

Ophthalmology and Optometry

Our vision for safe and sustainable patient eye care services

The COVID-19 pandemic will continue to affect the way primary and secondary eye care services are provided for patients for some time to come. The Royal College of Ophthalmologists (RCOphth) and The College of Optometrists have built on our learning over the last year to develop this joint vision to support our workforce and the provision of safe and sustainable eye care services that meet the needs of all patients. Services will need to incorporate innovative models to improve patient care and outcomes in a way that is sustainable within the limited resources of the NHS.

Harmful delays to treatment in the hospital eye service (HES) due to a lack of capacity were recognised well before the pandemic. The measures put in place to protect people from acquiring COVID-19, reluctance by patients to attend secondary care, together with reduced resource with staff being redeployed away from ophthalmology, resulted in further capacity reduction and will have undoubtedly led to vision loss that, in normal circumstances, should have been preventable.

As the COVID-19 restrictions evolve, it is important to develop more integrated eye care between all relevant organisations across the hospital eye service, the independent sector, community settings and primary care optometry. We need to build on the existing good pathway examples in all four nations, and innovations introduced at pace during COVID-19, to develop ambitious, co-ordinated and collaborative services for eye conditions across the whole sector with equitable access for all patients no matter where they live. Only by doing this rapidly and consistently can patients be protected from harmful delays.

Our vision for a safe and sustainable eye care service:

Our vision for the future is to provide pathways that ensure patients are prioritised based on their clinical need and to receive care that is appropriate and accessible. Multidisciplinary professionals will provide that care working collaboratively in primary care, community and hospital settings.

Our recommendations will pave the way for safer, more sustainable eye care for the long term.

Our vision for safe and sustainable eye care is underpinned by four key principles:

1. Reducing the risk of visual loss due to delayed eye care, in an equitable, appropriate and accessible way.
2. Multidisciplinary professionals working collaboratively in primary care, community, and hospital settings to provide care.
3. Direct patient contact taking place with a clinician capable of making appropriate management decisions including, where required, support by a senior decision maker e.g. an optometrist with higher qualifications or the independent prescribing (IP) certificate, or the hospital eye service.
4. All pathways led by the highest standards of joint optometry and ophthalmology clinical governance, applied equitably to all who are providing care, and underpinned by patient centred outcome measures.

We believe that:

For patients already in the hospital eye service (HES): Ophthalmology leads in the HES should continue to use risk stratification (into low/medium/high risk of harm) and clinical prioritisation of all patients to decide on ongoing management most suitable to their needs. Whilst there is a return to more face to face care with appropriate precautions, many patients will benefit from remote (telephone or video) and virtual diagnostic appointments provided by the hospital and in the community. Systems should be developed to take advantage of the expertise and facilities in primary care to allow patients to be managed in primary care optometry, with HES input as required.

For new non-urgent referrals: Utilisation of recognised pathways should be put in place for referral filtering and refinement by primary care optometrists, including advice and guidance for primary care optometrists and GPs, with accessible support from the HES.

For urgent and emergency referrals: Hospitals should provide accessible timely triage for urgent referrals and advice and guidance for primary care optometrists and GPs.

For all outpatients: Continued use of primary care optometry services to see patients who have conditions that can be diagnosed and/or treated within primary care, in conjunction with hospital-based referral and support from an appropriate clinician as required.

Managing patients in this way will help to support and facilitate the development of primary care and community services with close links to the HES. This will enable all patients to have equitable access to the eye care that they need at the time it is needed and avoid unnecessary visits to the HES.

Improved collaboration and partnership between eye care professionals and organisations are key to supporting our vision for the development of safe and sustainable patient care.

Our recommendations

1. Pathways

Key integrated pathways provided should include:

- Optometrists as first contact practitioners
- Urgent eye care
- Referral triage/advice and guidance
- Primary care-based management for new, low risk patients
- Primary care-based management for follow up of appropriate patients with long term low risk conditions

2. Foundation of long-term service frameworks

2.1. Professional development and upskilling

- There needs to be shared understanding across primary and secondary care of the core capabilities of optometrists, which go beyond performing routine sight tests. Based on core skills (with simple refresher training, if individuals require), all optometrists can provide services including MECS, EHEW, NI PEARS, CUES, glaucoma triage and cataract care.
- Local HES or systems may agree additional training or upskilling to increase hospital confidence in non-HES practitioners' skills and/or understanding of local requirements and decision-making processes, pathways and principles, and to build relationships between health professionals.
- There should be better utilisation of optometrists with appropriate independent prescribing (IP) and/or other higher qualifications. Optometrists who have completed higher qualifications can work with a greater degree of autonomy and provide a wider range of care.
- Experienced ophthalmologists and optometrists should facilitate shared learning and updates with all local practitioners who are delivering enhanced care. These include webinars, peer discussions, email group or regular video calls, anonymised case discussions, feedback on good practice and incident reporting.
- Training of trainee ophthalmologists, optometrists undertaking IP and other higher qualifications, other eye care clinicians, and all clinicians working across enhanced pathways should continue to be protected and promoted.

2.2. Pathways and models of care

- Pathways and services should be integrated at geographies larger than single hospital level, where possible, and long-term improvement plans put in place. There should be equity of access to enhanced services developed on the basis of population need, rather than on an historical basis.

