A vision for ophthalmology

The outpatient model needs to change – and ophthalmology could be a good place to start. A recent HFMA roundtable, supported by Allergan, discussed how recent innovations can be embedded and further change encouraged. Steve Brown reports

Former NHS chief executive Simon Stevens once famously described the outpatient model as obsolete, and he wasn't the first to call for reform. If change is needed, ophthalmology must be near the front of the queue for transformation. It is the biggest outpatient specialty, accounting for nearly eight million appointments a year – 8% of total outpatients activity – and second only to trauma and orthopaedics in terms of the overall waiting list for treatment.

Each year that goes by, the urgency of reform becomes greater. Between 2009/10 and 2019/20 outpatient attendances across all specialties grew by 43% to more than 96 million. Growth in ophthalmology attendances was slightly lower, but still a staggering 33%.

The Covid-19 pandemic has increased the pressure on the NHS, adding to the waiting list and the number of long waiters. There are additional concerns about a sizeable hidden waiting list of patients who delayed coming forward for treatment over the last 18 months.

Covid has undeniably accelerated the transformation programme for outpatients with, for example, the widespread adoption of virtual appointments. In July, the HFMA held a roundtable, supported by pharmaceutical company Allergan (part of AbbVie), to discuss how outpatient transformation could be incentivised, enabling the service to retain appropriate aspects of the changes over the past year and moving further.

There was recognition that payment systems would not deliver reform. The changes needed are, in many cases, cultural. But the finance system does have an important part to play in facilitating the changes.

The session was chaired by James Roach, managing director of consultancy Conclusio and a former clinical commissioning group chief officer. He said that some of the changes made as part of the response to Covid-19 provided a really good platform for further transformation. 'But we've got to make sense of that financially,' he said. And there were further opportunities in the adoption of digital technologies and changing roles across the whole ophthalmology pathway.

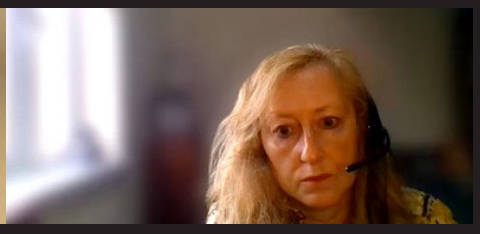
Mike Proctor, a former NHS chief executive and now a non-executive director with North Lincolnshire and Goole NHS Trust, outlined the challenge. 'The outpatient model served patients well for the first 30 years of the NHS, but it has become outdated,' he said, adding that it provided an inefficient way for GPs to seek consultant advice. At the same time, consultants had been 'brought up to see patients face-to-face'.

The rapid move to virtual consultations as part of the response to Covid-19 had taken most people by surprise and the future would

SHUTTERSTOCK


James Roach


Mike Proctor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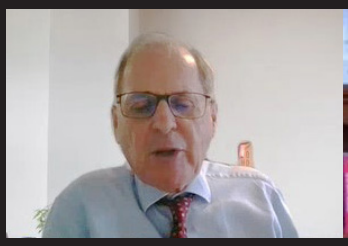
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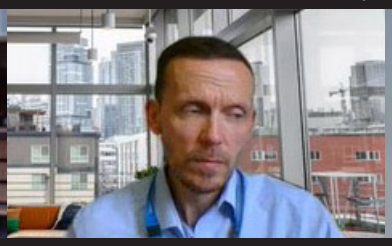
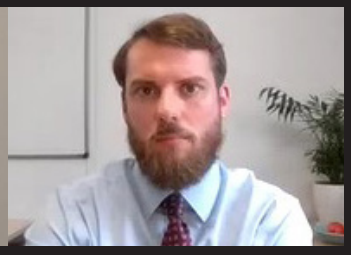
Andrew Geldard


Lee Rowlands


Robert Unsworth


Patrick McGinley


Anant Jani


Terry Whittle

Allergan, an AbbVie company, sponsored the overall facilitation of the roundtable. It did not have any involvement in choosing the attendees, the content, topic or agenda of the roundtable. Neither did Allergan have any input in the development of this article.

need to be a mixed model, said Mr Proctor. 'But let's not underestimate what we are asking consultants to do and be sympathetic to it,' he said. 'And the finance model has to make it work and be sustainable.'

