The ROYAL COLLEGE of OPHTHALMOLOGISTS

Commissioning Guidance

Emergency Eye Care: Executive Summary

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1 Executive Summary

This guidance is for the commissioning of emergency eye care in England for adult patients.

Emergency eye care may be required for any eye condition that is of recent onset and is distressing or is believed by the patient, carer or referring health professional to present an imminent threat to vision or to the general health of the patient[1]. True emergencies, where there is a health problem that occurs suddenly and which may be life- (or in ophthalmology sight-) threatening, need immediate attention and are more likely to have a better outcome when treatment is initiated as early as possible. Early treatment of certain serious conditions can prevent blindness and reduce sight loss. In addition, because some patients with life-threatening conditions can present with eye symptoms, early diagnosis can save life. Commissioners must ensure adequate access to specialist emergency care for such patients, regardless of geographic location or time of day.

There are increased attendances at hospital eye casualty departments and rapid access clinics – particularly those that have a walk-in service – although the rate of true emergencies is not increasing. Many patients who attend these services have conditions that are not emergencies and not sight threatening, which could be treated in alternative care settings with successful outcomes[1]. Local robust triage mechanisms need to be implemented to differentiate between true emergencies and those conditions that do not require such urgent treatment. Clarity on signposting and awareness of type and purpose of the services available are critical to providers, patients and the public.

Clinical Commissioning Groups (CCGs) and wider commissioning systems should undertake regular reviews of unplanned and emergency eye care provision, to discover the best ways to improve and maintain safe, high quality services. This may include development of alternative care pathways for minor eye conditions. All commissioned changes in service provision should:

- be audited to assess the cost effectiveness across the whole pathway
- be well led with appropriate governance, demonstrating adherence to protocols and guidelines
- be staffed by professionals who are appropriately skilled and trained to offer the level of care required in each setting, with evidence of competence in accordance with national standards
- have appropriate specialist equipment available in each setting
- include clear signposting of availability and scope of services, to enable patients to be directed smoothly, without barriers, to the most appropriate care setting.

2 Key Recommendations

A well-designed service should include:

✔	An understanding of the local population eye health needs and current service provision
✔	Whole pathway assessments – audit, cost effectiveness, governance This should be integral to new service design and occur before, during and after any changes are introduced
✔	New pathways and services should be designed by all stakeholders This should include patients, ophthalmologists, optometrists and commissioners
✔	Ensure the patient is seen at the right place, right time by the right professional. Minimising unnecessary patient visits, creating seamless pathways, working across boundaries, saving costs and enhancing efficiency – improving outcomes and patient experience.
✔	Specialist equipment and training This includes for all relevant hospital and community based staff assessing these patients
✔	Signposting – clear and unambiguous NHS 111, pharmacists, optometrists and general practitioners should have local directory of services and information for patients how to access the relevant service for them

Recommendation 1: Commissioners reviewing eye emergency services should work in partnership with a range of stakeholders including service users and carers, hospital services, non-hospital services including optometrists, general practitioners, health and wellbeing boards, community and pharmacy services, established local eye health networks, social care, Eye Clinic Liaison Officers (ECLOs), rehabilitation officers for visually the impaired, voluntary and third sector organisations, an adjacent clinical commissioning groups for service designed and assessment,

Recommendation 2: Provider organisations should use the guidance to assess their current Emergency Eye Care performance against evidence-based measures of best practice and identify priorities for improvement.

Recommendation 3: Commissioners should work to develop Emergency Eye Care pathways of care with a clear risk-stratified approach and efficient flow, to allow ease of access for all patients, especially those who require rapid access to care for better clinical outcomes.

Recommendation 4: Commissioners should be mindful of ensuring access for people who have difficulty accessing services, including vulnerable adults and those with multi-sensory impairment.

Recommendation 5: Non-medical eye healthcare professionals delivering Emergency Eye Care should demonstrate acquisition of and continuing professional development in the competencies described for level 3 of the Ophthalmic Common Clinical Competency Framework for Accident and Emergency Care https://www.rcophth.ac.uk/professional-resources/new-common-clinical-competency-framework-to-standardise-competences-for-ophthalmic-non-medical-healthcare-professionals/

Recommendation 6: Any provider of intraocular surgery or injection services withing either the NHS or independent sector should be able to ensure fast identification and treatment of patient with post-operative endophthalmitis. This requirement should be incorporated into at the point of commissioning for this service to ensure safety and continuity of care. There should be clear arrangements if needed for transfer for further specialist treatment.

