Royal Cornwall Hospitals
NHS Trust

Ophthalmology Management of Patients Who Report Deteriorating Eyesight Standard Operating Procedures

V1.0

June 2024

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Data Protection Act 2018 (UK General Data Protection Regulation – GDPR) Legislation.

The Trust has a duty under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team.

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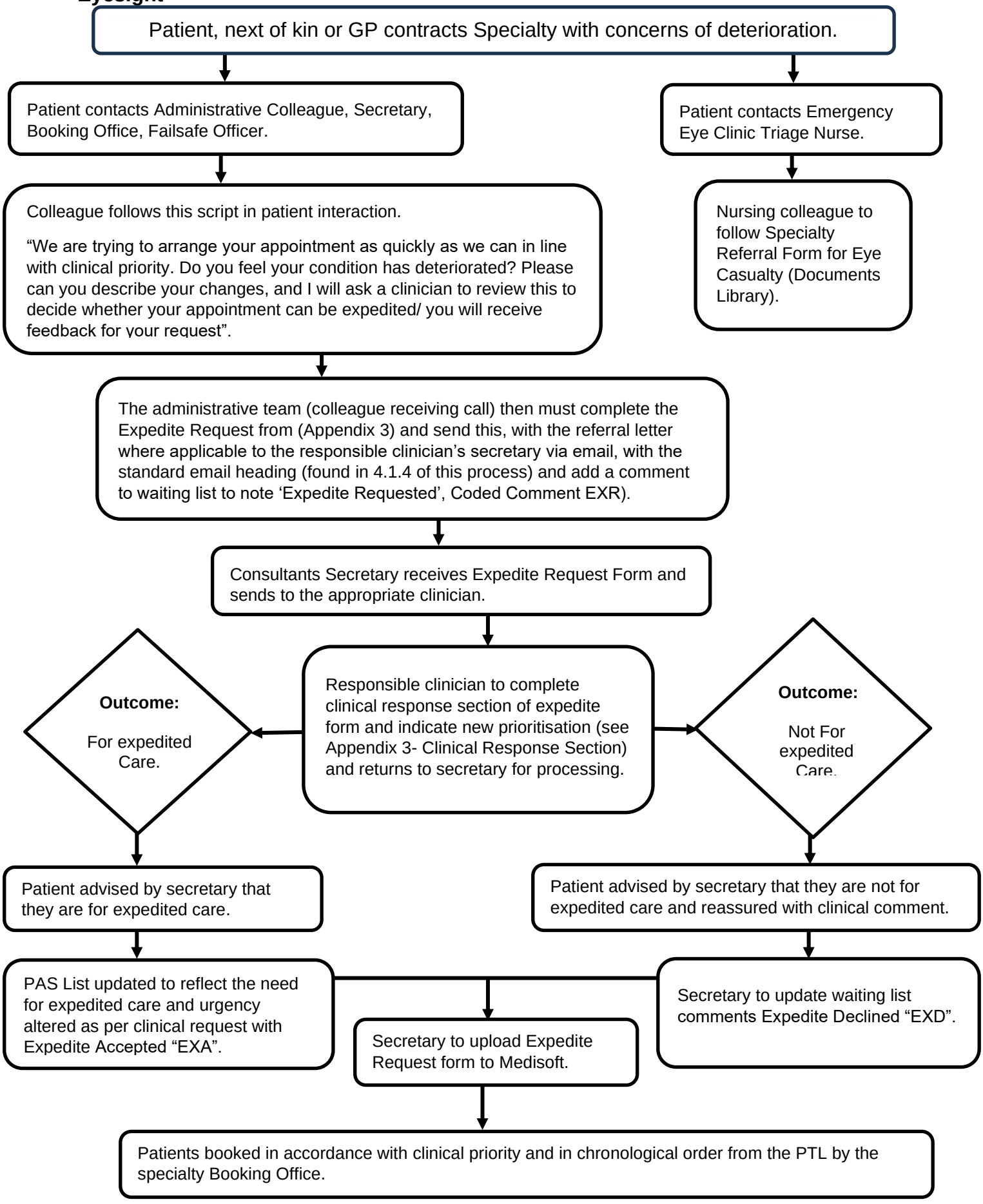
Summary - Flow Chart for the Management of Patients Who Report Deteriorating Eyesight



1. Introduction

1.1. Patients on outpatient and procedure waiting lists are listed and managed according to clinical priority at the time of triage or listing based on the recommended Latest Clinically Appropriate Date (LCAD) which is set as an outcome of outpatient attendance. Clinical priority can change whilst a patient is on a waiting list and this process describes how a patient can be expedited, by GP or patient request.

