WM QRS West Midlands Quality Review Service

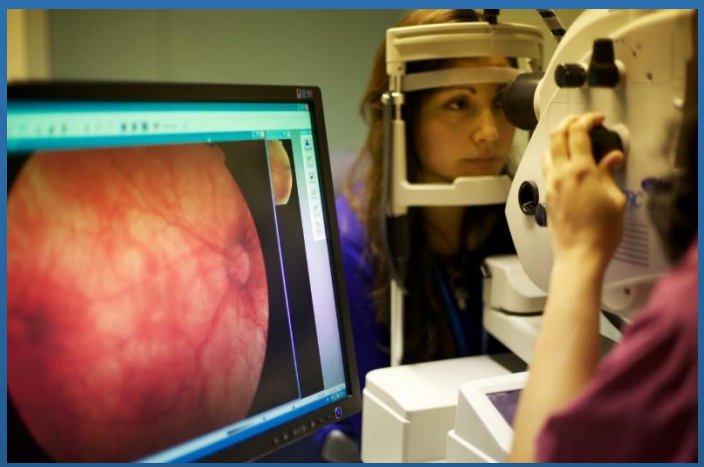
NHS

Eye Care Pathway (Adults and Children)

The Royal Wolverhampton NHS Trust

Visit Date: 18th June 2018 Report Date: October 2018

Images courtesy of NHS Photo Library



UKAS INSPECTION 8831

CONTENTS

INTRODUCTION

This report presents the findings of the review of The Royal Wolverhampton NHS Trust Eye Care Pathway that took place on 18th June 2018. The purpose of the visit was to review compliance with the following West Midlands Quality Review Service (WMQRS) Quality Standards:

- Eye Care Pathway Version 1.2

The aim of the standards and the review programme is to help providers and commissioners of services to improve clinical outcomes and service users' and carers' experiences by improving the quality of services. The report also gives external assurance of the care, which can be used as part of organisations' Quality Accounts. For commissioners, the report gives assurance of the quality of services commissioned, and identifies areas where developments may be needed.

The report reflects the situation at the time of the visit. The text of this report identifies the main issues raised during the course of the visit. Appendix 1 lists the visiting team that reviewed the services in the Wolverhampton health economy. Appendix 2 contains the details of compliance with each of the standards and the percentage of standards met.

This report describes services provided or commissioned by the following organisations:

- The Royal Wolverhampton NHS Trust
- NHS Wolverhampton Clinical Commissioning Group

Most of the issues identified by quality reviews can be resolved by providers' and commissioners' own governance arrangements. Many can be tackled by the use of appropriate service improvement approaches; some require commissioner input. Individual organisations are responsible for taking action and monitoring this through their usual governance mechanisms. The lead commissioner for the service concerned is responsible for ensuring action plans are in place and monitoring their implementation, liaising, as appropriate, with other commissioners, including commissioners of primary care. The lead commissioner in relation to this report is NHS Wolverhampton Clinical Commissioning Group.

ABOUT WEST MIDLANDS QUALITY REVIEW SERVICE

WMQRS is a collaborative venture between NHS organisations in the West Midlands to help improve the quality of health services by developing evidence-based Quality Standards, carrying out developmental and supportive quality reviews (often through peer review visits), producing comparative information on the quality of services and providing development and learning for all involved.

Expected outcomes are better quality, safety and clinical outcomes, better patient and carer experience, organisations with better information about the quality of clinical services, and organisations with more confidence and competence in reviewing the quality of clinical services. More detail about the work of WMQRS is available on www.wmqrs.nhs.uk

ACKNOWLEDGMENTS

West Midlands Quality Review Service would like to thank the staff and service users and carers of the Wolverhampton health economy for their hard work in preparing for the review and for their kindness and helpfulness during the course of the visit. Thanks are also due to the visiting team and their employing organisations for the time and expertise they contributed to this review.

Return to Index

PRIMARY CARE

General Comments and Achievements

Minor Eye Conditions services (MECS) were in place in primary care. Wolverhampton had also launched a care navigation programme to ensure wider GP practice staff were aware of the services and indicators for signposting to the MECS.

Primary care pathways were in place to refer directly to the urgent and acute macular degeneration services at the Wolverhampton Eye Infirmary (WEI).

A training programme for general practitioners, providers of general ophthalmic services and other health, social care and education practitioners working with groups of people with, or at risk of, vision impairment was in place and facilitated by the CCG and the Local Ophthalmic Committee (LOC). Changes to the training programme had taken place following evaluation and feedback from participants and an audit of primary care ophthalmic referrals undertaken by the LOC.

Good Practice

1. Reviewers were impressed that funding had been secured from NHS England for a collaborative improvement and innovation programme with Wolverhampton LOC. This work had a number of workstreams to improve patient care and reduce unnecessary referrals, using expert-led workshops with an ophthalmologist from the WEI and local optometrists, and ongoing audits of hospital referrals. This will improve both the quality and the responsiveness of the service patients received. Many local optometrists (thirty out of thirty-eight local practices) were now involved in this work.

Return to Index

THE ROYAL WOLVERHAMPTON NHS TRUST

WOLVERHAMPTON EYE INFIRMARY SPECIALIST SERVICE AND LOW VISION SERVICE

Compliance with Quality Standards is reported separately for the specialist (consultant-led) service and the low vision service (Appendix 2). These services were managed together as a single service and so reviewers' comments are combined. Reviewers met with staff from the vitreoretinal, strabismus and oculoplastic services, but did not review the paediatric ophthalmic service in great detail.

The WEI) operated across two sites, New Cross Hospital (which was seen as the main base) and Cannock Chase Hospital. A service level agreement to provide an ophthalmic service at Walsall Healthcare NHS Trust was in place, but this review did not include the Walsall service. At both the Cannock and the New Cross sites, a preoperative assessment and day surgery service was also provided, which was supported by eye theatre and recovery staff.

The service was provided by sixteen consultants, nine specialty and associate specialist doctors (non-training roles who have at least two years' experience in the specialty), ten specialty trainee doctors, two junior doctors, nurse specialists (6.03 wte) who covered uveitis, cornea conditions, acute macular degeneration (AMD) and glaucoma, ophthalmic advance nurse practitioners (6.68 wte) based in the Emergency Department, optometrists (8.33 wte), orthoptists (11.2 wte), ophthalmic technicians (7.15 wte), seven medical imaging staff and one eye clinic liaison officer (ECLO) based at the WEI.

At New Cross, a dedicated ophthalmology out-patients department was available, with clinics running in the evenings and on Saturday mornings. These evening and weekend clinics were being provided on a temporary basis to manage the high level of demand and lack of weekday capacity, although the service was reviewing its longer-term capacity requirements.

One low vision service clinic was held each week at the Cannock Eye Centre, and the New Cross low vision service was co-located in the out-patient department and provided daily access to optometrists and orthoptists.

Specialist nurses ran an ophthalmic emergency service within the Emergency Department (ED) of the Trust between the hours of 8.15am and 7pm, Monday to Friday, and 8.15am and 5.30pm on Saturdays, Sundays and Bank Holidays, and were able to refer directly to dedicated clinic slots within the Eye Referral Unit (ERU). A consultant on-call rota was in place 24/7.

The ERU operated between the hours of 8am and 7pm. Urgent referrals were accepted from the specialist ophthalmic nurses based in the ED and from general practitioners and local opticians who participated in the MECS.

An eye imaging department was based at New Cross and offered fluorescein angiography, indo-cyanine green angiography, and ultra-widefield (UWF™) retinal imaging. There was a designated consultant for ocular ultrasonography.

Annual activity was approximately 130,000 out-patient attendances, 5,000 cataract operations, 15,000 intravitreal injection procedures, 9,000 optometry attendances and 12,500 orthoptic attendances.

General Comments and Achievements

The service was provided by committed staff who were enthusiastic and were trying to develop and improve the care provided. Staff commitment to service improvement was highly visible and staff had good ideas for other developments. Teamwork and multi-disciplinary working was strongly evident.

Several specialist clinics had been set up, with the aim of reducing waits for both new and review appointments.

The team of sixteen consultants provided a wide range of specialist expertise for the following eye conditions: corneal and external eye disease, diabetes, glaucoma, medical retina conditions, ocular motility, oculoplastic, paediatrics, vitreoretinal conditions and uveitis. In addition, all consultants had specific roles and responsibilities in

the delivery of clinical governance for areas such as accident and emergency, information technology, infection control, equipment procurement, pharmacy, and research and development.

The pathway of care for patients needing day surgery was very good and included good pre-operative assessment. Ophthalmic day surgery was provided on the Mary Jones Ward in a spacious, calm environment. A good pathway was also in place for assessing patients who were suitable for surgery under local anaesthesia at the Cannock Eye Centre.