Recommendation 7: There are no specific quality indicators for emergency eye care. However, commissioners could adapt NICE Quality Standards (https://www.nice.org.uk/guidance/qs174) or the Clinical Council for Eye Health Commissioning SAFE Emergency and Urgent Care Framework. This can be audited and used by providers to demonstrate the quality of their services.

Recommendation 8: Commissioners should develop CQUIINs in discussion with providers. The CQUIN may contain goals relating to staged implementation of a new process as well as goals related to performance. The outcome of non-achievement of any stages should also be jointly discussed and agreed.

Recommendation 9: Patient information must be produced in formats compatible with the Accessible Information Standard https://www.england.nhs.uk/ourwork/accessibleinfo/.

Recommendation 10: There is a pressing national need for data to inform decision making around what represents highest-value pathway for emergency eye care service provision. This may vary by locality.

Recommendation 11: Any changes in commissioned services (e.g. MECS scheme or move from a walk-in eye casualty to a booked emergency referral service) must be accompanied by data collection to permit evaluation of the impact on numbers of eye-related attendances at:

- GP practices
- Optometry practices (outside commissioned scheme)
- General A&E
- Secondary care acute ophthalmology services (both eye casualty/acute referrals and out of hours/on-call attendances)

This data collection, coupled with historic local comparators to map secular trends, permits evaluation of the amount of unmet need awakened by any new service or pathway re-design. Disinvestment in services – such as decommissioning a MECS scheme or transition from walk-in to acute referral secondary acute ophthalmic services, provides a similar opportunity to identify what savings are on offer by disinvestment which is equally important.

Dissemination of the results of such evaluations by publication in peer reviewed journals would be of great benefit to the wider commissioning community and should be planned for in the initial commissioning of the service.

Recommendation 12: Further research into the effectiveness of MECS schemes should be undertaken. This should look at evaluation several MECS schemes using the same criteria rather than individual case studies.

3 Guideline Development Group for Emergency Eye Care Commissioning

A commissioning guidance development group was established to review and advise on the content of this commissioning guide. This group met quarterly, with additional interaction taking place via email.

Name	Job title	Role/representing
Dilani Siriwardena (Chair)	Consultant Ophthalmologist, Moorfields Eye Hospitals NHS Foundation Trust	The Royal College of Ophthalmologists and the British Emergency Eye Care Society
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Lawrie Frere	General Practitioner	GP with an interest in Commissioning
Melanie Hingorani	Consultant Ophthalmologist, Moorfields Eye Hospitals NHS Foundation Trust and Chair of the RCOphth' Professional Standards Committee	The Royal College of Ophthalmologists
Sally Jones	Consultant Emergency Medicine, Aneurin Bevan University Health Board	The Royal College of Emergency Medicine
Martin Keats	Volunteer	Patient/lay representative
Elizabeth Lynam	Volunteer	The Royal College of Ophthalmologists' Lay Advisory Group
Catherine Marsh	Consultant Ophthalmologist, The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	The Royal College of Ophthalmologists British Emergency Eye Care Society
Mary-Ann Sherratt	Optometrist and Immediate Past President of The College of Optometrists	The College of Optometrists
Katrina Venerus	Clinical Director	Local Optical Committee Support Unit (at time of drafting – until September 2018)
Seema Verma	Consultant Ophthalmologist, Guys and St Thomas' NHS Foundation Trust	The Royal College of Ophthalmologists and President of the British Emergency Eye Care Society
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Glyn Wood	Business Development Manager	Manchester University NHS Foundation Trust
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	Cochrane Eyes and Vision Group	

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- The Royal College of Ophthalmologists

Conflict of interest statement

Individuals involved in the development and formal peer review of commissioning guidance were asked to complete a conflict of interest declaration. It is noted that declaring a conflict of interest does not imply that the individual has been influenced by his or her interest. It is intended to ensure interests (financial or otherwise) are transparent and to allow others to have knowledge of the interest.

The following interests have been declared by the Group:

- Katrina Venerus – Local Optical Committee Support Unit provides advice on services to primary care providers and commissioners

4. Examples of triage tools currently in use in units throughout the UK

Below are several examples of triage tools currently in use in different types of secondary care units throughout the UK that may be useful. The RCOphth recommends that clear, consistent and transparent tools are used across emergency and urgent care pathways reflecting the different care settings.

