

The ROYAL COLLEGE of  
OPHTHALMOLOGISTS

# The Way Forward

Options to help meet demand for the current and future care of patients with eye disease

## Emergency Eye Care

This summary leaflet provides a quick reference guide to the options and practical steps outlined in the full report document available on the RCOphth website.

The Way Forward was commissioned by the RCOphth to identify current methods of working and schemes devised by ophthalmology departments in the UK to help meet the increasing demand on ophthalmic services. The **information aims to offer a helpful resource for members who are seeking to develop their services to increase capacity.** The findings are based on more than **200 structured interviews offered to ophthalmology clinical leads** in all departments in the four home nations.

**Models of care outlined in The Way Forward have, in general, grown rapidly through necessity because of the urgency of increased need in a climate of limited capacity.** The majority of the schemes and new ways of working reported, have been successful and the benefits and limitations are highlighted to provide a realistic picture.\*

This is one of four summary leaflets covering each of the particularly high volume areas of ophthalmic care:

- Cataract
- Glaucoma
- Medical retina – encompassing macular degeneration and diabetic eye disease
- Emergency eye care

More detailed report findings for each of these areas are available on the RCOphth website.\*\*

**The Way Forward can be shared amongst the ophthalmic community as a practical resource for the development of service redesign.** The RCOphth will facilitate communication by putting members in touch with those who have contributed to The Way Forward and who will be able to offer further information and advice.

**Professor Carrie MacEwen**  
President

# Emergency Eye Care

- Numbers attending for emergency eyecare are increasing year on year
- There is limited scope for preventing urgent eye conditions
- Managing demand and patient expectations is a challenge

## Organisational strategies to manage demand

There is a hierarchy in the way services are managed, commonly based on the size of the population served. Slotting patients into already over-stretched clinics is generally only possible in areas that serve small populations, with specific acute referral clinics being required to deal with a heavier load (Fig 1).



Figure 1: Emergency service configurations (with population served)

### Controlling patient access – Walk-in or Acute Referral?

Restricting access to patients who have been referred by their GP or optometrist leads to a reduction in numbers and moving to a referral-only service has the advantages of reducing the demand, but it changes the complexity of the cases attending such that may demand more medical input (Fig 2).

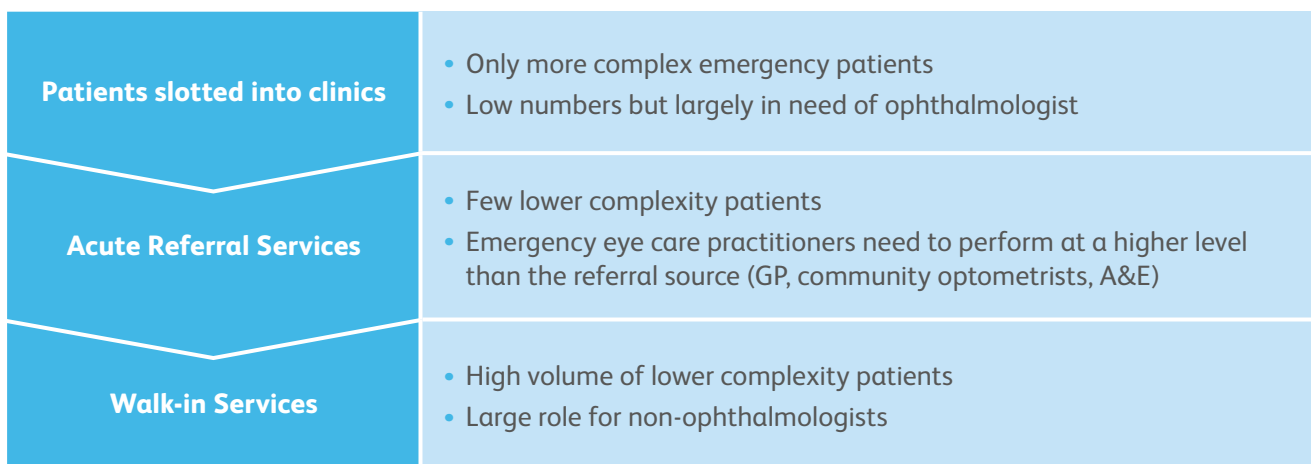


Figure 2: Access rules determine case complexity

## Community schemes

Several schemes have developed to help reduce the numbers attending eye emergency departments – 42% of departments reported a local community scheme (outwith Scotland and Wales – where these are almost universal).

- PEARS – Primary Eye-care Acute Referral Scheme
- ACES – Acute Community Eye-care Services
- MECS – Minor Eye Conditions Service

Successful schemes rely on:

- Engagement
- Co-operation
- Collaboration
- Communications
- Training
- Clear protocols

Benefits	Limitations
<ul style="list-style-type: none"> <li>• Can reduce referral rates</li> <li>• Patients with minor conditions can be treated without attending hospital</li> </ul>	<ul style="list-style-type: none"> <li>• Service unavailable out of hours</li> <li>• May result in duplication of service</li> <li>• Necessity to train optometrists to deliver care</li> </ul>

## Departmental triage

Triage by ophthalmic trained HCPs can refer patients to the correct clinic or service and determine the degree of urgency of each case. To be effective large numbers of low complexity cases and suitably trained staff are required (Fig 3).

