

Shifting ophthalmology-led care from hospital to community settings

Key messages

- Ophthalmology is well-placed to move some care from hospital to community settings, under consultant ophthalmologist oversight. Hospital eye services will remain important though, particularly for complex surgery, treating patients with complex needs and emergency care.
- Three models that can be expanded to drive this shift across the UK – underpinned by a single point of access model and supported by the necessary resourcing – are diagnostic centres in the community, enhanced optometry services and surgical hubs.
- Safely delivering this shift will require effective governance and quality assurance arrangements, improved IT interoperability, robust strategic commissioning, suitable facilities for diagnostic centres and appropriate funding for enhanced optometry services and the training of the non-medical workforce.

Why change is needed

Ophthalmology is the largest outpatient specialty in the NHS, with almost nine million appointments in England alone in 2023/24, an 11% annual increase.¹ This activity is growing quicker than other specialties, as are the costs. Total NHS spend on ophthalmology in England jumped by 52% between 2018/19 and 2022/23, primarily due to increased spending on cataracts following rising independent sector provision of NHS cataract surgery.² Too often NHS eye care services are commissioned in a piecemeal way across primary care, screening, secondary care and specialised care. This can result in a lack of commissioner control over service design, capacity and spend.

The government's 10 Year Health Plan highlights the need to move more care into community settings as part of a neighbourhood health service, and this can help build a more sustainable model for ophthalmology-led care.³ We are well placed to lead the way in doing this, with examples from England, Scotland, Wales and Northern Ireland demonstrating how shifting appropriate ophthalmology pathways out of the hospital, when backed with the required resources, can improve access, efficiency and sustainability.

Clear communication with patients is also essential, so they understand why their care may be delivered in a community setting and how it connects to the hospital eye service. It is vital that patients have confidence that ophthalmology care undertaken in community settings is delivered to the same high standards, with effective management of complications and changes in their condition.

Three proven models

Diagnostic centre with virtual review

A significant portion of patients with chronic conditions, such as glaucoma and age-related macular degeneration (AMD), are particularly well-suited to diagnostic centres in community settings. In this model, diagnostic tests are undertaken in-person, typically by trained technicians, with results reviewed later virtually by a clinician, such as a consultant, speciality and associate specialist ophthalmologist or suitably trained optometrist, in a separate setting.

This approach has delivered significant gains. Moorfields Eye Hospital's diagnostic centre in Brent Cross shopping centre in north London initially treated stable glaucoma, AMD and diabetic retinopathy, and later expanded to epiretinal membranes, vein occlusions, keratoconus and cataracts. It created 38,500 additional appointments per year and an immediate reduction in the waiting list of 8.1 days per week.⁴ Similarly, NHS Nightingale Hospital Exeter's virtual glaucoma and medical retina pathways, which sees a 45-minute virtual pathway delivered by ophthalmic technicians and an ophthalmic nurse, reduced the glaucoma waiting list from 807 patients in 2023 to 55 in 2024, with average waiting times cut from nine months to under six weeks.⁵

Because in this model the diagnostic centre is fully integrated within the hospital eye service (HES), integration with the rest of the patient's eye care record is simpler and the risk of duplication of testing or unnecessary appointments is reduced. Technological developments, such as the increasing use of artificial intelligence (AI) and video examinations, are likely to further increase the use and efficiency of this model. Diagnostic centres will help facilitate the introduction of AI, supported by effective oversight and governance.

A wide range of ophthalmic care can be delivered through diagnostic centres with virtual review, including monitoring of diabetic retinopathy and stable retinal vein occlusions following treatment. For glaucoma, referral refinement, follow-up of treated ocular hypertension and management of low-risk glaucoma can be expanded. Monitoring work for corneal care, such as keratoconus, can also be delivered in this way.

Enhanced optometry services

Primary care optometry services have a crucial role to play in managing low and suitable medium-risk patients and preventing unnecessary referrals into ophthalmology services, provided there is two-way digital connectivity and image sharing with the HES, robust governance and commissioning arrangements, appropriate funding, and clear routes for professional development and upskilling.