The low vision service based at the WEI provided a good service for the care of children and adults, with an open referral system in place for some patients. Processes were also in place for patients to consent to referral to special support services for children. Staff could, when necessary, access support from a qualified teacher of children with vision impairment, and low vision staff would attend review meetings for children who required education and health care plans. Guidance and processes were in place to enable children to transition to adult services. The team had a separate budget for equipment, and samples of equipment were available for patients to use before ordering.

The ECLO was new in post, although the post had been in place for several years. The post was part-funded by Beacon, a local sight loss charity in Wolverhampton, with the remainder being funded by the Trust; the ECLO provision had been extended to support patients attending the WEI during normal working hours.

Good joint working with dermatology, general paediatrics, neonatal and rheumatology services was evident.

Good Practice

1. **Education and training**

   Reviewers were impressed with the level of education and training provided by the different teams for staff within the service, those in training and professionals providing services in primary care.

   a. The practice education facilitator had developed a comprehensive education and competency package for registered nurses. Reviewers were told that there were also plans to develop a competency package for non-registered health care staff.

   b. The corneal service provided training for staff on the use of confocal microscopy in the assessment and diagnosis of ocular conditions such as acanthamoeba keratitis.

   c. The WEI was the regional centre for virtual cataract and virtual reality surgical training.

   d. Staff within the service provided an active and comprehensive training programme for doctors in training, providers of community-led MECS and other non-medical staff; this included training in onward referral to the WEI.

   e. Research and multidisciplinary learning sessions were held on a regular basis. The out-patient team also held a 'hub meeting' every morning at 8am to enable the sharing of information with all out-patient staff.

   f. The ocular imaging service had developed a competence-based training package for doctors in training and other imaging staff covering the application of various imaging techniques in the diagnosis and management of ocular conditions.

   g. Other workforce developments included the implementation of a skills-based training programme to enable Band 2 staff to progress to Band 3. Following completion, these staff were able to undertake a wider range of visual assessments.

2. **User and carer involvement**

   Across the service, user and carer involvement was actively encouraged and supported by clinical staff.

   a. Patient and carer groups were in place for a number of eye conditions, and a patient forum met at weekends. The patient forum was an active group providing regular feedback to the service about the

treatment and care they received. Staff also supported the meetings by providing education sessions covering a wide range of eye-related topics.

b. Feedback from patient experience audits seen by the reviewers, including the 'Friends and Family Test', was very positive, and staff were in the process of developing an electronic version of the survey for those users with sight loss who used assistive technology programmes on laptops and tablets.

3. **Acute macular degeneration (AMD) pathway**

The governance process for checking and consenting patients on the AMD pathway had been revised following learning from serious incidents and now included a three-station checking process. This required different staff to re-check the patient and treatment required at each stage of the pathway. Reviewers were impressed with the additional safety steps this added to the system. Since the implementation of the checking process no serious incidents had been identified.

4. **Information**

The range of information in different formats for those with sight loss was very good. Reviewers were impressed with the locally developed information, which was well structured to ensure that important information for users and carers was clear. The Trust booklet on falls prevention was particularly clear, with advice for those with sight and mobility problems.

5. **Development of non-medical practitioners**

Two orthoptists and four advanced nurse practitioners had extended roles and responsibilities. They were able to assess and manage patients as clinical specialists and to administer intravitreal anti-vegf (anti vascular endothelial growth factor) treatments for those patients requiring treatment for AMD.

6. **Paediatric low vision service**

The paediatric low vision service had a good IT system in place that 'flagged' children at the time of their fifth birthday so that staff could check that low vision assessments had been completed.

7. **Support for patients on discharge home from hospital**

Although only at the business case stage, reviewers were impressed with the Trust's plans to recruit volunteers who could provide a short term 'sitting service' to support patients being discharged from hospital.

Immediate Risks: None

Serious Concerns

1. **Provision of separate area for children in the eye referral unit (ERU)**

Facilities in the ERU did not enable appropriate separation of children from adults who attended the unit. The NHS recognises the specific needs of children through *Getting the right start: National Service Framework for Children. Standard for Hospital Services.*[1] This requires care to be provided in an appropriate location and in an environment that is safe and well-suited to the age and stage of development of the child or young person. Additionally, co-locating adult's and children's waiting areas increases safeguarding concerns.

[1] www.nhs.uk/nhsengland/aboutnhsservices/documents/nsf%20children%20in%20hospitlaldh_4067251%5B1%5D.pdf

Concerns

1. **Capacity and staffing**

   Some workload modelling was taking place to address activity by the better utilisation of nursing staff in theatres and out-patients, with staff working across both sites. However, reviewers had several concerns about the overall insufficient capacity within the ophthalmology service:

   a. An additional (temporary) 10 extra clinical sessions per week, and clinics on Saturday mornings, had been implemented to address the waiting times for patients to be seen and treated. These extra clinics were being run in addition to other consultant activity, which reviewers considered was not sustainable for consultant and other staff without additional staffing support in the future.

   b. Despite the additional clinical sessions, which were having an impact on the backlog, data for the end of May 2018 seen by reviewers showed that the total patient list was 1,589 patients, with 33.7% of these waiting more than 18 weeks from referral to treatment.[2]

   c. Capacity within the AMD service was insufficient, with theatre space being used outside theatre lists for other clinical work. Reviewers were told of plans to increase the clinical facilities for the delivery of intraocular treatments, which would reduce the number of clinics held on Saturdays. From discussion with some staff it was unclear if there would be sufficient support staff to run these sessions in the long term. The Trust told us they have appointed two full time clinical posts for eye injections, and there is a plan for support staff to be appointed once the clinical staff have completed their final training.

   d. Some capacity was available at the Cannock Eye Centre, but at the time of the visit any expansion of this service was constrained by a lack of available clinical staff. Work was in progress to look at new ways of working, to optimise efficiency with the current staffing levels.

   e. Processes were in place to triage patients attending the Emergency Department to 'see and treat'. There were no mechanisms in place to refer to appropriate primary care or community services. However, reviewers were told that the referrals from the ERU to the OPD (Out-patients Department) had increased and averaged 70 new patients per week requiring follow-up after their urgent visit, which was placing increased pressure on an already stretched service.

   f. Reviewers were concerned that, from discussions held with staff from the low vision service, referrals to the low vision service appeared lower than expected. Reviewers considered that the development of the ECLO role, with the new post holder, may help to address this issue, but that further work should take place to ensure that all patients who may benefit from the low vision service are referred when attending other specialist services.[3]

   g. There was no cover for absences for the ECLO. The patient pathway and the quality of patient care were therefore likely to vary during absences.

2. **Storage of topical ophthalmic preparations**

   a. Reviewers were concerned that optical medicines were accessible in opened boxes in a number of the clinic rooms. Reviewers were told that drugs were locked away when the rooms were not occupied and also at the end of the clinic day; however, on the day of the visit, reviewers observed several areas where this did not appear to be the case. While this practice may be prevalent in many units, some

[2] In England, under the NHS Constitution, patients 'have the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible'. The NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment.

[3] Linked to compliance for specialist service QS VN-504

reviewers commented that in their own organisations more robust security of medications had been implemented following advice from regulators, due to the nature of some preparations and the high risk of misuse and drug abuse.

b. Ambient temperatures of the clinic rooms where medicines were stored were not recorded. If these were outside the manufacturers' safe storage range, this could affect the viability of some ophthalmic solutions. Reviewers were concerned that staff were therefore unable to demonstrate the correct handling for medicine efficacy. The Trust have told us that they have sought pharmacy advice and that, given the current high usage rate and turn-over of opened medicines, pharmacy have told the service they assess this as safe practice. However, the service should consider this issue if their usage rates change for any medication.

3. **Safeguarding training**

   All staff had completed safeguarding training at level 2, but reviewers were concerned that no staff were trained to level 3, which they considered of concern due to the nature of the vulnerability of the patients cared for in the service.

Further Consideration

1. Patients who met with the reviewing team appreciated being able to attend clinical appointments out of hours (Saturdays and evenings). Reviewers acknowledged that the reason for offering clinic appointments outside of normal working hours was to address the waiting times from referral to treatment and that potentially this would not be an option in the future. Reviewers suggested that as part of any work to improve the service, consideration should be given to user and carer feedback and to whether clinics at other times could be maintained to improve the experience for patients.
2. Reviewers noted that the current ECLO was new in post, but considered this to be an extremely important development in providing those patients recently diagnosed with an eye condition with the practical and emotional support which they needed to understand their diagnosis, deal with their sight loss and maintain their independence. The post also acted as a signposting service to ensure patients were aware of, and could access, relevant advice and support. Reviewers were in agreement with the Trust's plans to apply to review the ECLO post so that it was more in line with other ECLO roles across the region.
3. A training programme was in the process of being developed for the ECLO role, and reviewers suggested that consideration should be given to the post holder accessing accredited training for ECLOs, such as courses provided by the Royal National Institute for the Blind (RNIB). From discussions with staff it was not clear that the ECLO induction programme was sufficient, as reviewers were advised that induction training only covered mandatory training. The reviewers also considered that this role would benefit from a more robust supervision process to ensure further development of the role.
4. Reviewers who met with the low vision service were not able to locate some key evidence (see compliance with the Quality Standards), and therefore compliance with the Quality Standards may not be a true reflection of the service being provided. Reviewers were aware that the lead for the low vision service was away at the time of the visit, but were also told by the team that they had not had sufficient time to prepare for the review.