- This can be carried out by telephone or face to face

Benefits	Limitations
<ul style="list-style-type: none"> <li>• Improve numbers with minor conditions being seen quickly</li> </ul>	<ul style="list-style-type: none"> <li>• Training and retaining appropriate staff</li> </ul>

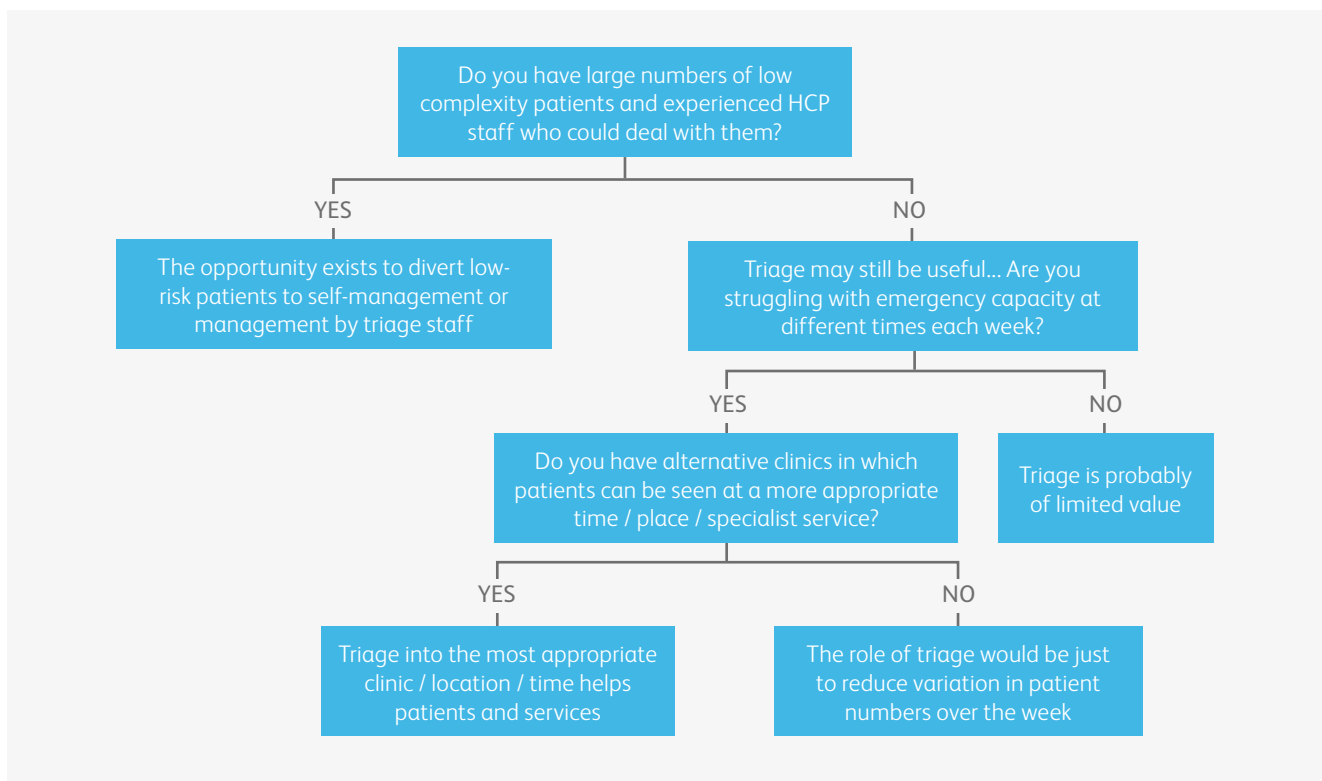


Figure 3: Decision making regarding whether triage may benefit a department

# Managing the service

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## Organisational options for emergency patient care

Emergency and acute ophthalmology care is traditionally delivered by ophthalmologists in training with consultants supervising while performing other clinical duties - therefore the direct input of consultants is variable. There has been a move towards increasing consultant input.

### Increase consultant input to emergency services

61% of departments reported dedicated consultant sessions in some or all of their emergency clinics

Benefits	Limitations
<ul style="list-style-type: none"><li>• Consultant staff are more likely to opt for longer outpatient follow up or discharge than other grades of staff</li><li>• Improved training opportunities</li></ul>	<ul style="list-style-type: none"><li>• Limited numbers of consultants – who commonly supervise while performing other clinical roles</li></ul>

### Working with other hospitals

Smaller ophthalmic units may find it difficult to deliver emergency care, particularly over a 24 hour period. Arrangements to share or transfer emergencies are becoming increasingly common with larger units providing a dedicated service.

Benefits	Limitations
<ul style="list-style-type: none"><li>• Patients seen as part of an emergency service</li><li>• More efficient use of staff</li></ul>	<ul style="list-style-type: none"><li>• Requires organisational arrangements for transfer of services</li><li>• Communication for patient follow up must be robust</li><li>• Needs clear patient sign-posting to different locations</li></ul>

### Telemedicine

The benefits of telemedicine are most likely to be realised in areas of low population density or as part of a hub and spoke arrangement.

