THE COLLEGE OF OPTOMETRISTS

Ophthalmology and Optometry: Our vision for safe and sustainable patient eye care services in England during and beyond COVID-19

12 Aug 2020

The pandemic continues to affect the way primary and secondary eye care services are provided for patients in England.

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Introduction

The Royal College of Ophthalmologists (RCOphth) and The College of Optometrists have developed a joint vision to support our workforce and the commissioning of safe and sustainable eye care services that meet the needs of all patients, improving patient care and outcomes during and beyond the pandemic.

Harmful delays to treatment in the hospital eye service (HES) have already been recognised before the pandemic. In eye care, the current measures in place to protect people from acquiring COVID-19 will undoubtedly lead to vision loss that in normal circumstances, would have been preventable, as additional safety measures will further reduce capacity.

As the COVID-19 restrictions are lifted it is important to develop more integrated eye care between the hospital eye service, community settings and primary care optometry and to build on the COVID-19 urgent eye care service (CUES) to develop similar co-ordinated services for more eye conditions.

As we look to the future, we want to continue the positive, collaborative working relationships between primary and secondary care that have developed to combat the devastating effects of the COVID-19 pandemic on ophthalmic patient care. We do not want to return to traditional ways of working that did not protect patients from harmful delays.

We believe that our recommendations will pave the way for a safer, more sustainable eye care service for the long term.

Our vision for a safe and sustainable eye care service:

Our vision for now and the future is the provision of 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 vision is underpinned by three key principles:

1. To balance risk of significant visual loss due to delayed eye care against the risk of acquiring COVD-19 infection as a result of a face-to-face clinical assessment
2. That direct patient contact should take 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 HES.
3. That all pathways are underpinned by the highest standards of joint optometry and ophthalmology clinical governance, applied equitably to all who are providing care.

We believe that:

For patients already in the hospital eye service (HES): Ophthalmology leads in the HES should continue to enable risk stratification and clinical prioritisation of all patients into low/medium/high risk of harm and decide on ongoing management. It is anticipated that many patients can be allocated to remote (telephone or video) and synchronous or asynchronous virtual appointments provided by the hospital. Alternatively, where systems and expertise are in place, patients can be managed in primary care, with HES input as required. Face to face care in the HES with appropriate precautions should be provided where essential.

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 during COVID-19 recovery and beyond 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 clinical management approaches and collaboration are key to supporting our vision for the development of safe and sustainable patient care in the delivery of that care.

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Our recommendations

1. Pathways

Key pathways commissioned should include:

- **Urgent eye care**
- **Referral triage/advice and guidance**
- **Primary care-based management for new, low risk patients**
- **Management of postponed HES patients with unplanned issues**
- **Interim or joint care of HES patients.**

We expect these pathways will be mapped and agreed with stakeholders through the NHS England/Improvement National Outpatient Transformation Programme and the Eye Care Restoration and Transformation Steering Group.

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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 required), all optometrists can provide services including MECS, CUES, glaucoma triage and pre- and post-operative cataract assessments
- Local HES or systems may specify additional training or upskilling to ensure hospital confidence in non-HES practitioners' skills and/or understanding of local requirements and decision making processes, pathways and principles
- There should be better utilisation of optometrists with appropriate IP and other higher qualifications. Optometrists who have completed higher qualifications can work with a greater degree of autonomy and provider a wider range of care then core competency optometrists
- Local ophthalmologists and optometrists with IP or HQ 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, and other clinicians should continue to be protected and promoted. Training across enhanced pathways should be considered i.e. within both primary and secondary care

2.2 Pathways and models of care

- Pathways and services should be integrated at system (STP or ICS) level where possible and long-term commissioning plans put in place. There should be equal availability of, and access to, enhanced services across the country
- Models of care should be evidence based eg based on confirmed or published success or accepted ophthalmology and commissioning guidelines (NICE), RCOphth, The College of Optometrists, GIRFT, NHSE, CCEHC/SAFE). Services commissioned 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 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 of local trusts and any other regional leads as required eg LOC chairs, LEHN Chairs. Leads must include primary and secondary care expertise. The two clinician leads should also be the clinical governance leads
- The wider service development group should be multidisciplinary, eg optometrists, ophthalmologists, DOs/CLOs, nurses and orthoptists, service managers, GPs, patients, LEHN chair, LOC, HES
- There should be agreed local protocols (between primary care optometrists and HES) for virtual telemedicine clinics and enhanced care in practice, eg keratitis, anterior uveitis, based on The College of Optometrists clinical management guidelines and other national guidance eg NICE 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 the default where possible, especially for first attendances. Support should also be available to ensure that digitally excluded patients can still access services
- There should be a dedicated ophthalmology advice & guidance phone line with rapid access to a senior clinician/decision maker and prescriber. 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 system
- Provision and adaptation of routine primary eye care eg sight test, monitoring, screening should follow The College of Optometrists guidance and provision and adaptation of secondary care should follow The Royal College of Ophthalmologists guidance. Where appropriate, the Colleges will look to develop joint guidance for integrated pathways