Return to Index

COMMISSIONING

NHS WOLVERHAMPTON CCG

General Comments and Achievements

A Capacity and Demand Modelling exercise was planned for 2018/19 as part of the NHS England Elective Care Transformation Programme.

A commissioning group was in place that looked at the provision of services for Wolverhampton as a whole. Working with the Local Eye Health Network, it was able to take a wider view of how services should be developed and configured.

Reviewers saw that public awareness of eye health was supported by a wide range of good quality patient information.

Good Practice

1. See Primary Care section of the report.

Further Consideration

1. Child eye health screening was not commissioned by Wolverhampton CCG. Reviewers were told that screening services were commissioned by the local authority from Public Health England, but reviewers were not clear how the CCG had oversight of monitoring and reviewing data for the child health eye screening programme. School entry child health screening was undertaken at the Cannock Eye Centre and was commissioned by Staffordshire CCGs.
2. Reviewers noted that there was strong cross service working, with a good understanding of service needs. This was led by the service provided by the Acute Trust. Reviewers noted that there were robust commissioning arrangements in place. Reviewers suggested that commissioners might want to consider if there was a truly horizontal integration of services. Achieving this would allow commissioners to consider a move to strategic commissioning, providing a wider forum to challenge the current, more traditional, model, which could further improve the way services are provided.
3. Reviewers looked at the contracting and performance information discussed by commissioners and providers, and noted that it was of good quality although it was not detailed and was only a high-level overview. Reviewers did note that it focused largely on reporting discrepancies and areas of non-conformance (exception reporting). Reviewers noted that there did not seem to be a forum to celebrate success and good practice to allow this to be formally recognised.
4. Reviewers noted that the low vision service lacked prominence among patients and service users. Some patients told the visiting team that they were unaware of this service. The low vision service has a strong role in providing support to patients with visual impairment, and commissioners may wish to consider what more they could do to signpost patients to this service. It was thought that the ECLO post may have a lead role in this.

Return to Index

APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Visiting Team		
Mary Bairstow	National Development Manager	Vision UK
Ravi Bhakhri	Social Care Lead – Sensory	Sandwell Metropolitan Borough Council.
Danielle Clark	Medicines Assurance Pharmacist	NHS South Worcestershire, NHS Redditch & Bromsgrove and NHS Wyre Forest Clinical Commissioning Groups
Mr Samer El-Sherbiny	Consultant Ophthalmic Surgeon	South Warwickshire NHS Foundation Trust
Julia Phillips	Lead Nurse/Advanced Glaucoma Practitioner	The Dudley Group NHS Foundation Trust
Claire Roberts	Chair, Local Eye Health Network	NHS England – West Midlands
Mr Suresh Sagili	Consultant Ophthalmologist	The Shrewsbury & Telford Hospital NHS Trust
Karen Webster	Senior Sister	Wye Valley NHS Trust
Judith Whalley	User Representative	
Lesley Woakes	Director of Primary Care	NHS Herefordshire Clinical Commissioning Group

WMQRS Team		
Tim Cooper	Director	West Midlands Quality Review Service
Rachael Blackburn	Assistant Director	West Midlands Quality Review Service
Sarah Broomhead	Assistant Director	West Midlands Quality Review Service

Return to Index

APPENDIX 2 COMPLIANCE WITH THE QUALITY STANDARDS

Analyses of percentage compliance with the Quality Standards should be viewed with caution as they give the same weight to each of the Quality Standards. Also, the number of Quality Standards applicable to each service varies depending on the nature of the service provided. Percentage compliance also takes no account of 'working towards' a particular Quality Standard. Reviewers often comment that it is better to have a 'No, but', where there is real commitment to achieving a particular standard, than a 'Yes, but' where a 'box has been ticked' but the commitment to implementation is lacking. With these caveats, table 1 summarises the percentage compliance for each of the services reviewed.

Table 1 - Percentage of Quality Standards met

Details of compliance with individual Quality Standards can be found in a separate document.

Service	Number of Applicable QS	Number of QS Met	% met
Primary Care	4	4	100%
Wolverhampton Eye Infirmary – Specialist service	43	32	74%
Wolverhampton Eye Infirmary - Low Vision Services	30	13	43%
Child health screening – Cannock only	1	1	100%
Emergency Department	1	1	100%
Commissioning- NHS Wolverhampton	6	3	50%
Health Economy	85	54	64%

Return to Index

PRIMARY CARE

Ref	Quality Standards	Met? Y/N	Reviewer Comments
VA-101	**Primary Care Information and Support** Information and support for patients and, if appropriate, their carers should be available, covering at least: a. Health promotion, including smoking cessation, healthy eating, weight management, exercise, alcohol use, sexual and reproductive health, and mental and emotional health and well-being b. Services available in the local patient pathway, including self-referral to the low vision service c. Condition-specific information d. Eligibility for patient transport Information should be available in a range of accessible formats. Written information should be in at least 14 point font size with good contrast.	Y	Information was well written and met all the requirements of this QS.
VA-299	**Training and Development Programme** General practitioners, providers of General Ophthalmic Services and other health, social care and education practitioners working with groups of people with, or at risk of, vision impairment should participate in the local programme of training and development for primary care staff (QS VZ-602).	Y	The Local Optical Committee (LOC) organised training for primary care optometrists. The CCG had a good training programme for GPs. Ongoing evaluation of the training programme meant that changes to the programme had been made as a result of feedback. Reviewers were impressed that funding had been secured from NHS England for an improvement and innovation programme and that 30 out of 38 local practices were now involved in this work.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
VA-501	**Primary Care Guidelines** Guidelines on primary care management should be in use, covering at least the role of primary care in: a. Diagnosis, monitoring and management b. Management of acute exacerbations and acute complications c. Indications for urgent and routine referral to: i. Specialist (consultant-led) eye service ii. Enhanced primary care eye services (if available locally) d. Information to be sent with each referral, including Inclusion of photographs or other images of the eye e. Rapid referral pathways for: i. Suspected wet age-related macular degeneration ii. Retinal changes including suspected retinal detachment iii. Infections of the eye iv. Eye problems in children v. Post operative problems vi. Corneal graft problems f. Indications and arrangements for referral to the Low Vision Service	Y	
VA-502	**Domiciliary Service** Guidelines for domiciliary service provision should be in use covering at least: a. Referral criteria b. Advice and patient education c. Eye tests including: i. What tests should and should not be performed ii. Options if recommended tests cannot be performed d. Portable equipment required e. Supply and fitting of spectacles f. Spectacles after-sales service g. Advice and supply of low vision aids h. Further tests if required i. Referral if indicated, including to the Low Vision Service	Y	Domiciliary services were commissioned by NHS England through a direct contract with Primary Care Optometrists.