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

Created by Emma Barret

	SAME SESSION	SAME DAY	WITHIN 24 HOURS	WITHIN 3 DAYS	NURSE LED CLINIC	NOT APPROPRIATE (SEE OPTICIAN/GP OR, GRADE TO CLINIC)
TRAUMA	*Chemical Injury (alkaline) *Penetrating injury	*Lid laceration *Blunt trauma	*Blunt trauma >1/52 <2/52		*Corneal abrasions *Corneal FB	
VISION	*Sudden complete loss of vision <6 hours	*Sudden loss of vision <12 hours (resolved/unresolved) *New flashing lights/floaters with prev history or risk factors (myopia, prev tear or RD, family hx) *Post op <2/52 - loss of vision	*Sudden loss of vision >12 hours but <1week (resolved/unresolved) *Increased floaters *Diplopia (New, sudden or worse) with orthoptists if binocular *Post op <2/52 blurred vision	*Sudden change in vision <2 weeks *Single floater with no flashing lights	*Mild blurring *Watery	*Visual distortion <1 week – fast track macular clinic *Gradual loss of vision >2 weeks – OO *No sudden change in vision (as above) *Bilateral visual disturbance <2 hours +/- headache – Advice – GP *Mild blurring, watery, GP
EYE PAIN SCALE 1-5	*4-5 Score *No relief from oral analgesia *With nausea/ vomiting	*3-4 Score *Keeping pt awake at night	*Relief with oral analgesia *Photophobia *Post-op <2/52		*FB sensation <2/52	*Irritation with discharge – see GP or advise lubricants *Gritty – see GP or advise lubricants *FB sensation – no hx of FB - GP
HEADACHE	*4-5 Score with ocular symptoms	*Painful scalp *Brow Pain *Painful temples (all with ocular symptoms)				*Tender temples – NO visual symptoms D/W ARC Dr – referral to medics

						*NO ocular symptoms – GP or OO
LIDS/FACIAL		*New droopy lid/ptosis *Acute Swollen lids (with pyrexia, +/- diplopia, distorted vision) *Pain on ocular movement *III nerve palsy	*Swollen lids (normal vision, apyrexial)		*Puffy lids and red eye <2/52 *Normal vision *Watery <2/52	*Chalazion – Advise steam and see GP *Blepharitis – follow guidelines – self treat or GP. *Allergic (sudden onset) – cold compress
CORNEA/ CONJUNCTIVA	*Cloudy *Red+++ (with pain)	*Hazy *Red++	*Clear cornea *Red around limbus	*Localised redness (not sub-conjunctival haemorrage)	*Red mild to + *Lost contact lens	*>2/52 – advise *Bacterial conjunctivitis – advice first *Sub-conj haem – GP for BP check
OTHER	*Acutely unwell adult with ocular symptoms, swollen lids, pyrexia – SEE IMMEDIATELY	*Feverish Adult *Profuse bleeding post minor- op				*Any patient with symptoms longer than 2 weeks should be referred to OPD unless agreed by consultant or in the urgent/ same session category.
PAEDIATRIC	*Unwell, pyrexial, swollen lids – D/W Dr in ARC - ?Referral to PGH	*Swollen lids - not unwell, apyrexial.				*Any child >1 month dependant on symptoms *?Absent red reflex – GP / refer to OPD
OPTOM REFERRAL		*Hypopyon *Hyphaema *IOP >40mmHg *Papilloedema	*Abnormal pupil with visual symptoms			*IOP up to 40mmHg asymptomatic OPD referral *IOP 30-40 – with symptoms urgent OPD referral *Unequal pupil size No ptosis, No visual loss *Gradual loss of vision >2 weeks – OO if OO or GP - Grade *No sudden change in vision (as above)

						*Asymptomatic pt refer to OPD
POST OP	*Painful ++ *Loss of vision *Profuse bleeding *SEE ABOVE IMMEDIATELY					Post op <6/12 refer to consultant sec. >6/12 GP to refer OPD pt drop query – med secs

