Our vision for better integrated eye care services

Safe and sustainable eye care across the UK

It is essential that ophthalmology and optometry continue to work hand-in-hand to deliver more integrated eye care services across the UK. In 2023 there were almost nine million ophthalmology outpatient attendances and over 15 million NHS sight tests in the UK, and we know patient need will only grow in the coming years as our population ages.

The Royal College of Ophthalmologists and The College of Optometrists believe there are two key solutions to enable us to deliver more timely, safe and effective integrated eye care services. First, we need to make better use of the expertise and facilities available in primary care optometry as first contact practitioners. Secondly, digital connectivity must be improved so that communication – and the patient pathway and experience – becomes seamless both for people accessing care and those clinicians providing it across the eye care pathway.

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 eye care professionals will provide that care working collaboratively in primary care, community, hospital and independent sector provider settings.

To enable this more integrated eye care for all patients – no matter where they live – clinicians and commissioners should put in place the key principles and recommendations outlined in this vision.

Core principles

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

1. Providing timely eye care in an equitable, appropriate and accessible way. This will reduce the risk of visual loss caused by delay.

2. Multidisciplinary professionals working collaboratively in primary care, community and hospital settings, including the independent sector, to provide care that is facilitated by effective digital communication and connectivity.

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 independent prescribing (IP) status, or the hospital eye service (HES).

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.

What does this look like in practice?

For patients already in the HES: HES leads 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. While face-to-face care remains the main mechanism for delivering care, many patients will benefit from remote (telephone or video) and virtual diagnostic appointments provided by the hospital and in the community. Where remote and virtual care is available and appropriate, patients should be offered support to access them.

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

For emergency referrals: Hospitals should provide timely access, advice and guidance for primary care optometrists, GPs and other secondary care providers.

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

For individuals who develop new eye or visual symptoms: Primary care optometrists and colleagues should be the first professionals consulted, and existing primary care pathways utilised to prevent unnecessary referrals to the HES. These pathways may include minor eye conditions, pre-operative assessments, referral refinement or repeat measures. Coordinated and consistent public awareness campaigns should signpost patients to primary eye care in the first instance.

IT infrastructure should be improved, including support for two-way connectivity and image sharing capability, to take advantage of the expertise and facilities in primary care and allow patients to be managed in primary care optometry, with HES input as required. This should be facilitated by collaborative implementation of electronic referral and feedback systems at agreed timescales, to enable safe and effective roll-out.

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 or variations solely due to where a patient lives.

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 and suitable medium risk patients
- Primary care-based management for follow up of appropriate patients with long term low risk and suitable medium risk conditions
- Two-way digital connectivity and image sharing between all health professionals involved, facilitated by electronic referral and feedback systems.

2. Foundation of long-term service frameworks

2.1. Professional development and upskilling

- There needs to be shared understanding across community, 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 urgent and/or emergency care, glaucoma triage and cataract care.

- Local health systems may agree additional sessions with primary or community care colleagues to support upskilling, improve understanding of local requirements and decision-making processes, pathways and principles, and to build relationships and increase trust between health professionals.

- There should be better utilisation of optometrists with appropriate IP and/or other higher qualifications. Optometrists who have completed higher qualifications can work with a greater degree of autonomy and provider a wider range of care, including for patients with more complex needs.

- 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. Clinical placements are a core aspect of this and should be encouraged.

2.2. Pathways and models of care

- Pathways and services should be integrated at geographies larger than single hospital level, and long-term improvement plans put in place. There should be equity of access to all eye services based on population need, rather than a historical basis.

- Models of care should be evidence-based on confirmed or published success or accepted ophthalmology and commissioning guidelines, such as The National Institute for Health and Care Excellence (NICE), Scottish Intercollegiate Guidelines Network (SIGN), The Royal College of Ophthalmologists (RCOphth), The College of Optometrists (COptom), Getting It Right First Time (GIRFT), and 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.

- Each pathway should have a named lead optometrist and lead ophthalmologist, with co-development and agreement from clinical lead ophthalmologists, their directors of operations of local hospital providers and commissioners. Pathway development should be overseen by the appropriate local system, such as integrated care body or health board.

- The wider service development group should be multidisciplinary, e.g. optometrists, ophthalmologists, dispensing opticians, contact lens opticians, nurses, 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 telemedicine clinics, Patient Initiated Follow-up (PIFU) and enhanced care pathways in practice for conditions such as keratitis and anterior uveitis, based on COptom clinical management guidelines and other national guidance such as that provided by NICE, SIGN and 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. Support should also be available to ensure that digitally excluded patients can still access services.

- There should be 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 scheme or support provided 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 RCOphth guidance.

2.3. Funding

- Both HES and primary eye care services need to be appropriately and equitably funded to meet growing patient needs.

- Assessment of service performance should include a holistic evaluation of value – covering cost and clinical effectiveness, safety and patient experience.

2.4. Referral

- HES and primary eye care should co-develop clear local referral criteria and care advice based on existing guidelines.

- 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 and two-way feedback and that supports image sharing. Primary care optical practices must have access to appropriate secure NHS electronic referral systems and email.

- Robust triage and referral refinement processes that involve direct contact between primary care optometrists and the HES should be supported, to minimise the risks or delay or additional steps in the pathway. Local triage guidelines should be agreed between primary care optometrists and HES. Joint risk stratification frameworks should underpin these guidelines.

- HES should respond to every referral from primary care with information on the diagnosis and subsequent management of the patient.

2.5. Governance

- There should be clear mechanisms for joint reporting and management of incidents/complaints/serious incidents, clinical audit (including submission to the National Ophthalmology Database cataract and Age-related Macular Degeneration audits) and shared learning across the whole pathway. This process should work effectively across different organisations and between primary and secondary eye care, and generate data to inform governance and learning.

- There should be proactive collection of data on activity, and clinical/quality/cost effectiveness across the whole system. This should be shared with funders, regional and national NHS bodies, HES and primary care. This should be underpinned by appropriate data sharing agreements, as required.

- Reporting and utilisation of 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 a local level. There should be flexibility to update service specifications in light of performance, clinical governance results and issues detected.

- Service performance management of contracts 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 key performance indicators should be agreed between primary and secondary care leads at a local level. For example:

    - Agreement within the service specification of what data is to be recorded and reported, and the arrangements for data analysis

    - Adherence to local clinical protocols

    - Every interaction and its outcome (treatment/referral/discharge/follow up) recorded for all services, whether or not there is onward referral

    - Numbers of patients seen, and in which type of care delivery

    - Number of patients who normally would have attended HES who do not attend due to new pathways

    - Did not attend rates in HES and optometry enhanced services

    - Number and/or proportion of follow up appointments for each type of care

    - False negatives and false positives seen at HES

    - Percentage of patients reported to national audits

    - Delays in treatment and impact on patient outcomes

    - Patient outcomes and experience.

To make this vision – and the recommendations that underpin it – a reality, the Royal College of Ophthalmologists and The College of Optometrists are committed to working with all relevant organisations across primary care, community, hospital and independent provider settings. Working in this collaborative way, we can build safe sustainable integrated eye care services into the future.

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