Return to Index

WOLVERHAMPTON EYE INFIRMARY – SPECIALIST SERVICE

Ref	Quality Standards	Met? Y/N	Reviewer Comments
VN-101	**Service Information** Each service should offer patients and, if appropriate, their carers information covering: a. Organisation of the service, such as opening hours, clinic times and transport arrangements b. Staff and facilities available c. Preparation for attending including, if appropriate, advice on driving and pupil dilation d. Availability of low vision aids e. How to contact the service for help and advice, including out of hours f. Eligibility for patient transport g. How to raise concerns about the service Information should be available in a range of accessible formats. Written information should be in at least 14 point font size with good contrast.	Y	A wide range of national and local information in suitable formats and language was accessible and visible in the areas visited by the Reviewers. The Trust booklet on falls prevention was particularly clear with advice for those with sight and mobility problems.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
VN-102	**Condition-Specific Information** Patients and, if appropriate, their carers should be offered information covering, at least: a. Brief description of their condition and its impact b. Possible complications and how to prevent these c. Therapeutic and rehabilitation interventions offered by the service, possible side-effects and likely outcomes d. Early warning signs of problems and action to take if these occur Information should be available for, at least, the following: i. Squints and other problems of vision development (children only) ii. Cataracts iii. Glaucoma iv. Eye trauma v. Corneal and conjunctival problems vi. Retinal problems including detachment, macular degeneration and retinopathy vii. Inflammatory eye conditions viii. Oculoplastics ix. Any other conditions commonly managed by the service Information should be available in a range of accessible formats, including digital and audio information. Written information should be in at least 14 point font size with good contrast.	Y	As QS VN-101.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
VN-103	**Visual Impairment and Information** Patients and, if appropriate, their carers should be offered information covering, at least: a. Managing with vision impairment or sight loss, including: i. Accessible information ii. Contrast and lighting iii. Magnification and visual aids iv. Aids and equipment available v. Safety, mobility and independent living, including training available b. Low Vision Service and how to access it c. Specialist Vision Impairment Teaching Service and how to access it d. Peer support groups available locally e. Range of statutory and voluntary services available locally, including counselling and psychological support services f. Sources of further advice and information including national organisations g. Certification of vision impairment (if appropriate) h. Benefits and welfare advice i. DVLA regulations and driving advice (if applicable) j. Health promotion, including smoking cessation, health eating, weight management, exercise, alcohol use, sexual and reproductive health, and mental and emotional health and well-being Information should be available in a range of accessible formats, including digital and audio information. Written information should be in at least 14 point font size with good contrast.	Y	As QS VN-101.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
VN-104	**Plan of Care** Each patient and, where appropriate, their carer should discuss and agree a plan of care covering at least: a. Preferred information format b. Agreed goals, including life-style goals c. Self-management d. Planned assessments, therapeutic and/or rehabilitation interventions e. Early warning signs of problems, including acute exacerbations, and what to do if these occur f. Planned review date and how to access a review more quickly, if necessary g. Name of 'key worker' who they can contact with queries or for advice h. Whether referred to or in contact with the Low Vision Service The patient should be offered a copy of their plan of care in their preferred format. The plan of care should be communicated to the patient's GP and, with the patient's agreement, their referring optometrist.	Y	Letters detailing treatment plans were sent to the referrer with a copy to patient and their General Practitioner. Reviewers considered that the QS was met but had some additional comments: 1. It wasn't clear if patients could receive letters in large print if required. 2. Patients attending for treatment for macular disease did receive a treatment plan but, due to the number of attendances for treatment, were not copied into the distribution of letters following each treatment session. 3. The day case service used a multilayer discharge sheet and staff would have to overwrite the carbonised print to make any advice clear for patients to read. Reviewers were told that these issues would improve once the new Trust electronic system was in operation.
VN-105	**Contact for Queries and Advice** Each patient and, where appropriate, their carer should have a contact point within the service for queries and advice. If advice and support is not immediately available, then the timescales for a response should be clear and should be specified for: a. Urgent queries b. Post-surgery queries c. All other queries Response times should be no longer than the end of the next working day. All contacts for advice and a sample of actual response time should be documented.	Y	Contact cards were given to patients with the relevant contact numbers

Ref	Quality Standards	Met? Y/N	Reviewer Comments
VN-106	**Education Health Care Plan (Services caring for children and young people only)** A Education Health Care Plan should be agreed with each child or young person whose eye condition impacts on their interaction with education materials or the educational environment, their family and their school. This plan should cover at least: a. Eye condition b. School attended c. Preferred format for learning materials and arrangements for sourcing materials in this format d. Safety and mobility while at school e. Aids and adaptations to learning environments f. Psychological and emotional support g. Care required while at school including medication h. Responsibilities of Specialist Visual Impairment Teaching Service, carers and school staff i. Likely problems and what to do if these occur, including what to do in an emergency j. Arrangements for liaison with the school k. Review date and review arrangements	Y	Staff from the specialist service would contribute to the Education and Healthcare Plans In general staff would liaise with the paediatric low vision specialist who would attended schools. Education Health Care Plans were completed for young people, usually by the paediatric low vision specialist. The ophthalmic consultants contributed to these plans as required. Good links with general paediatrics were in place.
VN-195	**Transition to Adult Services** Young people approaching the time when their care will transfer to adult services should be offered: a. The opportunity to discuss the transfer of care with paediatric and adult services b. A named coordinator for the transfer of care c. A preparation period prior to transfer d. Information in their preferred format about the transfer of care, including arrangements for monitoring during the time immediately afterwards	Y	Children transitioning to adult care stayed with their consultant if they provided care for both children and adults. This provided good continuity of care. The Paediatric Ophthalmologist would liaise with adult services as required. Reviewers were told that there were discussions taking place to make the transition process more robust.
VN-196	**Discharge Information** On discharge from the service patients and, if appropriate, their carers should be offered information in their preferred format covering at least: a. Care after discharge b. Safety, mobility and independent living c. Ongoing self-management of their condition d. Possible complications and what to do if these occur e. Who to contact with queries or concerns This information should be communicated to the patient's GP and, with the patient's agreement, their referring optometrist.	Y	The discharge leaflet given to patients was comprehensive.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
VN-197	**General Support for Patients and Carers** Patients and, if appropriate, their carers should have easy access to the following services and information about these services should be easily available: a. Interpreter services b. Independent advocacy services c. Complaints procedures d. Social workers e. Benefits advice f. Spiritual support g. *HealthWatch* or equivalent organisation	N	From discussions with staff the links with social services and access to independent advocacy services were not clear. Of note was that some of the information seen on the notice boards in the OPD areas were from 2008 (general information , IGA and Glaucoma).
VN-198	**Carers' Needs** Carers should be offered information on: a. How to access an assessment of their own needs b. What to do in an emergency c. Services available to provide support	Y	The arrangements for involving carers was very good. See good practice section of the report.
VN-199	**Involving Patients and Carers** The service should have: a. Mechanisms for receiving regular feedback from patients and, if appropriate, their carers about treatment and care they receive b. Audits of patients' experiences of: i. Accessing the service ii. Availability of accessible information c. Mechanisms for involving patients and, if appropriate, their carers in decisions about the organisation of the service d. Examples of changes made as a result of feedback and involvement of patients and, if appropriate, their carers	Y	See good practice section of the main report.
VN-201	**Lead Consultant and Lead Nurse** A nominated lead consultant and lead nurse should have responsibility for staffing, training, guidelines and protocols, service organisation, governance and for liaison with other services. The lead consultant and lead nurse should be registered healthcare professionals with appropriate specialist competences in this role and should undertake regular clinical work within the service.	Y	

Ref	Quality Standards	Met? Y/N	Reviewer Comments
VN-202	**Staffing Levels and Skill Mix** Sufficient staff with appropriate competences should be available for the: a. Number of patients usually cared for by the service and the usual age and case mix of patients b. Service's role in the patient pathway and expected timescales c. Assessments and interventions offered by the service d. Use of equipment required for these assessments and interventions e. Urgent review within agreed timescales An appropriate skill mix of staff should be available including: i. Ophthalmologists ii. Specialist nurses iii. Optometrists iv. Orthoptists v. Eye Clinic Liaison Officer vi. Other relevant allied healthcare professionals Cover for absences should be available so that the patient pathway is not unreasonably delayed, and patient outcomes and experience are not adversely affected, when individual members of staff are away.	N	At the time of the visit, with the high number of additional clinical sessions being held, reviewers were concerned that there were insufficient staff to manage the demand on the service. See also main report. The ECLO had no cover for absence.
VN-203	**Service Competences and Training Plan** The competences expected for each role in the service should be identified. A training and development plan for achieving and maintaining competences should be in place. Competences included should cover at least: a. Understanding the needs of children and adults with vision impairment and sight loss b. Communication with children and adults with vision impairment and sight loss c. Communication with people with hearing impairment d. Diversity specific to vision impairment and sight loss e. Interventions and procedures undertaken by non-consultant staff f. Use of equipment including biometry, OCT, microscope, flourescein, lasers	N	The service did not have a clear training plan place for each roles within the WEI. Competence frameworks were in place for all roles apart from health care assistant (HCA) roles. The Practice Education Facilitator did have plans to develop a framework for HCAs . A programme of skills training was in place for Band 2 staff to progress to Band 3 and for Band 4 staff to work alongside the ECLO. Competences were in place for the orthoptist and nurse practitioners who undertook intravitreal drug administration and injections. Ophthalmic diagnostic staff had developed specialist competences for their work in the eye imaging department. The new Practice Education Facilitator had also arranged for staff to visit Moorfields Eye Hospital to gain experience.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
VN-204	**Competences – All Health and Social Care Professionals** All health and social care professionals working in the service should have competences appropriate to their role in: a. Safeguarding children and/or vulnerable adults b. Dealing with challenging behaviour, violence and aggression c. Consent, Mental Capacity Act and Deprivation of Liberty Safeguards d. Resuscitation e. Information governance	N	Staff caring for vulnerable children and adults had not received Level 3 safeguarding training which reviewers expected some staff to have received. All staff had completed level 2 safeguarding training and other mandatory training had been completed.
VN-205	**Pathway Leads** A lead clinician for each of the following should be identified: a. Children's eye care, squints and other disorders of vision development b. Care of people with learning disabilities c. Cataracts d. Glaucoma e. Eye trauma f. Corneal and conjunctival problems g. Retinal problems including detachment, macular degeneration and retinopathy h. Inflammatory eye conditions i. Oculoplastics	Y	
VN-206	**Supervision** Arrangements should be in place for clinical supervision of non-consultant healthcare professionals providing specialist care.	Y	Supervision was in place for those non-consultant healthcare professionals with extended roles.
VN-299	**Administrative, Clerical and Data Collection Support** Administrative, clerical and data collection support should be available.	Y	