Benefits	Limitations
<ul style="list-style-type: none"><li>• May reduce patient travel time and expense of attending hospital</li></ul>	<ul style="list-style-type: none"><li>• Requires reliable and high quality IT systems</li><li>• Need to be managed with remote input to elicit and transmit clinical signs</li><li>• Local arrangements for delivering the treatment</li></ul>

# Discharge policies

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## Referral to other clinics

Acute and emergency care clinics should have clear policies for onward referral. Patients should not remain in the acute service as this reduces efficiency.

Benefits	Limitations
<ul style="list-style-type: none"><li>• Patients attend most suitable subspecialty / consultant for care and follow-up</li><li>• Emergency clinics able to concentrate on rapid management of acute cases</li></ul>	<ul style="list-style-type: none"><li>• Requires adequate space in other clinics</li></ul>

## Discharge with telephone review

Setting up telephone review for patients who have a self-limiting condition may improve discharge rates.

Benefits	Limitations
<ul style="list-style-type: none"><li>• Prevents unnecessary return visits – freeing up appointments</li><li>• More convenient for patients</li></ul>	<ul style="list-style-type: none"><li>• Potential risk to patients who are unable to self-assess condition adequately</li><li>• Training required to ensure confidence to discharge appropriate patients</li><li>• Patient information sheets required for common conditions and with clinic contact details</li></ul>

# Questions to consider for improving your services

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## Managerial

- Obtain data regarding the number of emergency eye service attendances each year for the past 3+ years. Try to break these down into new and follow up patients
- Meet with your managers to discuss the future of your service. Discuss actual numbers of patients seen by clinician per clinic and prepare a staffing plan
- Consider a switch to a paperless / paper-light system using Electronic Patient Records to improve communication with referral sources by permitting automated email feedback
- Map what Emergency Eye Care services exists in your surrounding areas and disseminate this information to your primary referral sources

## Demand Reduction

- Consider whether potential referring GPs/optometrists could discuss cases with you and possibly avert referrals. Set up a referral support line for primary care colleagues to access advice
- Arrange regular training sessions with general Accident & Emergency, Minor Injuries Unit or Walk-In Centres staff, in order to maximise their capacity to deal independently with eye problems
- Disseminate guidelines for eye examination and management of common conditions to general A&E/MIU/WIC staff, and ensure they have the facility to perform visual acuity testing
- Involve yourself with local GP continuing professional development teaching programmes and consider distribution of locally adapted red eye or visual problem algorithms

- Evaluate a sample of the patients coming to your Emergency Eye Care service. If sufficient low-complexity patients were identifiable as being low-risk prior to presentation and could have been diverted to another provider, consider starting a community optometrist PEARS/MECS scheme
- If a scheme (PEARS/MECS) is proposed in your region, work with those setting up the scheme to ensure scheme evaluation is built into the design. Growth in the evidence base in this area is urgently needed. Plan to publish your findings

### **Optimising Capacity**

- Triage of emergency referrals may be helpful for your service; evaluate what resources exist to triage referrals and what benefits you expect this triage service to convey. Evaluate with pre-determined benchmarks at prescribed time points whether the triage is delivering the improvements you were expecting
- Repeated or unnecessary follow-up appointments waste capacity. Early senior ophthalmologist input reduces follow-ups. Construct a departmental strategy to increase senior input into emergency cases at their first presentation
- Create clear access routes into each subspecialty service. Acute appointments for senior or specialist acute review should be established and protected with feedback to the referring doctor to discourage low-value use of this resource
- If your service is dependent on HCPs (such as Nurse Practitioners), clear succession planning should be conducted years in advance of predicted retirement
- If your service is not dependent on HCPs, try to get HCPs engaged in the emergency service; perhaps by opening disease specific clinics (such as uveitis or anterior segment reviews). Evaluate their performance and set the numbers of patients to be seen per session
- Evaluate follow-up appointments generated from acute patients. Consider conducting telephone reviews or improving routes for patients to re-access help (for instance with an acute enquiry phone number) so that clinicians can discharge with confidence

### **Grow Emergency Eye Care as a subspecialty**

- Encourage appointment of a consultant with a specific remit for Emergency Eye Care
- Those already engaged with the emergency service should join the British Emergency Eye Care Society for peer learning and support
- Junior doctors with an interest in Emergency Eye Care should be informed that this is a subspecialty option and that they can arrange Trainee Selected Components (TSC) or Fellowships to progress this agenda

**\*Where schemes do not comply fully with RCOphth standards, this has been highlighted**

**\*\* The more detailed report findings for each of the high volume areas of ophthalmic care are available at [www.rcophth.ac.uk/standards-publications-research/the-way-forward/](http://www.rcophth.ac.uk/standards-publications-research/the-way-forward/)**

**Members can email: [wayforward@rcophth.ac.uk](mailto:wayforward@rcophth.ac.uk) for more information**



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