- Models of care should be evidence based on confirmed or published success or accepted ophthalmology and commissioning guidelines such as NICE, SIGN, RCOphth, The College of Optometrists, GIRFT, NHS Optometric advice from the four nations. Services must be driven by the evidence and deliver the best outcomes for patients, without stifling innovation.
- Services should be based on robust evidence of local eye health needs (i.e. capacity determined by population need). This is facilitated by a data-led approach, based on real time clinical activity, unmet population need and clinical capacity.
- There should be a joint lead optometrist and lead ophthalmologist for the pathways, with co-development and agreement from clinical lead ophthalmologists and their directors of operations of local hospital providers and any other regional eye care leads as required. Leads must include primary and secondary care expertise. The two clinician leads should ensure there are named clinical governance leads for both ophthalmology and optometry.
- The wider service development group should be multidisciplinary, e.g. optometrists, ophthalmologists, dispensing opticians, contact lens opticians, nurses and orthoptists, service managers, GPs, patients, and involve local eye health/optical committees and groups.
- There should be agreed local protocols (between primary care optometrists and HES) for virtual telemedicine clinics and enhanced care pathways in practice, e.g. keratitis, anterior uveitis, based on The College of Optometrists clinical management guidelines and other national guidance e.g. NICE, SIGN and the RCOphth. Learning and feedback should drive improvements in these protocols.
- There should be specific provision for HES remote prescribing or IP optometrist prescribing as required, rather than via a patient's GP.
- Video/phone/virtual consultations should be integrated into pathways where beneficial. Support should also be available to ensure that digitally excluded patients can still access services.
- There should be a straightforward and, where urgent, rapid access to advice and appropriate guidance from clinical decision-makers and prescribers. This may be via a single point of advice or support manned by optometrists with IP and/or other higher qualifications and ophthalmologists, or via the local HES.
- Digital platforms should be adopted to allow clinical and imaging data sharing and seamless integration and flow of clinical data across the whole eye care system.
- Provision and adaptation of routine eye care should follow the appropriate [College guidance](#).
- Infection control procedures should follow appropriate public health and professional body guidance.

2.3. Funding

- These services need to be appropriately and equitably funded to meet growing patient needs in both HES and primary eye care.
- Assessment of performance and success of services should include a holistic evaluation of value, covering cost and clinical effectiveness, safety and patient experience.

2.4. Referral

- Referral systems should be electronic and support assessment and improvement of referral quality and activity.
- Referral should be supported by a digital system that provides virtual review. Primary care optical practices must have access to appropriate secure NHS electronic referral systems and email.
- Strengthening of triage and referral refinement processes by direct contact between primary care optometrists and the HES should be supported, to minimise the risks or delay or additional steps in the pathway
- HES and primary eye care should co-develop clear referral criteria and care advice.
- HES should respond to every referral from primary care with information on the diagnosis and subsequent management of the patient.
- Local triage guidelines with a reasonably comprehensive list of conditions/urgency/setting for care should be agreed between primary care optometrists and HES. Joint risk stratification frameworks should underpin these guidelines.

2.5. Governance

- There should be clear mechanisms for joint reporting and managing of incidents/complaints/serious incidents, clinical audit and shared learning across the whole pathway, including between primary and secondary eye care. This should include a process to manage and report incidents, data and learning across different organisations and between primary and secondary eye care.
- There should be proactive collection of data on activity/clinical/quality/cost effectiveness across the whole system and shared with funders, regional and national NHS bodies, HES and optometrists. This should be underpinned by appropriate data sharing agreements, as required.
- Reporting, and utilisation of the data should lead to learning with rapid improvement actions, particularly for new services.
- Clinical governance leads from primary and secondary eye care should be identified at the outset. These may or may not be the local ophthalmology/optometry clinical leads. There should be flexibility to update the service specifications in light of performance, clinical governance results and issues detected after initial implementation.
- Performance management of professionals should be delivered in an integrated and collaborative manner and clearly outlined in the local service specification governance arrangements. This should be evidenced with data on all interactions and outcomes.
- Clinical audit and performance measures should be agreed between optometric and ophthalmic leads and any other regional/ transformation leads. For example:
 - Agreement within the service specification of what data is to be recorded and reported and what the arrangements for analysis of the data is going to be.
 - Adherence to local clinical protocols.

- Every interaction and its outcome (treatment/referral/discharge/follow up) must be recorded for all services, whether or not there is onward referral.
- Numbers of patients seen, and in which type of care delivery.
- The number of patients who normally would have attended HES who do not attend due to new pathways.
- Do not attend rates in HES and optometry enhanced services.
- How many/% follow up appointments for each type of care.
- False negatives, false positives seen at HES.
- Delays in treatment and impact on patient outcomes.
- Patient outcomes and experience.

All those working in the provision of eye care across primary, secondary and community services should put in place these key principles and recommendations to enable the development of safe and sustainable patient care and professional support in the delivery of that care.

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Glossary

CUES : COVID-19 urgent eye care service

EHEW: Eye Health Examination Wales

GIRFT : Getting It Right First Time

MECS : Minor Eye Conditions Service

NICE : National Institute of Health Care & Excellence

NI PEARS: Northern Ireland Primary Eyecare Assessment and Referral Service

RCOphth: The Royal College of Ophthalmologists

SIGN: Scottish Intercollegiate Guidelines Network