Ref	Quality Standards	Met? Y/N	Reviewer Comments
VN-301	**Support Services** Timely access to an appropriate range of support services should be available including: a. Low Vision Service b. Psychological support c. Smoking cessation service d. Dietary advice e. Specialist pathology service f. Genetic counselling g. Pharmacy h. Falls Prevention Service or staff with specialist expertise in falls prevention i. Occupational therapy Services caring for children and young people should also have access to: j. Paediatrician with a specialist interest in the care of children and young people with eye problems k. Child development team l. Specialist Visual Impairment Teaching Service	N	The referral routes or referral criteria to access to psychological support, dietary advice and occupational therapy were not clear. Smoking cessation services were not commissioned locally.
VN-302	**Supra-Specialist Eye Services** Timely access to an appropriate range of support services should be available: a. Specialist imaging of the eye i. Electro-diagnostic services ii. Ultrasound biomicroscopy iii. Corneal topography b. Ocular oncology c. Artificial eye service d. Specialist contact lens fitting e. Ocular complications of transplants	Y	
VN-303	**Imaging Services** Timely access to the following should be available: a. External photography b. Plain x-ray, ultrasound, CT and MRI	Y	
VN-304	**Other Specialist Services** Timely access to the following services should be available: a. Skin cancer multi-disciplinary team b. Endocrinology c. Rheumatology d. Neurology and neuro-surgery e. Vascular surgery f. Stroke service	Y	

Ref	Quality Standards	Met? Y/N	Reviewer Comments
VN-305	**Theatres and Anaesthetic Service** Timely access to appropriate theatres and anaesthetic services should be available, including: a. Lead anaesthetist with overall responsibility for ophthalmic anaesthesia and critical care pathways b. Theatres with staff with eye surgery competences	Y	
VN-401	**Facilities and Equipment** Facilities and equipment should be appropriate for the assessments, therapeutic and/or rehabilitation interventions offered by the service for the usual number and case mix of patients, including: **All facilities:** a. Suitable for the care of people with vision, physical and hearing impairments b. Easy availability of low vision aids c. Facilities for children and young people should be child-friendly and should ensure separation from adult patients d. Appropriate storage for medications, contact lenses and other disposables **Out-patient clinics**: e. Ability to change lighting levels and block out light f. Dedicated room for intravitreal injections g. Dedicated 'clean' procedure room **In-patient wards**: h. Isolation beds for patients with eye infections	Y	
VN-402	**Imaging Facilities and Equipment** The following imaging should be available within the eye unit or very close to where the service is delivered: a. Anterior and posterior segment photography b. Optic disc imaging c. Optical coherence tomography d. A & B scan ultrasound e. Angiography available within two days (where clinically indicated) Evidence of regular calibration of all equipment should be available. Images should be accessible from all locations where care is delivered and should be capable of being linked to the patient's medical record by their NHS number.	Y	

Ref	Quality Standards	Met? Y/N	Reviewer Comments
VN-403	**Lasers** Facilities where lasers are used should have appropriate radiation protection service certification of compliance with safety guidelines for laser treatments.	Y	
VN-499	**IT System** IT systems for storage, retrieval and transmission of patient information should be in use for patient administration, clinical records, outcome information and other data to support service improvement, audit and revalidation, including functionality for: a. Storage of images of the eye b. Timely retrieval of stored images c. Viewing historic images d. Viewing images taken in other services e. Producing large print letters and information in the patients' chosen format f. Secure transmission of patient-identifiable data to other services involved in the patient's care Monitors should be of the quality required for diagnosis of patient images captured from retinal angiograms or retinal screening, and for viewing other digital examinations.	Y	
VN-501	**Referral Triage** If referral pathways (QS VA-501) include triage of referrals the following arrangements should be in place: a. Patients and, if appropriate, their carers should be given information about the triage process, including clear timescales by which they will be informed of the outcome b. Staff with appropriate competences should be available to perform triage c. Appropriate facilities and equipment for triage of referrals should be available d. Clinical guidelines covering the triage process should be in use e. Timescales from referral to triage and from triage to appointment should be specified and monitored f. Data on the number of referrals for triage and the outcome of triage should be collected g. Arrangements for feedback to both the patient's GP and, with the patient's agreement, their referring optometrist h. Audit of implementation of clinical guidelines ('d') and appropriateness of triage decisions	N	Guidance covering triage of referrals was not seen by reviewers. Reviewers were told that guidance was available on the 'w' drive but when asked staff could not locate it. In practice Consultants would triage referrals into sub specialities. Emergency Department Practitioners also had a checklist which included when to seek further advice.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
VN-502	**Clinical Guidelines** Guidelines on diagnosis, assessment, management and discharge should be in use covering the usual case mix of patients referred to the service including: a. Squints and other disorders of vision development b. Cataracts c. Glaucoma d. Eye trauma e. Corneal and conjunctival problems f. Retinal problems including, at least, detachment, macular degeneration and retinopathy g. Inflammatory eye conditions h. Oculoplastics Guidelines should be specific on: i. Assessment of children and young people using techniques and methods appropriate to their age and development including, where appropriate, refraction and fundus examination after cycloplegia ii. Assessment of people with learning disabilities using appropriate techniques and methods, including orthoptic and functional visual assessment iii. Care during pregnancy and breast feeding, where applicable iv. Monitoring and follow up, including frequency of follow up, depending on the condition and stage on the patient pathway. Monitoring and follow up may be through shared care arrangements with General Ophthalmic Services. v. Arrangements for emotional support after discharge vi. Discharge of people who did not attend appointments	Y	

Ref	Quality Standards	Met? Y/N	Reviewer Comments
VN-503	**Ophthalmic Anaesthesia and Interventions** Guidelines should be in use covering: a. Patients needing a medical assessment prior to the intervention b. Management of minor operations in out-patients, including use of the WHO 'Safer Surgery' or other appropriate checklist c. Pre-operative assessment d. Choice of anaesthetic technique, including indications for sedation and contra-indications to local anaesthesia e. Pre-, intra-and post-intervention checklists f. Risk and posturing during vitreoretinal surgery for patients with intraocular gas tamponade g. Arrangements for emergency surgery outside normal working hours Guidelines should be specific about care of children, where applicable.	Y	Guidance covering pre-, intra-and post-intervention checklists and risk posturing during vitreoretinal surgery for patients with intraocular gas tamponade were not available at the time of the visit, however these were povided at a later date. Posturing advice is written in pts notes.Guidelines covering all other aspects of the QS were in place.
VN-504	**Local Referral Guidelines** Guidelines on referral to the following services should be in use: a. Low Vision Service b. Specialist Vision Impairment Teaching Service c. Eye Clinic Liaison Officer	N	Local referral guidelines were not yet place.
VN-505	**Onward Referral Guidelines** Guidelines should be in use covering referral of patients needing care not provided by the service or for which the service undertakes low volumes of activity, including at least: a. Specialist imaging of the eye i. Electro-diagnostic services ii. Ultrasound biomicroscopy iii. Corneal topography b. Ocular oncology c. Artificial eye service d. Specialist contact lens fitting e. Ocular complications of transplants f. Any other eye care services not provided locally	Y	

Ref	Quality Standards	Met? Y/N	Reviewer Comments
VN-595	**Transition** Guidelines on transition of young people from paediatric to adult services should be in use covering, at least: a. Involvement of the young person and, where appropriate, their carer in planning the transfer of care b. Involvement of the young person's general practitioner in planning the transfer c. Joint meeting between paediatric and adult services in order to plan the transfer d. Allocation of a named coordinator for the transfer of care e. A preparation period prior to transfer f. Arrangements for monitoring during the time immediately after transfer g. Informing the young person's GP and, with their agreement, other services involved in their care	N/A	As QS VN-195.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
VN-601	**Operational Policy** The service should have an operational policy describing the organisation of the service including, at least: a. Expected timescales for the patient pathway, including initial assessment, start of therapeutic and/or rehabilitation interventions and urgent review, and arrangements for achieving and monitoring these timescales b. Local policy for offering accessible information c. Identifying how patients prefer to move around the department and ensuring their wishes are followed whenever possible d. Arrangements for follow up of patients who 'do not attend' e. Arrangements for supply of: i. Optical correction ii. Medication, including first prescription iii. Education in use of ophthalmic medication iv. Spectacle vouchers f. Notification of visually impaired children and young people to the Specialist Visual Impairment Teaching Service g. Arrangements and responsibilities for certification of vision impairment h. Arrangements for collection, labelling and transfer of pathology samples i. Arrangements for care of patients requiring follow up from diabetic retinopathy screening, including separation of new, surveillance and follow-up patients j. Arrangements for management of patients that require timely follow-up due to their condition	N	An operational policy covering the requirements of the QS was not yet in place. Some policies were available.
VN-602	**Rapid Referral Pathways** The following rapid referral pathways should be in place: a. Suspected wet age-related macular degeneration b. Retinal changes including suspected retinal detachment c. Infections of the eye d. Eye problems in children e. Post operative problems f. Corneal graft problems	Y	

