NWNODN ROP Treatment Referral Pathway

Title:	**NWNODN ROP Treatment Referral Pathway**
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Target Audience	NWNODN Clinicians NWNODN Ophthalmologists Northwest, North Wales and Isle of Man Children's Heart Network SMT and Board members
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17/06/24	V0.3	Claire Arnold	Document amendment

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Introduction

Retinopathy of prematurity (ROP) is one of the few causes of childhood visual disability which is largely preventable. Retinopathy of prematurity (ROP) occurs in premature and low birth weight infants when abnormal blood vessels and scar tissue grow over the retina leading to visual impairment/blindness. Many extremely preterm babies will develop some degree of ROP although in the majority this never progresses beyond mild disease which resolves spontaneously without treatment. A small proportion, develop potentially severe ROP which can be detected through retinal screening. If untreated, severe disease can result in serious vision impairment and consequently all babies at risk of sight-threatening ROP should be screened. Whilst most infants screened may have a degree of ROP that does not require treatment, a small proportion of infants do. Timely intervention will prevent blindness in most cases. This treatment guideline has been developed in line with The Royal College of Ophthalmologists (RCOphth) clinical guideline for ROP treatment.

Purpose

The purpose of this guideline is to outline the principles for the treatment of ROP in the NWNODN which is compliant with national standards outlined in the clinical guideline "Treating Retinopathy of Prematurity in the UK".

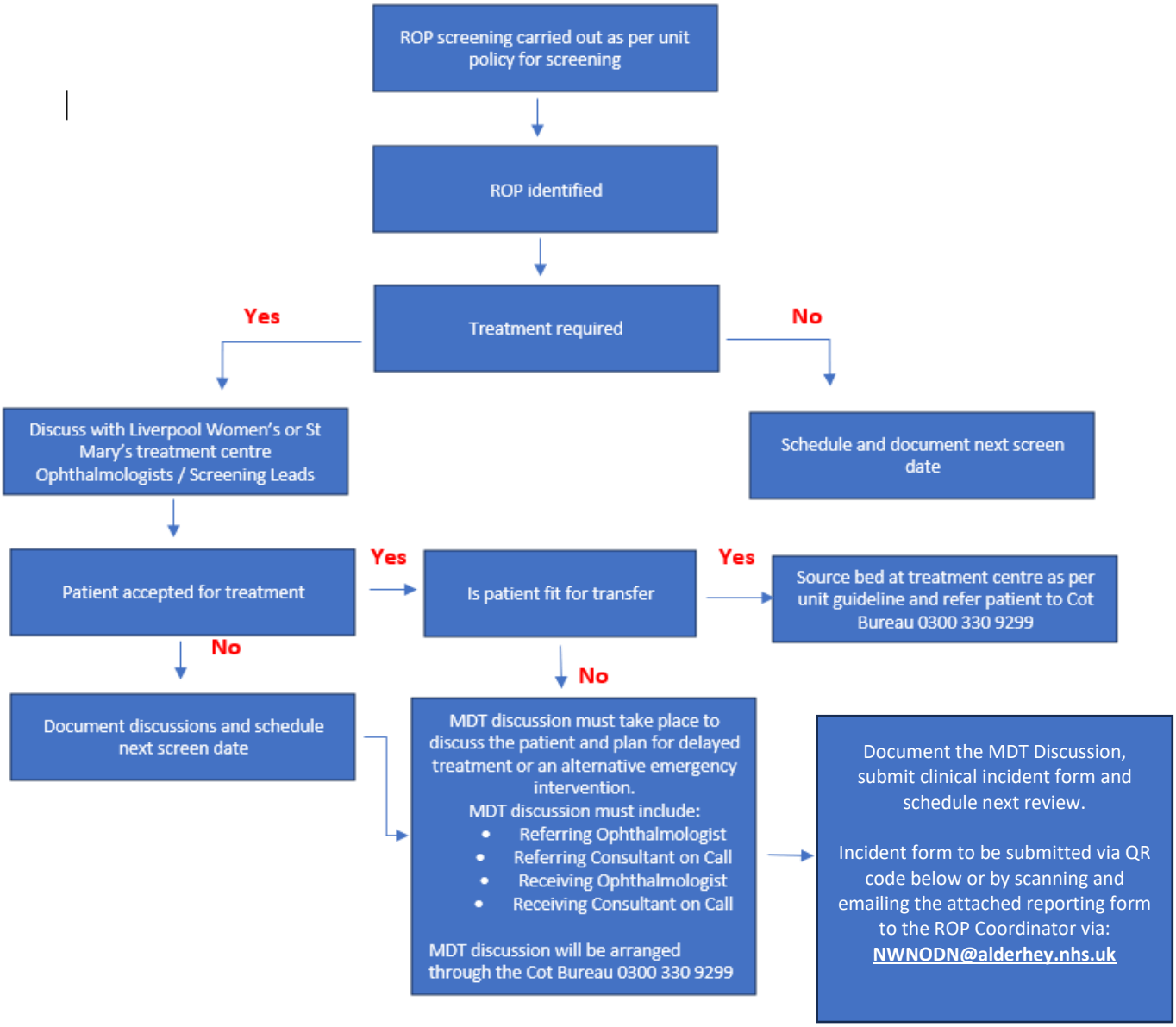
This guideline will ensure that all surgical treatments are carried out in specialist surgical centres. It's aims to ensure:

- Patient focused at all times.
- Carer and family focused.
- Equity of access for neonates and providers across the NWNODN.
- Workforce model compliant with NHSE and service specification.
- Governance processes are in place.