Patrick McGinley, head of costing and service line reporting at Maidstone and Tunbridge Wells NHS Trust, insisted that transformation could look different for different pathways. 'We should not think about a single pathway or transformation. There is no one size fits all. We should be asking what should a transformed glaucoma pathway look like. What is the wet age-related macular degeneration (AMD) pathway? And what is the strabismus pathway? They won't be the same as each other.

'There is no single ophthalmology pathway and a single cost or tariff is unlikely to reflect the complexities of the different pathways.'

However, he said that at the moment, analysis of outpatient activity would be difficult, because diagnosis data was not recorded for outpatient attendances – a point that would come up later when discussing the data requirements to inform transformation.

Transformation is already under way across the country. Moorfields Eye Hospital NHS Foundation Trust and other specialist and non-specialist trusts have set up a number of diagnostic hubs for high-volume outpatient investigations.

A patient moves through the lanes having their pressures taken, an optical coherence tomography (OCT) scan and whatever else they need, without seeing another patient. The revised pathway reduces the time each patient spends in clinic to just 45 minutes and cuts the number of overall face-to-face reactions.

Consultant ophthalmologist Declan Flanagan, vice president of the Royal College of Ophthalmologists and a former medical director at Moorfields, said the eye hospital had also put a lot of effort into optimising virtual pathways, as well as the reporting, patient communication, IT infrastructure and 'fail safe' structures that support them. These are essential in providing an acceptable service to patients and in making best use of the multidisciplinary team.

'A lot of my colleagues have become more like radiologists, sitting at screens making diagnoses and ordering interventions,' he said.

However, funding flows now needed to change to support these new working practices. 'The issue comes down to making sure the virtual clinics are properly funded by commissioners,' he added. 'They don't come free and do require some investment, but they can be more cost-effective than traditional clinics in many situations.'

Terry Whittle, director of finance at

Participants

- Declan Flanagan, vice president, Royal College of Ophthalmologists
- Andrew Geldard, former chief officer, West Essex CCG
- Anant Jani, director of clinical insight, Conclusio
- Patrick McGinley, head of costing and service line reporting, Maidstone and Tunbridge Wells NHS Trust
- Visseh Pejhan-Sykes, chief finance officer, Leeds CCG
- Mike Proctor, non-executive, North Lincolnshire and Goole NHS Trust
- James Roach (chair), managing director, Conclusio
- Lee Rowlands, contract director, Manchester University NHS Foundation Trust
- Kathryn Skill, specialty general manager for ophthalmology, Nottingham University Hospitals NHS Trust
- Robert Unsworth, head of pricing strategy, NHS England and NHS Improvement
- Terry Whittle, director of finance, Milton Keynes University Foundation Trust

HFMA ROUND TABLE

Milton Keynes University NHS Foundation Trust, acknowledged that change often needs investment. 'But we need to go into conversations aware of the constraints around resources,' he said. 'If we are looking for investment to support transition or to pilot a new approach, we also need to apply creative thinking to areas where we can recycle resources.' Linking new investment to the identification of waste could lead to 'potent discussions', he added.

Anant Jani, director of clinical insight at consultancy Conclusio, as well as a research fellow at the University of Oxford who formerly worked on the NHS RightCare programme, said transformation also had to involve stopping some activity, not just doing it better. 'I've been speaking to GPs and their workload hasn't decreased [as a result of virtual consultation during the pandemic],' he said.

'We have made consultations more efficient for patients, but the fundamental question we should be answering is: should we be doing it in the first place?'

Mr Jani gave two examples. In Oxford, imaging activity has gone up 8%-10% a year in recent years, a pattern seen across the country. 'It's all done to a high-quality standard, but we have no idea of the clinical utility of these diagnostics,' he said. He highlighted a massive variation in thyroid testing discovered by the RightCare programme, with little clarity as to what the right rate of testing should be.

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'Before jumping into solutions to improve productivity, let's find out what problem we are trying to solve and eliminate the things we shouldn't be doing in the first place, so we can free up resources that can be used to invest in higher value activities and drive overall improvements in the NHS,' he said. 'We need to understand the levels of transformation we can realistically achieve.'

Payment role

The national tariff system of payment by results is now recognised as inappropriate for the new context of collaborative system working.

Robert Unsworth, head of pricing strategy at NHS England and NHS Improvement, said that the system had worked well for the task it faced in 2006 – supporting the reduction of waiting times. But it had increasingly been identified as an obstacle to service change, creating conflict between commissioners and providers.