Ref	Quality Standards	Met? Y/N	Reviewer Comments
VN-603	**Multi-Disciplinary Discussion** Arrangements for multi-disciplinary discussion of relevant patients should be in place, including: a. Children and young people: Multi-disciplinary assessment and discussion with the child development team, relevant paediatricians and the Specialist Visual Impairment Teaching Service and any other relevant services b. People with learning disabilities: Multi-disciplinary discussion with learning disability services c. People with diabetes: Multi-disciplinary discussion with the specialist diabetes team d. Other multi-disciplinary discussion appropriate to the case mix of the unit e. Oculoplasty	N	Multidisciplinary discussion of patients was only in place for oculoplasty, for those patients with dry eye conditions and with patients with diabetes (when appropriate).
VN-604	**Liaison with Other Services** Review meetings should be held at least annually with key services to consider liaison arrangements and address any problems identified, in particular with: **All services:** a. Low Vision Service b. Diabetes Service c. Service for people with learning disabilities d. Emergency Department **Services caring for children and young people:** e. Child Development Team f. Paediatrician with a specialist interest in the care of children and young people with eye problems g. Specialist Visual Impairment Teaching Service	Y	
VN-605	**Specialist Clinics** The following specialist clinics should be available: a. Patients with glaucoma b. Patients with diabetes and eye problems c. Biomicroscopy for patients with diabetes and ungradeable images d. Laser treatment	Y	
VN-606	**Local Eye Health Network** Links with the Local Eye Health Network should be in place so that information about the work of the network is communicated to relevant staff and issues of concern to the service can be raised with the Local Eye Health Network.	Y	

Ref	Quality Standards	Met? Y/N	Reviewer Comments
VN-701	**Data Collection** Regular collection and monitoring of data should be in place, including: a. Referrals to the service, including source and appropriateness of referrals b. Number or assessments, urgent reviews and therapeutic and /or rehabilitation interventions undertaken by the service c. Outcome of assessments and therapeutic and /or rehabilitation interventions d. Number of discharges from the service and type of care after discharge e. Key performance indicators f. Types of anaesthesia used, including topical anaesthesia g. Patients referred to the Low Vision Service h. Children and young people referred to the Specialist Visual Impairment Teaching Service i. Patients certified as visually impaired j. Patients receiving ongoing care from the service k. Referrals for triage and the outcome of triage (if triage provided) l. Out-patient follow up to new ratio for each sub-specialty	N	Reviewers did not see evidence of data collection covering all the requirements of this QS. Data on 'a, b' and referral to treatment times were available.
VN-702	**Audit** The services should have a rolling programme of audit covering: a. Evidence-based clinical guidelines (QS VN-500s) for each sub-specialty b. Standards of record keeping c. Timescales for key milestones on the patient pathway d. Any active Royal College of Ophthalmologists national audits e. Certification of vision impairment	Y	However reviewers did not see any evidence of submission to any national audits.
VN-703	**Key Performance Indicators** Key performance indicators (QS VN-701) should be reviewed regularly with Trust (or equivalent) management and with commissioners.	N	As QS VN- 701.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
VN-798	**Multi-Disciplinary Review and Learning** The service should have multi-disciplinary arrangements for a. Review of and implementing learning from positive feedback, complaints, outcomes, incidents and 'near misses' b. Review of and implementing learning from published scientific research and guidance c. Ongoing review and improvement of service quality, safety and efficiency	Y	
VN-799	**Document Control** All policies, procedures and guidelines should comply with Trust (or equivalent) document control procedures.	Y	

Return to Index

WOLVERHAMPTON EYE INFIRMARY - LOW VISION SERVICES

Ref	Quality Standards	Met? Y/N	Reviewer Comments
VP-101	**Service Information** Information on the Low Vision Service should be widely available covering: a. How to contact the service for help and advice b. Arrangements for patients who are housebound c. How to access the service d. Opening hours e. Range of services, staff, facilities, equipment and technology available f. Eligibility for free or subsidised transport to the service and how to arrange this g. How to raise concerns about the service Information should be available in local optometrists' premises, diabetic retinopathy screening locations and in the local specialist eye service. Information should be in a range of accessible formats. Written information should be in at least 14 point font size with good contrast.	N	There was a wealth of patient information available for all the services provided. However, for low vision specifically, it was unclear to reviewers what the actual referral route to the service was. The Eye Clinic Liaison Officer (ECLO) had been in contact with everyone who had a Certificate of Visual Impairment. But reviewers highlighted that the route for patients who did not require certification was unclear. Reviewers concluded that they could not be certain that patients were fully aware of what was available either and therefore that they did not have the right level of information available to them.
VP-102	**Condition-Specific Information** Service users and, if appropriate, their carers should be offered information covering, at least: a. Common eye conditions b. Possible complications and how to prevent these c. Early warning signs of problems and action to take if these occur Information should be available in a range of accessible formats including digital and audio information. Written information should be in at least 14 point font size with good contrast.	Y	

Ref	Quality Standards	Met? Y/N	Reviewer Comments
VP-103	**Visual Impairment Information** Service users and, if appropriate, their carers should be offered information covering, at least: a. Managing with visual impairment or sight loss, including: i. Accessible information ii. Contrast and lighting iii. Magnification and visual aids iv. Aids and equipment available v. Safety, mobility and independent living, including training available b. Specialist Vision Impairment Teaching Service and how to access it c. Peer support groups available locally d. Range of statutory and voluntary services available locally, including counselling and psychological support services e. Sources of further advice and information including national organisations f. Certification of vision impairment (if appropriate) g. Benefits and welfare advice h. DVLA regulations and driving advice (if applicable) i. Health promotion, including smoking cessation, health eating, weight management, exercise, alcohol use, sexual and reproductive health, and mental and emotional health and well-being Information should be available in a range of accessible formats. Written information should be in at least 14 point font size with good contrast.	Y	

Ref	Quality Standards	Met? Y/N	Reviewer Comments
VP-104	**Personalised Plan** Each service user and, where appropriate, their carer should discuss and agree their personalised plan of care, and should be offered a written record covering at least: a. Preferred information format b. Summary of assessment of visual function and eye health c. Agreed goals, including life-style goals d. Self-management e. Planned interventions and associated costs including, if applicable: i. Preventing further sight loss ii. Safety, mobility and independent living training iii. Provision of optical and non-optical equipment and technology, including any associated costs iv. Social care provision v. Counselling and emotional support vi. Specialist Vision Impairment Teaching Service support vii. Employment advice and support f. Welfare and benefits advice g. Certification of vision impairment (if appropriate) h. Early warning signs of problems, including acute exacerbations, and what to do if these occur i. Planned review date and how to access a review more quickly, if necessary j. Who to contact with queries or for advice The service user should be offered a copy of their personalised plan of care in their preferred format. The plan of care should be communicated to the patient's GP and, with the patient's agreement, to other services involved in their care.	N	There was no evidence of personalised care plans available to reviewers at the time of the review and therefore it is not clear whether the requirements of this QS are in place. However, reviewers noted and commented that there was limited administrative support available which may impact on the ability of the team to deliver all the requirements of this QS.
VP-105	**Contact for Queries and Advice** Each service user and, where appropriate, their carer should have a contact point within the service for queries and advice. If advice and support is not immediately available, then the timescales for a response should be clear. Response times should be no longer than the end of the next working day. All contacts for advice and a sample of actual response time should be documented.	Y	