1.2. The aim is to avoid the need for patients to return to primary care to initiate a GP or optometry expedite request and to create a safety net for ophthalmic patients who are routinely being seen outside of LCAD.

1.3. The service recognises that at times delays experienced by patients can be due to both hospital and patient factors.

1.4. Delayed waits can lead to patients contacting the specialty experiencing a deterioration or concerns with their condition.

1.5. This operating procedure sets out the expected standards and process to follow to ensure all patients who contact the department with concerns regarding their condition are treated equally against a set criterion for escalation.

1.6. The aim of this is to protect patient safety and provides staff with the tools to ensure appropriate levels of ownership and responsibilities for each staff group.

2. Purpose of this Standard Operating Procedure

2.1. To ensure that patients are treated in order of clinical need and are only expedited when this is agreed by the responsible clinician because of deterioration in their condition.

2.2. To avoid unnecessarily expediting patients and negatively affecting the treatment of other patients on the waiting list.

Definition: Expedite means that the referrer or patient has requested their appointment or admission date is brought forward because their condition has deteriorated and they require an earlier appointment/admission, or that the patient has flagged a deterioration in their condition whilst waiting.

This procedure aligns with the Standard Operating Procedure for Expediting Patients on a Waiting List (Outpatient, Diagnosis or Elective).

2.3. Due to the differences in administrative management of patients in ophthalmology's subspecialities, the decision has been made by the specialty that there is a requirement for this specific process and guidance for staff who process expedite requests for ophthalmic patients.

3. Ownership and Responsibilities

3.1. Role of the Service Manager and Clinical Leads.

Service Manager and Clinical Leads are responsible for:

- Ensuring patient pathways are managed in accordance with the trust access policy.
- Ensuring patients are treated fairly and equitably.
- Ensure the process as identified in this standard operating procedure is followed by both clinical and non-clinical staff when a patient or next of kin calls the speciality with concerns or a deterioration in their eyesight that they believe is related to their overdue appointment.

3.2. Role of the Administrative Staff – First Point of Contact regarding Escalation/Concern Request.

- Administration staff, namely inpatient and outpatient booking teams and secretaries, are likely to be the first point of contact regarding escalation/concern request.
- The fundamental role of the administrative staff member is to note the initial concern and escalation by the patient as accurately as possible, following the process for patients who call with concerns as defined in the flowchart on page 3 of this standard operating procedure.
- Escalation of patient's current wait and expected clinical interval to be seen based on current clinical capacity and utilisation as defined in the flowchart on page 3 of this standard operating procedure.
- Rebooking of successfully expedited patients into clinical slots based on feedback from medical reviews of patients reported symptoms and urgency.
- Communicating an outcome, successful or not, to the patient, following clinical review.
- Recording and notating any escalation on hospital administrative systems and Medisoft Electronic Patient Record (EPR).
- Escalation and monitoring of any patient request that has gone unseen or unanswered by clinical or non-clinical colleagues.

3.3. Role of the Nursing Staff – First point of contact regarding escalation/concern request via Emergency Eye Clinic.

If the first point of contact regarding escalation/concern is made to the Emergency Eye Clinic, this standard operating procedure must not be followed. In these circumstances the nursing staff are expected to triage the patient by following the speciality referral form for Eye Casualty found in the document's library.

3.4. **Role of Clinician for Escalation/Concern.**

- The clinician for the escalation is responsible for the timely review of the patient's concern, and the assessment of their perceived risk of the patient's concern based on the information provided to them.

- The clinician for the escalation is responsible to clearly communicate the outcome of their concern or escalation by means of amended urgency and new recommended clinical interval.