While providers may have wanted to move outpatients to a virtual setting or explore consultations on the same day as a diagnostic, the tariff structure meant this often led to a loss of income. 'It didn't make a good environment for transformation,' he said.

One response could have been to create more and more outpatient tariffs. But instead, the national tariff bodies have proposed an aligned payment and incentive approach as the default mechanism for payment.

This will go live once the current temporary block contract arrangements as part of the Covid response come to an end.

The new system will see commissioners/systems agree fixed payments with providers based on agreed levels of activity. A variable element will initially be used to adjust for levels of elective activity different from plan. Separately for this year, an elective recovery fund has been put in place to support the recovery of elective services.

However, Mr Unsworth said this could not just involve rolling forward block contracts at fixed prices, which would simply lock in existing problems. Instead, fixed payments had to increasingly reflect the local cost of delivering agreed levels of activity.

'A number of things are hampering this for outpatients,' he said, adding that the coding of patients is one. 'In the data, we can't differentiate between a cataract follow-up from an acute uveitis. And that makes it difficult for setting the fixed payment.'

Increasingly, he said, systems would need to develop an understanding of system costs and this would be far more important than tariff prices, which will continue to be published, but only as a benchmark.

Visseh Pejhan-Sykes, chief finance officer for Leeds Clinical Commissioning Group, backed moves away from payment by results. While she accepted the current elective recovery programme, which pays full tariff rates for activity above 2019/20 levels as one way of addressing the backlog, a different mechanism was needed 'in times of peace'.

"Colleagues have become more like radiologists, sitting at screens making diagnoses and ordering interventions"

Declan Flanagan

She described the aligned incentive contracts that had been adopted in Leeds since 2018 – a system that shares common characteristics with the proposed new national approach.

'We had challenging conversations over payment by results with the local trust,' she said. 'No-one ever won, but we were constantly arguing over tens of millions of pounds.'

After detailed discussions with clinicians, it became clear the activity-based system was preventing pathway changes – with a switch to virtual consultations, for example, leading to significant loss of income for providers.

'So we agreed in the first instance to safeguard the money going into each specialty,' she said.

'If a rheumatologist or dermatologist agreed to use cheaper drugs or did fewer follow-ups, they would still get the same money, as long as waiting lists didn't increase and primary care didn't see a knock-on impact. We also had to ensure that primary care didn't take advantage of the fixed payment arrangements by increasing referral rates.'

Describing this as a 'first stage change', Ms Pejhan-Sykes said this worked well for changes within specialties, with waste reduction conferences helping to spread pathway improvements across the organisation. However, this doesn't address the challenge of moving funds from one part of the system to another – acute to community, say.

Lee Rowlands, contract director of Manchester University NHS Foundation Trust and chair of the HFMA Payment Systems Special Interest Group, agreed this was the key challenge. Even under payment by results, he said, the Greater Manchester city region had helped facilitate local payment approaches to support reform.

For example, his trust designed a local pathway for AMD, supported by a year-of-care tariff, which was then implemented – a significant move away from the national tariff approach at the time, but using the flexibility of a local variation.

But more generally, said Mr Rowlands, block contracts in recent years had provided opportunities for transformation, albeit within services. 'We are still at the start of the journey in terms of understanding how to move funds between services,' he said.

The more integrated way of working pioneered by the city as part of the Greater

Manchester devolution programme did provide a better platform for such changes, Mr Rowlands added.

Mr Flanagan said the proposed fixed payment system must be used to ensure that every integrated care system [ICS] has an adequate cataract service for its population. However, it is not yet possible to predict and calculate, with the same degree of accuracy, the demand for glaucoma care and the costs of providing it for a given population.

This is because glaucoma care is long-term and requires robust risk stratification with the optimum care model still not completely clear.

'You can calculate reasonably accurately from the Office for National Statistics data what the cataract demand will be for a given population and the expected annual increase,' said Mr Flanagan.

'Each ICS can then agree with the relevant providers what funding is required and how it is shared out among various providers, both NHS trusts and independent sector providers.'

He highlighted joint guidance recently published by the Royal College of Ophthalmologists and the College of Optometrists stating that patients do not require hospital follow-up after routine, uncomplicated surgery, which he said was approximately 80% of all cataract surgery.

Outcome data

However, it is essential that the National Ophthalmic Database still receives timely outcome data on cataract surgery to document that patients continue to receive a high standard of care. This leaves an issue with ensuring outcomes are recorded.