Ref	Quality Standards	Met? Y/N	Reviewer Comments
VP-106	**Education Health Care Plan (Services caring for children and young people only)** An Education Health Care Plan should be agreed with each child or young person whose eye condition impacts on their interaction with education materials or the educational environment, their family and their school. This plan should cover at least: a. Eye condition and other medical conditions (if applicable) b. School attended c. Preferred format for learning materials and arrangements for sourcing materials in this format d. Safety and mobility while at school e. Aids and adaptations to learning environments f. Psychological and emotional support g. Care required while at school including medication h. Responsibilities of Specialist Visual Impairment Teaching Service, carers and school staff i. Likely problems and what to do if these occur, including what to do in an emergency j. Arrangements for liaison with the school k. Review date and review arrangements	Y	There was no documentary evidence available to reviewers at the time of the review. However, from discussions, there was evidence that the paediatric low vision specialist attended schools and had input into the discussions at schools and had contributed to the Education Healthcare Plans.
VP-196	**Discharge Information** On discharge, service users and, if appropriate, their carers should be offered information covering at least: a. Maintaining agreed goals, including ongoing self-management b. Possible problems and what to do if these occur c. How to re-access the service d. Who to contact with queries or concerns This information should be communicated to the service user's GP and, with the service user's agreement, to other services involved in their care.	N	Reviewers were not provided with any copies of discharge letters so were unclear as to what information was actually included in the discharge letter.
VP-197	**General Support for Service Users and Carers** Service users and, if appropriate, their carers should have easy access to the following services: a. Interpreter services b. Independent advocacy services c. Complaints procedures d. Spiritual support e. HealthWatch or equivalent organisation	N	No evidence was seen for ‘b, d or e’.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
VP-198	**Carers' Needs** Carers should be offered information on: a. How to access an assessment of their own needs b. What to do in an emergency c. Services available to provide support d. Services specific to visual impairment including sight awareness training	Y	
VP-199	**Involving Service Users and Carers** The service should have: a. Mechanisms for receiving regular feedback from service users and, if appropriate, their carers about treatment and care they receive b. Audits of service users' experiences of: i. Accessing the service ii. Availability of accessible information c. Mechanisms for involving service users and, if appropriate, their carers in decisions about the organisation of the service d. Examples of changes made as a result of feedback and involvement of service users and, if appropriate, carers	Y	
VP-201	**Lead Professional** A nominated lead professional should have responsibility for staffing, training, guidelines and protocols, service organisation, governance and for liaison with other services. The lead professional should be a health or social care professional with appropriate specialist competences for this role and should undertake regular work within the service.	Y	

Ref	Quality Standards	Met? Y/N	Reviewer Comments
VP-202	**Staffing Levels and Skill Mix** Sufficient staff with appropriate competences should be available for the: a. Number of users of the service b. Service's role in the local pathway and expected timescales c. Assessments and interventions offered by the service d. Equipment, technology and training provided by the service An appropriate skill mix of staff should be available including: i. Optometry / orthoptics ii. Social work iii. Occupational therapy iv. Psychological support v. Mobility, orientation and daily living skills vi. Eye Clinic Liaison Officer Cover for absences should be available so that service provision is not unreasonably delayed, and outcomes and experience are not adversely affected, when individual members of staff are away.	Y	However, they did observe that there appeared to be a lack of integration between the paediatric and adult low vision services.
VP-203	**Service Competences and Training Plan** The competences expected for each role in the service should be identified. A training and development plan for achieving and maintaining competences should be in place. Competences included should cover at least: a. Safeguarding children and/or vulnerable adults b. Understanding the needs of children and adults with vision impairment and sight loss c. Communication with children and adults with visual impairment and sight loss d. Communication with people with hearing impairment e. Diversity specific to vision impairment and sight loss f. Providing emotional support g. Dealing with challenging behaviour, violence and aggression	N	Reviewers did see evidence of training and competency plans for staff. However, reviewers noted that for the low vision team (who are dealing with vulnerable children and adults due to the nature of their condition) that they would expect some staff to have received Level 3 safeguarding training. Reviewers did not see any evidence of compliance with 'd or g'. Reviewers were told that supervision for the ECLO was not yet in place and the postholder had only received limited induction training - restricted to the Trusts mandatory training programme.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
VP-299	**Administrative, Clerical and Data Collection Support** Administrative, clerical and data collection support should be available.	Y	No dedicated administrative support was in place for the adult low vision service. There was some provision in paediatrics. The Optometrists all contributed to the Low Vision work and therefore the admin team participated in this work too. There was no backlog.
VP-301	**Services providing Support and Advice** If these are not part of the Low Vision Service multi-disciplinary team (QS VP-202), timely access to the following services should be available a. Optometry b. Social work c. Occupational therapy d. Psychological support e. Mobility, orientation and daily living skills f. Eye Clinic Liaison Officer g. Falls Prevention Service or staff with specialist expertise in falls prevention h. Specialist Vision Impairment Teaching Service	N	A Trust falls team was based on hospital site, however Reviewers were told that there was no mechanism in place for referring patients attending WEI to the falls team. The trust subsequently sent a falls prevention service referral form, but there is no evidence of how or when its used. Referral to the Specialist Vision Impairment Teaching Service (SVITS) was included as part of the pathway following diagnosis - and was therefore assumed. The trust have since informed us that each patient is asked at their next routine visit if the referral has happened. It was believed that all referrals were appropriately actioned. However, reviewers noted that there was no governance in place to audit how many referrals had happened as planned.
VP-401	**Facilities** Facilities available should be appropriate for the assessments and interventions offered and designed or adapted for the needs of people with visual, physical and hearing impairments.	Y	Low vision aids were evident in clinical rooms. However, at the time of the visit the ECLO was used by other services although reviewers were advised there were plans to address this.
VP-402	**Low Vision Assessment** Appropriate equipment for eye examinations should be available and appropriately maintained.	Y	

Ref	Quality Standards	Met? Y/N	Reviewer Comments
VP-403	**Equipment Supplied** At least the following equipment should be available, including for demonstration and loan: a. Hand and stand magnifiers b. Table mounted stand magnifiers c. Spectacle mounted plus lenses d. Hand held monocular / binoculars e. Contrast enhancing tints and glare protection shields f. Other low vision and independent living aids g. Special optical solutions for people with stroke Information should be available on how to access equipment and technology not supplied locally. Facilities available should be appropriate for the assessments and interventions offered and designed or adapted for the needs of people with visual, physical and hearing impairments.	Y	However, 'g' was provided by the stroke team and not the low vision team.
VP-499	**IT System** IT systems for storage, retrieval and transmission of service user information should be in use for administration, clinical records, outcome information and other data to support service improvement, audit and revalidation.	N	Reviewers noted that the ECLO had a good system in place for recording relevant information and for analysing the data. However, there was no evidence yet of outcome data or data that was in a format to support service improvement, audit and validation.
VP-501	**Assessment Guidelines** Guidelines on assessment should be in use covering at least: a. Eye examination (unless the service has evidence of a recent examination or referral for examination) b. Functional visual assessment c. Holistic needs assessment, including screening for depression d. Falls risk assessment	N	Good guidelines for 'a' eye examination (the low vison protocol included a trigger for a clinical assessment at an appropriate point in the pathway and optometrists could make this decision). However, there was no evidence for 'c or d'.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
VP-502	**Guidelines** Guidelines should be in use covering, at least: a. Provision or prescription of optical and non-optical low vision aids b. Training to enable vision aids to be used effectively, for example, eccentric viewing or rehabilitation training c. Provision of or referral to: i. Home assessment and mobility rehabilitation services ii. Counselling iii. Education and employment services iv. Benefits advice v. Peer support groups d. Monitoring and follow up	N	No evidence was available for 'b, c or d'.
VP-503	**Referral for Equipment and Technology** Guidelines on referral for specialist equipment and technology not supplied by the service should be in use covering, at least, referral for: a. Spectacle mounted telescopes b. Biopic telescopes c. Reverse telescopes d. Hemianopia prisms e. Other equipment and technology not supplied by the service	N	No written guidelines were in place and referrals appeared to be based on individual 'needs assessment' rather than following any standardised guidance.
VP-601	**Operational Policy** The service should have an operational policy describing the organisation of the service including, at least: a. Expected timescales for the local pathway and arrangements for achieving and monitoring these timescales, including ensuring contact is made within 10 days of referral, urgent assessments are completed within two weeks of referral and all assessments are completed within 18 weeks of referral b. Local policy for offering accessible information c. Arrangements for follow up of service users who 'do not attend' d. Arrangements for multi-disciplinary discussion of appropriate service users e. Arrangements for liaison with specialist eye services f. Arrangements for liaison with Specialist Visual Impairment Teaching Services g. Arrangements and responsibilities for certification of vision impairment	N	Reviewers did not see a copy of an operational policy which covered the requirements of the QS. In practice there were arrangements covering 'b,c,e,f and g'. A referral to treatment pathways was in place.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
VP-602	**Liaison with Other Services** Review meetings should be held at least annually with key support services to consider liaison arrangements and address any problems identified, in particular with: a. Specialist eye care services for the local area b. Specialist Visual Impairment Teaching Services for the local area c. Other relevant voluntary sector services available locally	N	See QS VP301 above for SVTI. The ECLO had excellent knowledge of the services available. However, there was no evidence of formal meetings. There was also some confusion as to whether the ECLO could refer to these services. The ECLO reported to the reviewers that he could not but the leads for the ophthalmology service said that processes were in place for the ECLO to refer directly as required.
VP-606	**Local Eye Health Network** Links with the Local Eye Health Network should be in place so that information about the work of the network is communicated to relevant staff and issues of concern to the service can be raised with the Local Eye Health Network.	Y	
VP-701	**Data Collection** Regular collection and monitoring of data should be in place, including: a. Referrals to the service, including source and appropriateness of referrals b. Number or assessments and interventions undertaken by the service c. Outcome of assessments and interventions d. Number of discharges from the service e. Key performance indicators including: i. Number of first contacts within 10 days of referral ii. Completion of urgent assessments within two weeks of referral iii. Completion of all assessments within 18 weeks of referral	N	The reviewers did not see any evidence of data collection - as required by this QS for the adult service. Some referral data was seen for the paediatric service (not 'b to e') A good system was in place in the paediatric service that flagged a child's 5th birthday, so checks could be made to ensure that a low vision assessment had been completed.
VP-702	**Audit** The services should have a rolling programme of audit of compliance with: a. Evidence-based clinical guidelines (QS VP-500s) b. Standards of record keeping c. Timescales for key milestones on the local pathway	N	Reviewers saw some audits in the paediatric service although they were limited. There was no evidence of audits being completed in the adult low vision service.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
VP-703	**Key Performance Indicators** Key performance indicators (QS VP-701) should be reviewed regularly with service managers and commissioners.	N	Although KPIs were collected in the department they did not appear to include a set of specific measures for the low vision service.
VP-798	**Multi-Disciplinary Review and Learning** The service should have multi-disciplinary arrangements for: a. Review of and implementing learning from positive feedback, complaints, outcomes, incidents and 'near misses' b. Review of and implementing learning from published scientific research and guidance c. Ongoing review and improvement of service quality, safety and efficiency	N	Reviewers recognised that review and learning was taking place within the department, however, they did not see that this included representation from the low vision team. Although the ECLO had many good ideas and was collecting data on the service this information did not appear to be fully integrated with the data from other teams in the department.
VP-799	**Document Control** All policies, procedures and guidelines should comply with local document control procedures.	N	The documentation that was seen by reviewers for the low vision service did not include any meta data to demonstrate when the document had been published or when it was due for review.