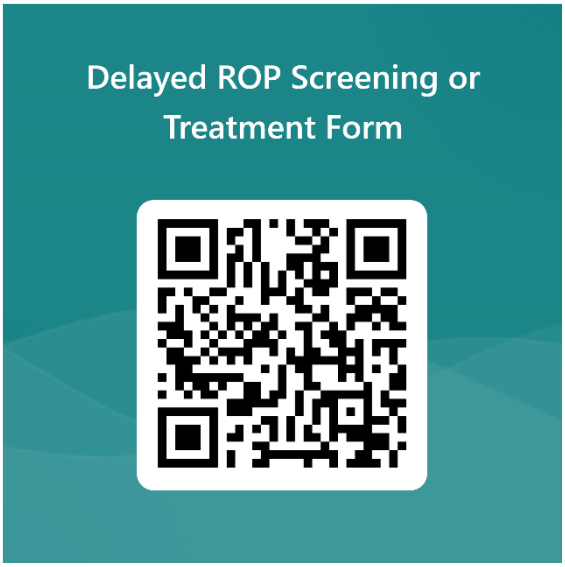
Screening Pathway

All ROP screening should continue utilising current provision and following individual unit pathways. **However, in the event that the baby is clinically unstable and unable to undergo an ROP Screen then it is requested that a clinical incident form is also completed – via the attached QR code or by completing the Delayed Screening/ Treatment Form below and emailing to: NWNODN@alderhey.nhs.uk**

Treatment Pathway



All care and transfer arrangements to be discussed and agreed with parents/guardians.
Written or electronic information should be provided including signposting to treatment centres website.



https://forms.office.com/e/yweYgycGix

Roles and Responsibilities

These roles and responsibilities are delegated to each individual unit:

- Ensuring that guidelines are implemented according to the agreed process.
- Ensuring that the effectiveness of the guideline is monitored.
- Reviewing current service provision ensuring that deficiencies are identified and reported on and that recommendations and action plans are developed to be compliant with the guideline.
- Nurse, Ophthalmologists and Consultants are accountable to the appropriate clinical lead to ensure that they comply with the guideline.
- The referring Consultant is accountable to the ODN to complete and forward the clinical incident form (via the QR Code or email using the attached form).

Clinical Action	Rationale
• All treatments should occur at either Liverpool Womens Hospital or St Marys Hospital. ***(*with exception of AHCH as a Paediatric Surgical Unit <u>for in-house Neonates only</u>)***	• Both intravitreal and laser treatment options for ROP are surgical procedures that should be carried out in specialist surgical centres. • Treatment will be equitable for all. • The surgical centres provide experienced expertise in all treatments.
• MDT discussion including referring/receiving Ophthalmologists and referring/receiving on call consultants.	• A decision that a patient is not fit for transfer should be reviewed by the consultants to formulate a plan of when the patient will likely be fit or if there is an alternative way to provide treatment. • These discussions should be documented, and parents should be informed and involved in all decision making.
• MDT discussion should be arranged via cot bureau.	• This ensures all relevant clinicians are on the call and the lines are recorded. • Should a transfer then be agreed, cot bureau can take this information.
• Referral for treatment should go through cot bureau.	• To assist Connect NW with the logistics and organisation of the transfer.
• Clinical Incidence Form	• Provides governance and assurance around missed or delayed treatments. • Allows for those neonates to be monitored and tracked to ensure screening/ treatment is conducted as soon as clinically acceptable.

References

- Royal College of Ophthalmologists (2022) Treating Retinopathy of Prematurity in the UK. Clinical Guideline. https://www.rcophth.ac.uk/resources-listing/uk-retinopathy-of-prematurity-guideline/
- Royal College of Paediatrics and Child Health (2022) UK Screening of Retinopathy of Prematurity. Clinical Guideline. https://www.rcpch.ac.uk/resources/screening-retinopathy-prematurity-rop-clinical-guideline

Delayed ROP Screening / Treatment

Referring Hospital / Neonatal Unit:		
Hospital Number:		
Date of first admission to a Neonatal Unit:		
Episode to be delayed / cancelled: **(Please Tick)**	**Screening**	**Treatment**
Date ROP screen / treatment due:		
Dates for week long screening window: **Include start and end dates**		
Dates of treatment window: **Include start and end dates**		
Current ROP Diagnosis:		
Clinical reason for cancelling screening / treatment:		
Clinical Observations – HR, SaO2, RR, BP		
Ventilation Settings:		
Has the ROP team / Ophthalmologist been informed? (Date and time)		
Name of Consultant making decision to cancel:		
Did consultant update the parents and has this been updated on Badger (Date and time)		
Is there potential to reassess before the screening / or treatment window expires:		
Is the baby to be transferred to another NNU and if so where?		
Date and time of MDT discussion including names of referring/receiving on call consultant and referring/receiving Ophthalmologist		
Any further information you feel is relevant?		