Mr Flanagan said optometrists are best placed to provide this outcome data and there needs to be an informed discussion about the appropriate level of remuneration for this.

'Multidisciplinary teams and surgeons also need to rapidly improve processes and working practices to ensure they can deliver eight to 10 cataract procedures in four hours,' he said.

Providers and commissioners must also include training of surgeons and the whole multidisciplinary workforce in planning and resourcing cataract services.

'The NHS needs to deliver up to half a million cataract procedures a year to meet demand to give the population the service it should receive,' Mr Flanagan added.

'This cannot be done at an affordable price without substantial changes in working practices and requires every ICS to engage with

"The outpatient model served patients well for the first 30 years of the NHS, but it has become outdated"
Mike Proctor

NHS trusts and independent sector providers in an equitable, transparent fashion.'

One of the problems for ophthalmology is a shortage of capacity to meet demand. There was agreement among roundtable participants that the payment system should encourage earlier intervention downstream and perhaps incentivise the uptake of risk stratification.

The participants backed moves away from a focus on income, effectively encouraged by the old tariff system, and towards a greater understanding of pathway costs.

Mr McGinley said any payment system had to meet the legitimate costs of a provider in delivering the commissioned care.

However, this hadn't been the case under the tariff system – and the fact remains that fixed prices in future will be heavily influenced by tariff prices, at least initially.

'The national cost indices were published recently and the average cost for a follow-up in ophthalmology was £101, yet the tariff was £59,' he said. 'The gap is £100m nationally on our cost base – that is the size of the challenge.'

The fixed costs relating to Maidstone and Tunbridge Wells' private finance initiative hospital limited the system's ability to reduce costs, he added.

Mr Whittle agreed with the need to focus on provider costs and accept that unless changes led to a reduction in staff, consumables or buildings, it was disingenuous to suggest resources would be reduced. He asked how many outpatient transformations would lead to reductions in the physical space needed or fewer staff.

Instead, systems needed to broaden their focus to look at full costs across the pathway and be able to describe packages of change and the overall impact on system resource.

He used diabetes as an example. 'We may celebrate in a silo, thinking we have successfully reduced activity through triage by 20%,' he said. 'But unless you have supported that change by putting management plans out into the community or invested in education or widened access for support programmes such as Dafne [a course to support diabetics to keep blood glucose levels stable], then you are probably going to be seeing those patients presenting later in the pathway in a more expensive way because you've not addressed the underlying issue.'

Structures will also be important in supporting transformation. One problem in driving change in recent years has been a perceived power imbalance between small clinical commissioning groups and large provider bodies.

The move to systems could correct this by effectively creating bigger 'commissioners' and giving the integrated care board a leading role in the system. But he said there were still issues to resolve around accountability. With providers retaining their own financial targets, there remained the potential for conflict between organisations and systems.

Ms Pejhan-Sykes warned that the increasing commissioner size should not go too far, underlining the importance of retaining place-based relationships between providers and commissioners.

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And Andrew Geldard, former chief officer of West Essex Clinical Commissioning Group, said that the system changes had to do more than consolidate existing power blocks – the concept of 'commissioning' needed further attention.

'I prefer to separate out paying from commissioning,' he said. 'CCGs have probably been drawn into paying rather than commissioning in recent times.

'But there may be organisations in systems that are better placed to pay for pathways and manage pathways that are not the local CCG or central ICS. So for the ophthalmic pathway, is the local specialist acute better placed for a number of reasons?'

Provider innovation, governance and the right data flows could make this the case. 'Do we need to come away from some of the traditional commissioner-provider splits and come up with a model that sings more to the integration agenda?' Mr Geldard added.

Kathryn Skill is specialty general manager for ophthalmology at Nottingham University Hospitals NHS Trust – part of the Nottingham and Nottinghamshire ICS – and one of the leaders in the move to more integrated care through system working. She said that as a result of the integration approach, there were more conversations across system players.

Backlog problems pre-exist Covid-19, although the pandemic has clearly exacerbated the position. However, she said, relationships

were good and there was agreement about the need to reduce touch points in tertiary centres and to make more use of community optometrists.

'We want to reduce footfalls into the trust, free-up capacity for more complex cases, and make it easier for patients,' Ms Skill said. 'It's a win-win.'

However, she said that, although everyone was on the same page, there were challenges in moving from talking about change to putting proposals into practice.