2.3 Funding

- Pricing and remuneration should reflect actual costs, including training and equipment costs, risk and complexity of cases, in both primary and secondary care
- Additional primary care-based services should not be assumed to be covered by GOS funding or any existing enhanced services such as MECS
- Funding models and pricing should not lead to any perverse incentives or inconsistent payments for the same work and resource use across organisations.
- Where urgent COVID (eg CUES), or MECS, services are not already commissioned, there is a need to ensure that a mechanism is put in place to swiftly enable primary care optometrists to provide urgent and enhanced care

2.4 Referral

- Referral should be supported by a digital system that provides real time virtual review. Primary care optical practices must have access to nhs.net or equivalent NHS systems
- Where possible, 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 need to 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 care
- There should be proactive collection of data on clinical/quality/cost effectiveness across whole system
- Rapid reporting and learning leading to improvement actions are required for a new and rapidly implemented service
- The clinical leads should be governance leads and have the 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
- Clinical audit and performance measures should be agreed between optometric and ophthalmic leads and any other regional leads. For example:

    - Every interaction and its outcome (treatment/referral/discharge/follow up) must be recorded
    - Adherence to local clinical protocols
    - Incidents of inappropriate care
    - Numbers of patients seen, and in which type of care delivery
    - How many patients who normally would have attended HES do not attend because of alternative provision
    - Do not attend rates in HES
    - How many/% follow up appointments for each type of care
    - How many/% being seen in video or face to face by optometrist later need to attend HES
    - False negatives, false positives seen at HES
    - Delays in treatment and impact on patient outcomes

- Patient outcomes and experience

2.6 COVID-19 and infection control

- Appropriate PPE should be available as required for all patient contacts, no matter which setting
- There should be clear information on PPE, infection control and social distancing in all settings
- Patients who are suspected/likely COVID-19 positive (identified through appropriate means e.g. symptoms, testing etc.) should not be seen face to face and should be deferred until safe to be seen, unless it is an emergency, in which case the next steps should be discussed with the HES

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3 The National Eye Care Restoration and Transformation Programme is working on the following enablers to support improved models of care

- Continued adaptation of routine primary eye care during the pandemic
- Interim funding mechanisms for new pathways and services and plans for a sustained funding model
- IT systems for video consultations and for connecting primary and secondary care to share referrals, feedback, clinical information and images.
- Agreed risk stratification models across primary and secondary care
- Agreed clinical management guidelines across primary and secondary care
- Systems for remote prescribing
- Technologies and innovation to improve access to care and improve capacity for face-to-face consultations
- Improved patient resources for information and self-care support
- Restoring patient confidence in accessing care
- Learning from the successes and challenges of solutions adopted in the UK's other three nations

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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RCOphth COVID-19 guidance

CCEHC SAFE guidance

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Glossary

DO: Dispensing Optician
CCEHC: Clinical Council for Eye Health Commissioning
CLO: Contact Lens Optician

CUES: COVID-19 urgent eye care service
GIRFT: Getting It Right First Time
LEN: Local Eye Network
LEHN: Local Eye Health Network
LOC: Local Optical Committee
MECS: Minor Eye Conditions Service
NHSE/NHSI: National Health Service England/Improvement
NICE: National Institute of Health Care & Excellence

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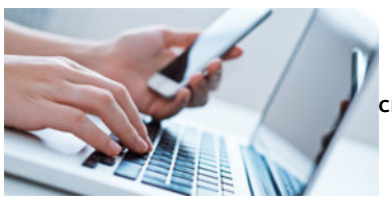

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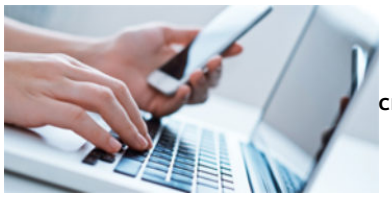

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