospital more effectively

- Releasing consultants to utilise their skills more effectively for the most complex patients.

September 7th Hospital Summit

The Southend and Mid Essex hospitals' ophthalmology clinical summit on 7th September was well attended and there was positive discussion. There was agreement that:

- The proposed future service model as described above is the right model 'in principle' – a service where patients are seen by the *right* clinician at the *right* time and in the *right* location
- Service transformation is a system-wide solution but it should be driven by the hospitals with support from commissioners and community providers
- Developing an ophthalmology programme, with the right resources to drive forward workstreams at pace, would be the only way to deliver systemic transformation in a timely way.

Prof Raj Aggarwal, Southend's ophthalmology clinical lead, fed back from the summit to the CCGs' clinical network meeting on the 14th September as per the points above and with some suggested workstreams to drive forward pathway development, IT solutions, estates and workforce & training issues. It was noted that project resource would be required to drive this forward, but the CCG was impressed at the hospitals' progress.

CCGs view

On September 8th, a day after the hospital summit, the CCGs put an options appraisal to their joint board with their preferred option for the CCGs to work together with the hospitals to transform services rather than undertake whole scale procurement of out of hospital ophthalmology services.

The options appraisal below is based on the options that went to the CCGs joint board. The hospitals did not have sight of this options appraisal until after they had presented back to the CCGs on the 14th September on the outcomes of the hospital summit.

Option 3 as preferred by the CCG is supported by hospital clinicians who want to be instrumental in driving service transformation.

On October 10th, the CCG clarified its intent with a commissioning intentions paper, stating *'The STP CCGs will be commissioning a new model of care for ophthalmology from 1st April 2018. This will include the decommissioning of around 50% of current acute ophthalmology activity which will be recommissioned through the new pathway under different contractual and funding arrangements.'*

The CCGs contractual and funding arrangements are not yet clear and need further discussion. The earlier CCG options appraisal seemed to suggest that primary/community services should be commissioned by the hospitals. This is unlikely to be supported by the hospitals.

Investing project resource into service transformation which will see loss of activity and income in hospital services seems counter-intuitive. However, clinicians have concerns that if the CCGs undertake whole scale procurement of community services, it may lead to a fractured system of service provision if they are not involved in driving clinically appropriate pathways out of hospital.

Given the scale of transformation an options appraisal is being considered by the Portfolio Group chaired by the Chief Transformation Officer.

Conclusion

Phasing and governance arrangements in relation to the Southend, Mid Essex and Basildon ophthalmology model of care will be discussed and agreed at the October Portfolio Group.

Mr Niral Karia has been appointed as the clinical lead for the ophthalmology service transformation programme.

The first meeting for the newly formed steering group programmed, chaired by Charlotte Williams – MSB Group Director of Strategy New Care Models (on behalf of Celia Skinner) took place on 16th November during which concerns were raised by the CCG about the hospitals not wanting to be commissioned for the enhanced optometrist services (box in red in the proposed service model). The CCG stated that if this were the case they would need to go out to procure all of the services shown in red and blue on the proposed future model as a package rather than negotiate a service variation on the existing contract. The CCG lead is going to meet with Tom Abel to provide clarification on the contracting model.

Next Steps

Clarification on contracting model
Capacity and demand model to be completed across the system
Audit of new referrals received within the hospitals and the private triage services in Mid Essex to be undertaken to understand the sub-specialty demand