- It is also expected that, given capacity constraints in the specialty, should the new clinical interval create the need for cancellation or reprioritisation of current patients booked into clinics or theatre lists, that the responsible clinician tries to reprioritise another patient to ensure that this escalation requirement can be safely met.

    - ❖ If this is not possible due to booked urgency, then this escalation for the requirement of extra capacity needs to be clearly requested to the service's clinical administration lead and service manager.

- If a deterioration of a patient's eyesight is escalated and re-prioritised to be booked sooner than the wait-risk coefficient, and a patient has lost vision due to their wait time, it is the responsibility of the Doctor that reviews the patients in clinic to report this as a clinical incident via the incident reporting system.

4. Standards and Practice

4.1. **Standards.**

4.1.1. Only a responsible clinician can make an informed decision around the appropriateness of a patient's escalation based on their judgement.

4.1.2. The administrative management of the patient's escalation to the responsible clinician should only follow the process and procedures outlined in this standard operating procedure and should be documented and evidenced on trust clinical systems.

4.1.3. The standard operating procedure and guidelines have been created to create the most standardised version of this process as possible to ensure that all patients experience the same service. Unwarranted variation in the way that patient concerns are escalated may lead to patients coming to harm.

When sending the expedite request form (Appendix 3) the following email subject heading must be used:

Confidential Urgent Action: Request to Expedite Care due to Deterioration (Patient CR) (DATE OF EMAIL).

4.2. **Practice**

4.2.1. The practice for this standard operating procedure is in the flow chart the process for patients who call with concerns as defined in the flowchart on **page 3** of this standard operating procedure.

4.2.2. The escalation process must be followed in practice and escalated to the following clinicians for each sub-specialty for escalation review.

- Glaucoma – Virtual Glaucoma Consultant.
- Medical Retina – Virtual Retina Consultant.
- Diabetic Ophthalmology – Virtual Diabetic Consultant.
- Other subspecialties; Corneal, Vitreoretinal, Oculoplastic, Strabismus/ Squint, Paediatric, Cataract – escalation for Consultant Lead for subspecialty or Consultant On-call.

5. Dissemination and Implementation

5.1. This document replaces the trust process specifically for the Ophthalmology department. All other non-ophthalmology specialties should follow that process.

5.2. This document should be disseminated to all staff in the Ophthalmology department and shared upon sign-off via the specialty Business and Governance meeting.

5.2.1. Administrative staff should receive this information as part of their training/induction.

5.2.2. Clinical staff will need to read and digest this information as part of their first week of induction into processes in the department.

5.3. The implementation of this standard operating procedure will be through amendment to the current process with the current team.

5.4. Compliance to this change in process will be managed by the service manager and clinical admin lead to ensure that patients who escalate are being appropriately managed in accordance with this process in initial 6 monthly audits.

6. Monitoring Compliance and Effectiveness

Information Category	**Detail of Process and Methodology for Monitoring Compliance**
Element to be monitored.	Evidence of process being followed by the PAS coded comment entries aligned with the form for completion in.
Lead.	Service Manager.
Tool.	PAS Waiting Lists for Ophthalmology. Coded Comment Entries.

Information Category	Detail of Process and Methodology for Monitoring Compliance
Frequency.	Initial 6 Monthly Audit to ensure Compliance.
Reporting Arrangements.	Speciality Business and Governance Meetings. The lead or committee is expected to read and interrogate the report to identify deficiencies in the system and act upon them.
Acting on Recommendations and Lead(s).	Ophthalmology Service Manager. Ophthalmology Clinical Lead. Specialist Services Leadership Team if required for escalation.
Change in Practice and Lessons to be Shared.	Required changes to practice will be identified and actioned within one month of sign off, of this document. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.

7. Updating and Review

This section covers information regarding the review process. All procedural documents should be reviewed no less than every three years. Where appropriate, the author may set a shorter review date.

8. Equality and Diversity

8.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the Equality Diversity And Inclusion Policy or the Equality and Diversity website.