Courtesy of Sarah Anderson

	Immediate (including OOH)	Same day (within social hours)	Within 1-2 days	Within 3-7 days	Outpatients /other specialty	MECS or other service as alternative
PAEDIATRICS	• Orbital Cellulitis	Suspected NAI (contact paed oph if not normal exam, on call to see in situ)			Any child with symptoms for >1/12 (dependent on symptoms)	
TRAUMA/ SURGICAL	• Chemical injury • Penetrating injury • Endophthalmitis • Post op (within 3 weeks) reduced vision and pain	• Hyphaema • Hypopyon • Lid laceration • Corneal abrasion (if at all) •Corneal FB				Corneal abrasion
MEDICAL RETINA	CRAO – Central retinal artery occlusion **(WITHIN 8 HOURS)**			• Retinal haemorrhage (with symptom) • CSR (Central Serous Retinopathy)	• Dot haemorrhage • Macular oedema (urgent macular) • New retinal vessels (urgent diabetic eye clinic) • CRVO – Central retinal vein occlusion • BRVO – Branch retinal vein occlusion • Wet AMD (urgent slot) • Occlusion	
OCULO-PLASTICS	• Orbital cellulitis (ADULTS)	•New sudden onset ptosis •Lid laceration			• Ectropian • Entropian • Lumps • Ingrowing lashes	

GLAUCOMA	• **Acute angle closure glaucoma**	• **Iris rubeosis** • **IOP >35 (symptomatic)**	• **IOP >35 not sympto matic**	• **IOP 30-35 on Goldma n test**	• **Reaction to glaucoma drops (contact prescribing doctor)** • **IOP <30**	• **Ocular pain** • **Field defect with NO other symptoms**
CORNEA/ ANTERIOR SEGMENT	• Corneal graft problems	• Corneal ulcer • Iritis/ Uveitis • AAU • Corneal abrasion (if at all) • Dendric ulcer • Corneal FB	• Margina l ulcer/ keratitis • Shingles **WITH** redness / pain/ photoph obia	• Non-resolving conjunct ivitis		• Blepharitis • Ocular pain • Dry eyes • Watery eyes • Red eyes (with **NO**other specific symptoms)
VITREO-RETINAL	• Retinal detachment (macular on)	• Vitreous haemorrhage • Retinal detachment (macular off)	• Retinal hole **WITH** sympto ms	• PVD	• Macular hole • Retinal hole (no symptoms) • Flashes and floaters for >1/12	• Flashes and floaters with **NO** field defect
NEURO-LOGICAL	• GCA **AND** vision affected	• Papilloedema • Diplopia (new/ sudden) **AND** visual disturbance • Bell's palsy **WITH** red eye			• Unequael pupils (no ptosis, no visual loss) • Hemianopia – suggest stroke service	• Ocular mograne (e.g. bilateral zigzag lines for 20 min) – suggest primary care • Amaurosis fugax – suggest TIA clinic • Possible GCD no eye symptoms (ambulatory care will do biopsy under acute physicians)

Eye casualty triage (based on patient symptoms e.g. during self-referral)
Adapted by Sarah Anderton 2017

	Immediate (including antisocial hours)	Same day (within social hours)	Within 1-2 days	Within 3-7 days	Outpatients/ other service	MECS
PAEDS	• <16-year-old **AND** Pyrexia **AND** swollen lids	• <16-year-old **AND** any symptoms <1/12			• Any child with symptoms or <1/12 (dependent on symptoms)	
TRAUMA	• Chemical injury • Penetrating/ high velocity injury	• Blunt force trauma • Lid laceration • Visible hyphaema • Corneal FB/ Abrasion (if at all)				• Minor eye injury e.g. finger in the eye
VISION	• Sudden complete unilateral visual loss **WITHIN** ,8 hours • Post-op (<2/52) reduced vision & pain	• Flashes and Floaters **WITH** field defects/ curain • Dipoloia (new/sudden) **WITH** headache • Sudden loss of vision (for >12 hrs but < 1 week)	• Visual distortion • Diplopia (new/ sudden)	• Flashers and Floaters >1 week • Increased floaters >1 week	• Gradual loss of vision greater than 4 weeks (see by optician)	• Visual field defects with **NO** other symptoms • Gradual loss of vision >4 weeks
LIDS/ FACIAL		• New/ sudden onset ptosis • Acute swollen lids with decreased vision or pyrexia	• Discharge not clearing after antibiotic drops • Lost contact lens • Periorbital rash with eye pain/ redness/ photophobia		• Inverted/ Everted eye lids • Problems with glaucoma drops (discuss with prescribing team) • Lumps on lids • In growing eyelashes	• Discharge • Lost contact lens
CORNEA/ CONJUNTIVA	• Previous corneal graft **AND** reduced vision/ redness/ pain	• Corneal ulcer • Contact lens wearer and red eye	• Clear cornea **AND** limbal redness		• Watery eyes • Intermittent red eyes	• Intermittent red eyes • Dry eyes