Work undertaken in Gloucestershire provides a positive example of how optometry and ophthalmology can work together to support a shift from hospital to the community. In place since 2022, the Community Ophthalmic Link Project allows participating optometrists real-time access to all relevant patient information – including images taken in the HES and clinic letters.⁶ It is estimated this has prevented 2,500 unnecessary referrals.

Scotland has gone furthest in enabling optometrists to deliver an enhanced eye care service, with stable glaucoma cases, for example, now being managed in optometry instead of the HES. As Harper et al summarise, the Scottish General Ophthalmic Service contract 'provides for more clinical and comprehensive eye examinations, with financial support for education'. Nearly a third (29%) of optometrists have an independent prescribing (IP) qualification, compared to 7% in England, 10% in Wales and 10% in Northern Ireland.⁷

This model properly funds enhanced eye care services in primary eye care and supports training the non-medical workforce. It is not clear, however, that these reforms have reduced referrals going into the HES. Analysis by El-Abiary et al found that 'the quantity of IP-qualified optometrists had no

significant impact on referrals to HES'.⁸ Ensuring referral quality through robust governance processes and effective two-way image and information sharing is essential.

Other treatments can also be shifted from the HES to high street optometry, with the right governance processes, appropriate funding, robust commissioning and quality assurance in place. For glaucoma, this includes referral refinement (if practices have optometrists with higher glaucoma qualifications), follow-up of treated ocular hypertension and low risk primary open angle glaucoma. For cornea, a significant amount of keratoconus care may be undertaken in high street optometry, assuming availability of corneal tomography machines. Likewise, for oculoplasties, orbital and lacrimal, follow-up activity such as cancer surveillance and thyroid eye disease can be undertaken in optometry with appropriate failsafe structures and education.

Surgical hubs

Surgical hubs in ophthalmology are dedicated facilities that deliver planned procedures efficiently and at high volume. They can be located in a range of settings, separate from the main hospital eye service, such as standalone high-volume low-complexity units and modular units with mobile theatres.

One of the major benefits is expanded surgical capacity. The Golden Jubilee Eye Centre near Glasgow is a purpose-built site with six twin theatres performing more than 18,000 cataract procedures annually.⁹ At a smaller scale, Cardiff and Vale deployed modular units and mobile laminar flow theatres to rapidly increase capacity, from 138 each month to more than 400. In this model, there is no need for patients to visit the main hospital building.¹⁰

There can also be significant financial savings from moving to this surgical hub model. At Sussex Eye Hospital, cataract services were redesigned by stratifying patients, converting clinical rooms into theatres, and introducing nurse-led pre-operative clinics. This freed up 19 additional theatre sessions each week and is forecast to save £1.37 million, while reducing the cataract backlog.¹¹

The critical role of a single point of access

Effective referral management is integral to these models of community-based ophthalmology-led care. This can be achieved via a single point of access (SPoA) – a central hub of expert clinical staff who review and triage all eye care referrals in a defined area to ensure that patients are referred to the right care setting first time. In 2023, a North Central London pilot for wet AMD reduced avoidable referrals from 62% to 29% and cut average triage times from 11 days to one day, and earlier this year RNIB estimated that a national rollout of SPoA could save the NHS £170m annually.¹²

The importance of hospital-based ophthalmology care

Although many of the more than a dozen ophthalmic subspecialties have scope to move more care out of the hospital, much ophthalmology care will need to remain within the HES – particularly for complex care and surgery and emergency care. Effective coordination between the HES and the different community settings is essential to ensure timely high quality care is delivered for patients.

Our position

To ensure we can safely deliver the hospital to community shift of ophthalmology-led care across the UK, improving the efficiency and accessibility of care while maintaining the same high standards, it is essential that the following enablers are in place:

1. Appropriate governance and quality assurance arrangements, overseen by consultant ophthalmologists.
2. Improved IT interoperability, underpinned by a single point of access (SPoA) model, to allow images and patient information to be transferred more easily between different settings and providers.¹³
3. Suitable facilities for diagnostic centres in communities, whether part of existing NHS estate or retail premises.
4. Robust strategic commissioning with effective oversight of capacity, standards and spend so we put in place the services that are needed locally to meet patient need and reduce health inequalities.
5. Appropriate funding for enhanced optometry services and non-medical workforce training.

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