8.2. Equality Impact Assessment.

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Ophthalmology Management of Patients Who Report Deteriorating Eyesight Standard Operating Procedure V1.0
This document replaces (exact title of previous version):	New Document.
Date Issued / Approved:	May 2024.
Date Valid From:	June 2024.
Date Valid To:	June 2027.
Author / Owner:	Fergus Laity, Service Manager, Ophthalmology.
Contact Details:	fergus.laity@nhs.net
Brief Summary of Contents:	Ophthalmology administrative process for escalation of patient concerns.
Suggested Keywords:	Booking, Ophthalmology, Escalation, Concerns.
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer.
Approval Route for Consultation and Ratification:	Specialty Leadership Team. Care Group Leadership Team.
Manager confirming Approval Processes:	Roz Davies.
Name of Governance Lead confirming consultation and ratification:	Maria Lane.
Links to key external standards:	None.
Related Documents:	None.
Training Need Identified:	Yes Please see the training detailed in section 5 of this Standard Operating Procedure.

Information Category	Detailed Information
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet.
Document Library Folder/Sub Folder:	Clinical/Ophthalmology.

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
May 2024.	V1.0.	New.	Fergus Laity Service Manager.

All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity, and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Ophthalmology Management of Patients Who Report Deteriorating Eyesight Standard Operating Procedure V1.0
Department and Service Area:	Ophthalmology.
Is this a new or existing document?	New.
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Fergus Laity.
Contact details:	fergus.laity@nhs.net

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed).	Patients who are escalating their changed symptoms to the department and the staff who receive and process these calls.
2. Policy Objectives.	Reduce potential for patients to come to harm due to mismanaged escalations. Encourage staff to ensure all relevant information is collected and shared for each patient.
3. Policy Intended Outcomes.	Reduced variation in the management of patient escalations. Improvements in patient safety for all patients.
4. How will you measure each outcome?	Monitoring compliance to process through methods discussed in section 6 of this standard operating procedure
5. Who is intended to benefit from the policy?	Patients and Staff.

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category).	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: Yes
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Ophthalmology Outpatient booking team. Ophthalmology Inpatient booking team.
6c. What was the outcome of the consultation?	Approved.
6d. Have you used any of the following to assist your assessment?	Process Maps.

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age.	No	
Sex (male or female).	No	
Gender Reassignment (Transgender, non-binary, gender fluid etc).	No	
Race.	No	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc).	No	
Religion or Belief.	No	

Protected Characteristic	(Yes or No)	Rationale
Marriage and Civil Partnership.	No	
Pregnancy and Maternity.	No	
Sexual Orientation (e.g. gay, straight, bisexual, lesbian etc.).	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Fergus Laity.

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis

Appendix 3. Expedite Request Email Template

GP or Patient Expedite Request – for Clinical Review (for patients on outpatient, diagnostic or elective waiting lists)	
Patient Details	
Name.	
Date of Birth.	
Hospital No.	
NHS No.	
Expedite request	
Date of Patient Contact or receipt of GP Letter.	DD/MM/YYYY
Specialty.	
Name of Responsible Clinician (if applicable).	
Outpatient/Diagnostic/Elective Procedure	(delete as applicable)
Date listed (for new outpatients, diagnostics and procedures).	DD/MM/YYYY
Date to be seen by (for follow-up appointments).	DD/MM/YYYY
Current Priority.	PA, PB, P2, P3, P4, D1, D2, D3, TB
Reason for expediting request (please document symptoms of deterioration).	
Clinical Response	
Request to Expedite Approved/Declined.	(delete as applicable)
Amended Priority *(see Appendix 4).*	
Comments.	
Coded Comment updated on PAS.	(tick to indicate completed)
Booking Office notified of Change of Priority.	(tick to indicate completed)

Appendix 4: Waiting List Prioritisation

National surgical prioritisation		RCHT PAS code
P1a	Urgent-Emergency <48 hours.	PA
P1b	Urgent < 72 hours.	PB
P2	Urgent < 1 month.	P2
P3	Urgent < 3 months.	P3
P4	Routine > 3 months.	P4
TB	Planned procedure.	TB

RCHT diagnostic prioritisation	
D1	Urgent diagnostic 2ww.
D2	Urgent diagnostic.
D3	Routine diagnostic 4-6 weeks.
TB	Planned procedure.

RCHT delay category	
P5	Patient wishes to postpone procedure because of COVID-19 concerns.
P6	Patient wishes to postpone procedure due to non-COVID-19 concerns.