Data challenge

Information will be key to identifying opportunities for change, addressing health inequalities and assuring that changes have led to the planned improvement.

However, there was agreement among participants that there needed to be an improvement in the data recorded around outpatient appointments across the board and within ophthalmology specifically.

Mr Whittle said there was only a 'shallow pool' of data on outpatient first appointments and follow-ups – highlighting little more than the specialty and the date it took place.

While electronic patient records should provide the mechanisms for collection, far more detail was needed on diagnosis, outcomes, effectiveness and patient experience.

'When we look at waiting lists and the impact of Covid, we know that relative ease of access is a huge driver of inequality,' he said. 'But we don't have sufficient information to get our heads around this to drive how we target our resources.'

Asked to identify a single indicator that isn't currently collected or reported, but should be for ophthalmology outpatients, there was agreement that sight was the obvious outcome metric and data was needed on any deterioration in vision.

Mr Rowlands highlighted earlier comments about the need to record diagnosis as part of an outpatients dataset so that data analysis could be more meaningful.

Mr Proctor added that this could help organisations to focus on risk. 'At Lincolnshire and Goole, we have about 30,000 patients awaiting an outpatient follow-up who have yet to be given an appointment and a third of these are in ophthalmology,' he said.

'But without diagnostic codes, we can't filter the data to establish a view about the risk of patient harm [from waiting],' he said.

Mr Unsworth backed the inclusion of a cost metric to balance up any outcomes data. 'It would be good to see the full system cost of seeing a cohort of patients or a segment of the population, not just the sliver of acute patient-level costs we might have. What is their impact on the whole NHS?

'It's when you balance that off against outcome measures that you can make some really important decisions.'

Ms Pejhan-Sykes suggested a metric that gave some indication of the potential to have avoided the current treatment if an intervention had been made earlier.

This could support decisions about where to allocate scarce resources and also help with the health inequalities agenda, she said.

However, there was recognition that prevention was difficult to measure and often required a three- to five-year time frame.

Ms Skill called for more information about patients with multiple eye conditions rather than everything having a sub-specialty focus.

She argued that it would also be good to see ophthalmology data alongside information from other surgical departments.

'A lot of the time, it would be useful to use figures from other departments to validate why we want to go ahead with a particular form of eye treatment,' she said.

As well as the treatment's own merits, it could reduce demand on other services – for example, preventing a future fall and therefore avoiding orthopaedic surgery.

'Sometimes an eye case is seen as less of a priority compared with other treatments or surgery,' Ms Skill said. 'But if we don't do something in ophthalmology, it potentially has an impact on the trust elsewhere and adds to the backlog of other services.'

Mr Roach agreed that the NHS often overlooked the impact of not intervening in its decision-making processes.

He added that all the suggested indicators should be measurable and collectable.

'And they would give us a broader focus on outcomes and challenge systems to understand why they are doing things,' he said.

But Mr Jani warned that data on its own was not enough. The intended audience also needs to be comfortable using data.

'Until stakeholders are able to process and effectively utilise the data to drive improvement, providing more data is meaningless,' he said.

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> **Visseh Pejhan-Sykes**

He called for more engagement with managers and clinicians to help them understand the data and use it on the ground. Data needs to be embedded in the improvement cycle to support a learning health system approach – data is collected; data-derived insights are presented to key stakeholders; changes are made; and data continues to be collected to support feedback loops that demonstrate the improvements have been realised and the gaps that need to be addressed.

'Without that mindset, providing data is necessary, but not sufficient,' said Mr Jani.

Ophthalmology faces a major challenge in addressing its part of the NHS backlog, both in terms of inpatient and outpatient attendances.

Transformation is essential in meeting the existing demand and the potential increasing need from an ageing population.

Maintaining current pathways is not an option and there will need to be changes in role across the ophthalmology workforce, supported by an increasing use of digital technology.

In summary, Mr Roach said that the payment system had to support these changes, such as the move to non-face-to-face consultations. 'Taking payment by results out of the conversation is important. We need to lose the transactional focus and instead have conversations about addressing waste.'

The focus also has to move from an annual cycle to a five-year focus, enabling short-term changes to funding flows to be balanced against longer term improvements for patients and for overall system finances.

And relationships across organisational boundaries within systems would be vital. 'This won't happen overnight,' he said. 'But if we take a five-year view, we have got a real opportunity to address the challenges.'

HFMA ROUND TABLE