Return to Index

CHILD HEALTH SCREENING – CANNOCK ONLY

Ref	Quality Standards	Met? Y/N	Reviewer Comments
VK-601	**Newborn Screening** Services providing eye and vision screening for newborn babies should have: a. Guidelines on undertaking eye examinations of newborn babies b. Staff with competences in undertaking newborn eye screening c. Indications and arrangements for onward referral of babies with possible eye problems d. Arrangements for communication with parents and GP about the possible problem and follow-up arrangements e. Collection of data on: i. Coverage of newborn screening ii. Number of babies referred for further investigation or assessment iii. Number of babies referred to a specialist eye service	N/A	Neither Cannock or WEI services were commissioned to undertake eye vision screening for newborn babies.
VK-602	**Six to Eight Week Screening** Services providing eye and vision screening for babies aged six to eight weeks should have: a. Guidelines on undertaking eye examinations of babies, including equipment required b. Staff with competences in undertaking eye screening in babies c. Indications and arrangements for onward referral of babies with possible eye problems d. Arrangements for communication with parents and GP about the possible problem and follow-up arrangements e. Collection of data on: i. Coverage of six to eight week screening ii. Number of babies referred for further investigation or assessment iii. Number of babies referred to a specialist eye service	N/A	Neither Cannock or WEI services were commissioned to undertake eye and vision screening for babies aged six to eight weeks old.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
VK-603	**School Entry Screening** Services providing eye and vision screening for children on school entry should have: a. Guidelines on undertaking eye examinations of school entry children, including equipment required b. Staff with competences in undertaking eye screening in children c. Indications and arrangements for assessment by an optometrist before referral to a specialist eye service (unless contraindicated) d. Indications for referral to a specialist eye service e. Arrangements for communication with parents, school, Specialist Vision Impairment Teaching Service and GP about the possible problem and follow-up arrangements f. Arrangements for multi-disciplinary discussion with Child Development Centre and community paediatric services g. Collection and reporting of data on: i. Coverage of school entry screening ii. Number of children assessed by an optometrist and outcome of this assessment iii. Number of children referred to a specialist eye service	Y	School Entry screening was only delivered at the Cannock Eye Centre and commissioned by Staffordshire CCGs for the local population.

Return to Index

EMERGENCY DEPARTMENT

Ref	Quality Standards	Met? Y/N	Reviewer Comments
VE-501	**Emergency Eye Care** Guidelines should be in use covering: a. Triage of patients with eye problems b. Types of eye problems accepted by the service c. Age of patients with eye problems accepted by the service d. Hospitals to which patients not accepted by the service (age and type of problem) should be referred For patients with eye problems accepted by the service: e. A dedicated room with appropriate equipment and drugs available f. Availability of staff with competences in the care of people with eye problems g. Arrangements for supervision of junior medical staff h. Access to consultant ophthalmologist advice (24/7) i. Arrangements for patients to be seen by a specialist eye service (24/7) j. Arrangements for local follow up of patients seen by non-local specialist eye services	Y	Guidelines were not in place covering the requirements on the QS. However, the service accepts and treats all people who arrive at the door. there is no age restriction. See and Treat policy means all patients are triaged by the see and treat process. There are no restrictions on case mix as they see everyone. Therefore although there is not a direct policy for 'a to d' technically the standard is met.

Return to Index

COMMISSIONING- NHS WOLVERHAMPTON

Ref	Quality Standards	Met? Y/N	Reviewer Comments
VZ-601	**Needs Assessment and Strategy** For the eye health pathway, commissioners should have an agreed: a. Needs assessment b. Strategy for the development of services to meet local needs across the patient pathway The local strategy should cover, when appropriate, prevention (primary and secondary), assessments, therapeutic interventions, rehabilitation and re-ablement.	N	Wolverhampton CCG had an active Ophthalmology Development Workstream and work was in progress to develop a strategy and needs assessment. A plan across the Sustainability and Transformation Partnership (STP) to agree a methodology aligned to 'Getting it Right First Time' (GIRFT) for ophthalmology surgery was in the process of being implemented.
VZ-602	**Commissioning of Services** Services for the eye health pathway should be commissioned including: a. Prevention and awareness raising programmes b. Training and awareness programme for primary care and other health, social and education practitioners working with groups with, or at risk of, vision impairment. c. Shingles vaccination for people aged over 70 d. Child health screening for eye and vision problems at birth, age six to eight weeks and school entry e. Triage of referrals (optional) f. Enhanced primary care eye service (optional) g. Specialist (consultant-led) eye service h. Low Vision Service For each service, commissioners should specify: i. Range of assessments, therapeutic and/or rehabilitation interventions offered ii. Criteria for referral to and discharge from the service including, for the Low Vision Service, self-referral and referral from any health and social care professional iii. Whether the service cares for children, adults or both iv. Locations from which patient care is to be provided v. Key performance indicators	N	Reviewers saw that some elements of this were in place; however, the arrangements for: c. Overseen by Public Health England d. Reviewers were not able to see commissioning plans for this group. It was understood that the local authority had some role in commissioning child health screening.
VZ-603	**Public Awareness** A programme of public awareness of eye health, eye care and preventing eye problems should be run locally.	Y	Wolverhampton CCG actively engaged with national and local campaigns to ensure that a programme of public awareness of eye health, eye care and preventing eye problems was in place

Ref	Quality Standards	Met? Y/N	Reviewer Comments
VZ-606	**Local Eye Health Network** The commissioner should ensure that meetings of the Local Eye Health Network, involving patients and, if appropriate, their carers, representatives of services in the local pathway and commissioners, are held at least annually.	Y	A Pan-commissioning group was in place.
VZ-701	**Quality Monitoring** At least annually, commissioners should monitor for each service commissioned: a. Key performance indicators b. Aggregate data on activity and outcomes	Y	Contract review meetings were in place. Data seen by reviewers was high level and did not show any operational detail; but reviewers saw strong evidence that data was being used to inform decisions. Reviewers noted that much of the reporting covered exception reporting where the service did not meet agreed key performance indicators. Reviewers considered that it was difficult to see therefore how the service was recognised and success celebrated during these meetings. Reviewers noted that there was a good understanding of commissioning, but this was not yet fully horizontally integrated. Reviewers felt that a move to greater strategic commissioning might allow commissioners to challenge the use of different models of care from a more traditional model.
VZ-702	**Quality Monitoring - Screening** At least annually, commissioners should monitor: a. Coverage of each screening programme b. Referrals for further investigation or assessment c. Referrals to specialist eye service of children with screening- detected problems	N	Reviewers noted that for child health screening there was no local process for monitoring child health screening data, although the responsibility for delivering this was with PHE.

Return to Index