Gloucestershire Safety and Quality Improvement Academy 2025

# *Reducing Unnecessary Follow-Up Appointments in Emergency Eye Care Clinics*

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## The Safety Concern

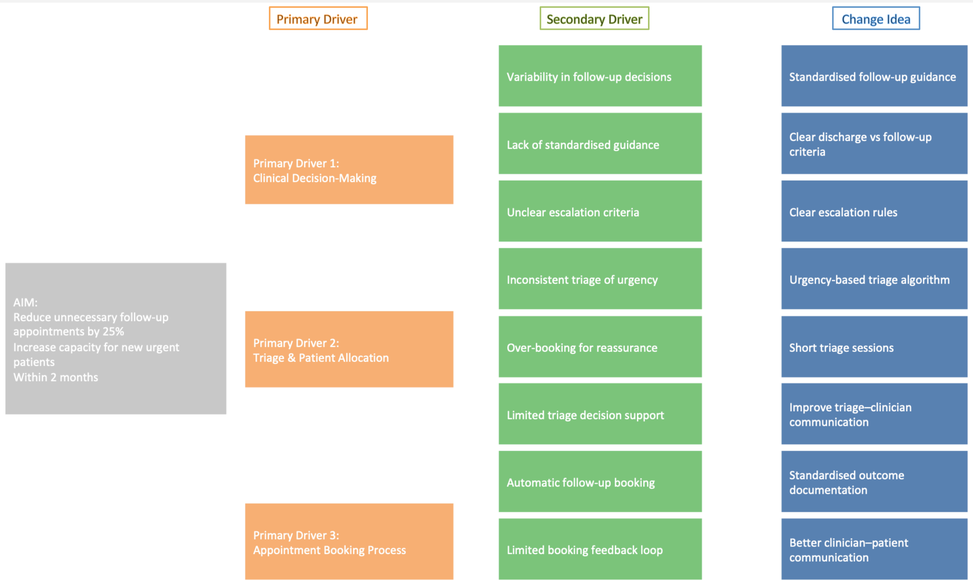
- Emergency Eye Clinics is experiencing a high volume of follow-up appointments, reducing capacity for new urgent cases.
- Lack of standardised guidance for follow-up decisions led to variability in practice, clinic overcrowding, increased waiting times, and staff pressure.
- This posed a risk to timely access for new acute ophthalmic presentations.

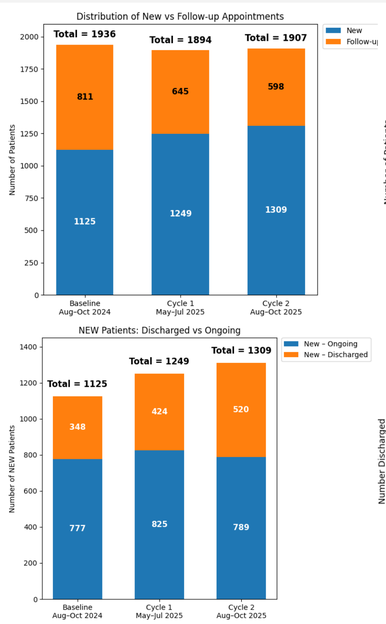
## The Aim

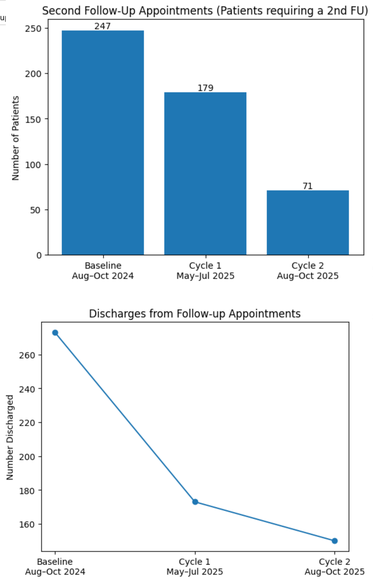
- To reduce unnecessary follow-up appointments in Emergency Eye Clinics by at least 25%, thereby increasing capacity for new urgent patients, within 2 months of implementing standardised triage and follow-up guidance.

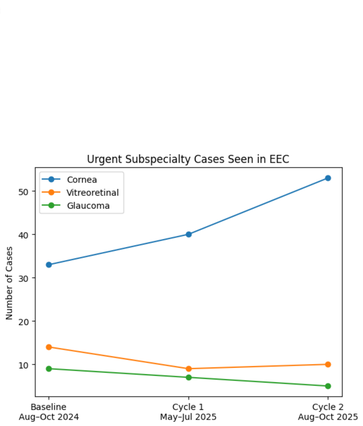
## Measures

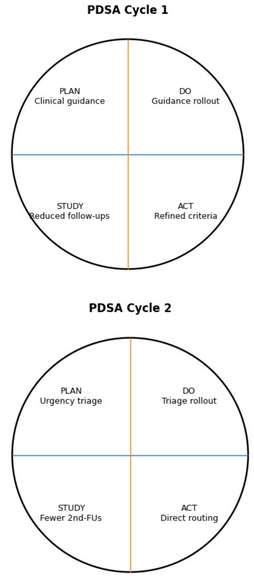
- Outcome Measure:
  - Number of follow-up appointments booked per patient
- Process Measures:
  - Proportion of patients discharged at first visit
  - Proportion of new vs follow-up appointments
- Balancing Measures:
  - Re-attendance rates




## Outcome

1. Overall FU proportion reduced by 10.6% ( 41.9% to 31.3%)
2. Increase 10.6% in new patient capacity (58.1% to 68.7%)
3. Improved discharge at FIRST encounter for NEW patients +8.8 % (31% to 40%)
4. Decreased second FU booked in EEC by 71.3 %
5. Deceased Discharge post first FU encounter by 8.6% (33.7% to 25.1%)

- **Demonstrates sustained reduction in unnecessary follow-up workload**
- **Clinic capacity successfully redirected toward new urgent presentations**
- **Indicates improved clinical decision-making and reduced precautionary follow-ups**

## Remarks

1. Corneal cases rebooking into EEC increased from 33 → 53, representing a +61% increase over the study period
2. The divergence between subspecialties highlights an opportunity to further refine routing of urgent cases
3. Improve rebooking pathways for known subspecialty patients
4. Reduce re-entry of known cases as “new” EEC attendances
5. Enable direct, expedited access back to subspecialty clinics where appropriate
6. Refine clinical decision-making at triage
7. Enhance senior input to filter urgent cases directly to subspecialty services
8. Strengthen signposting to community pathways to reduce hospital attendances

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