Quality Standard Self-Assessment Tool

Commissioners of ophthalmology services

The Royal College of Ophthalmologists champions excellence in care. In order to provide the best care for patients, and to generate improvements in care, it is important to be able to measure the quality of clinical services provided. In addition, measuring quality provides quality assurance data for patients, regulators and commissioners.

Please send feedback on the form and how you have used it to assess and change your services to Beth Barnes, Head of Professional Support beth.barnes@rcophth.ac.uk.

Standards for best practice and innovation

	Question	Reference	Yes/No	Comment
1.	Is there engagement, cooperation and collaboration between community, secondary care colleagues and commissioners?			
2.	Does the commissioning specification include requirements for training, accreditation and ongoing CPD for provider staff?			
3	Is there a performance management structure including a process for dealing with underperforming or potentially unsafe professionals?			
4	Are clear evidence based protocols in places for the service?			
5	Are suitable patient information leaflets about their condition available for patients and any causes of concern given to the majority of attendees?			
6	Is a discharge summary or letter sent to GPs after all attendances?			

7	Are there clear communication channels for sharing clinical and clinical governance information between primary and secondary care ophthalmology?			
8	Are there named clinical governance leads and identified medicolegal responsibilities for all care provided?			
9	Are there facilities for incident reporting and complaints, for investigating these and for sharing the learning across the whole primary and secondary care network?			
10	Is there clinical audit of care against recognised and agreed standards, and ideally processes for joint clinical audit of care between primary and secondary care?			
11	Is patient satisfaction measured regularly?			
12	Are there facilities for joint clinical governance, case review and educational meetings across organisations?			
13	Are there clear, meaningful and realistic KPIs, including any false positive and false negative referrals to secondary care, unplanned return rate?			
14	Are there regular formal assessments of cost effectiveness involving the commissioners?			
15	Is the CCG capturing data using the VISION 2002UK portfolio of indicators as a tool to demonstrate improvement within the local eye health and sight loss pathways? (Use indicators for local contract measures or local audit)?			

16	There is an agreed policy covering do not attend (DNA) patients, cancellations and rescheduling that takes into account visual disability, the needs of vulnerable adults, communication with patients and primary care physicians and also ensures clinician input into decisions on timing of rebooking or discharge			
17	Is there easy access to an Eye Clinic Liaison Officer or patient support officer?			
18	Is there access to low vision aid (LVA) services within the 18 weeks referral to treatment time?			

Glaucoma

Full document: RCOphth Quality Standards for Glaucoma Services
https://www.rcophth.ac.uk/standards-and-guidance/

	Question	**Yes/No**	**Comment**
1	At least 80% of patients affected by glaucoma are seen within a dedicated glaucoma service with appropriate triage of cases between specialist and general clinics?		
2	New patient visits: Patients attending with glaucoma or OHT or as suspected glaucoma have baseline IOP, gonioscopy, pachymetry, visual field assessment and optic disc imaging performed?		
3	The service consistently reviews patients regularly in line with College and NICE guidelines on glaucoma and adheres to clinician requested timing of appointments based on clinical risk or progression?		

Adnexal Services

Full document: RCOphth Quality Standards for Adnexal Services
https://www.rcophth.ac.uk/standards-and-guidance/

	Question	Yes/No	Comment
1	Is there at least one consultant with subspecialist adenxal disease training?		
2	Are patients affected by significant or serious adnexal eye disorders (defined above) are seen within a dedicated adnexal service?		
3	Are care and outcomes audited, using recognised standards (e.g. the BOPSS national ptosis audit), and used for quality assurance and to improve services?		

Cataract Services

Full document: RCOphth Quality Standards for Cataract Services
https://www.rcophth.ac.uk/standards-and-guidance/

	Question	Yes/No	Comment
1	Is care compliant with NICE cataract surgery guidelines. Staff are aware of and follow the guidelines or use local cataract care guidelines based on the NICE publication?		
2	Are pre and post-surgical cataract patients managed by appropriately trained clinical staff, or trainees under the supervision of fully trained staff, and appropriate protocols are adhered to?		
3	Where nonmedical staff see cataract patients, are appropriate governance arrangements are in place including regular in-house training, extended role protocols and recorded competency standards?		
4	Are outcomes of cataract surgery are audited, using recognised standards, and used for quality assurance and to improve services and are provider organisations contributing to the National Ophthalmology Audit?		

	If necessary, postoperative data should be obtained from community optometrists		

Corneal Services

Full document: RCOphth Quality Standards for Corneal Services
https://www.rcophth.ac.uk/standards-and-guidance/

	Question	Yes/No	Comment
1	Are patients affected by significant or serious corneal and external eye disorders seen within a dedicated corneal and external service?		
2	IS Corneal imaging and diagnostic instruments available for use on site or within the network when appropriate?		
3	Are outcomes for corneal surgery audited, using recognised standards, and used for quality assurance and to improve service?		
4	Is data is submitted for patients undergoing grafting to the national corneal audit via NHS Blood and Transfusion NHSBT “yellow form” system?		

Diabetic Retinopathy Services

Full document: RCOphth Quality Standards for Diabetic Retinopathy Services
https://www.rcophth.ac.uk/standards-and-guidance/

	Question	Yes/No	Comment
1	Is there a system and the necessary staff and infrastructure for logging new referrals of patients with DR and tracking their attendance, appointments and treatments in line with standards of the national diabetic eye screening programme?		
2	Is there a system and the necessary staff and infrastructure for ensuring that patients with active proliferative DR (R3A, Scotland R3, R4) and sight-		

	threatening diabetic maculopathy (M1A, Scotland M2) are assessed and treated within the time frame stipulated by the nation al diabetic eye screening programme?		
3	Are all patients with a diabetic retinopathy grade of R2, R3A or M1A (Scotland R3, R4 and M2) assessed and treated in clinics with access to retinal imaging, intravitreal injection and laser treatment facilities in appropriate time scales?		
4	Do patients have access to vitreoretinal surgery, within a local network if required?		
5	Does the DR service routinely has access to referral letters from, and photographic images taken at, community DR screening encounters?		
6	Does the hospital DR service have a mechanism for ensuring the screening programme, GP and patient are notified of the visual acuity, retinopathy grade and pathway status of each patient within the DR service?		
7	Does the service regularly monitor adherence to clinic requested timing and has no significant “follow up backlog” or appointment delays (follow up and treatment appointments occur within 25% of the planned interval, including following hospital initiated cancellations)?		
8	Is there a policy for do not attend (DNA) patients, cancellations, rescheduling and discharge that considers vulnerable groups, communication with primary care physicians and the local screening programme, and ensures clinician input into decisions on timing of rebooking or discharge?		
9	Are care outcomes audited, using recognised national standards, and used for quality assurance and to improve services (e.g. timing to assessment and laser treatment from		

	referral; adherence to NCIE criteria for intravitreal injections; complication rates for intravitreal injections?		

Medical Retina Services

Full document: RCOphth Quality Standards for Medical Retina Services
https://www.rcophth.ac.uk/standards-and-guidance/

	Question	Yes/No	Comment
1	Is there a MR/AMD/diabetic retinopathy clinic coordinator or failsafe officer to ensure high risk patients are seen and managed on time?		
2	Is LogMar visual acuity testing in routine use (defined as over 75% of the time) for patients?		
3	Are specialist investigations available where appropriate?		
4	Is there a local rapid referral proforma and pathway for suspected wet AMD for optometrists and general practitioners?		
5	Are appropriate governance arrangements in place including regular in-house training, extended role protocols and recorded competency standards for non-medical staff seeing MR patients (including no-nmedical staff undertaking intravitreal injections)?		
6	Does the service regularly monitors adherence to clinician requested timing and has no significant “follow up backlog” or delay?		
7	Is there an agreed policy covering do not attend (DNA) patients, cancellations and rescheduling that takes into account visual disability, the needs of vulnerable adults, communication with patients and primary care physicians and also ensures clinician input into decisions on timing of rebooking or discharge?		

Neuroophthalmology Services

Full document: RCOphth Quality Standards for neuroophthalmology Services
https://www.rcophth.ac.uk/standards-and-guidance/

	Question	Yes/No	Comment
1	Are patients affected by significant or serious neuro-ophthalmic disorders seen within a dedicated neuro-ophthalmology clinic?		
2	Are appropriate investigations available with rapid access if required?		
3	Is multidisciplinary care available and utilised where appropriate?		
4	Does the service undertake regular audits using recognised standards?		

Vitreoretinal Services

Full document: RCOphth Quality Standards for Viteroretinal Services
https://www.rcophth.ac.uk/standards-and-guidance/

	Question	Yes/No	Comment
1	Are patients affected by significant or serious VR disorders seen within a dedicated VR service?		
2	Are VR imaging and diagnostic instruments available for use when appropriate?		
3	Are at least 95% of patients who present with acute symptomatic macula-on rhegmatogenous retinal detachment ssessed by an ophthalmologist competent in examining and assessing the retina within 24 hours of initial diagnosis?		
4	Are at least 95% of patients who present with acute symptomatic macula-on rhegmatogenous retinal detachment scheduled for surgery in a timeframe which is appropriate to the clinical scenario?		
5	Is retinal detachment surgery carried out by a surgeon who is competent to		

	carry out the procedure (consultant VR surgeon, a trainee under the supervision of a consultant VR surgeon, or a senior VR trainee with sufficient experience to operate unsupervised)?		
6	Does the unit hve in place clear protocols to allow timely surgery including arrangements with other regional/national VR units for urgent cover?		
7	Are outcomes for VR surgery audited, using recognised standards, and used for quality assurance and to improve services? Outcome audits should be case mix adjusted		

Action Plan

Issue identified	Action to be taken	Who will lead action	Date for completion