

## CUES: COVID-19 Urgent Eye Care Service –

Temporary service to support NHS care during Coronavirus (COVID -19) Pandemic

### 3.2 Service description/ care pathway

To populate 3.2 of the service specification schedule 2

#### 1. Scope

##### 1.1 Service outline

The service will provide telephone triage, remote consultation and where necessary assessment and management of recent onset symptomatic / urgent ocular presentations.

The service will maintain a minimum number of face to face patient interactions by:

- adopting remote consultation by the most appropriate clinician
- triage to the most appropriate clinician if a face to face appointment is necessary
- optimising each consultation with ophthalmologist, or optometrist with independent prescribing advice & guidance, where appropriate.

**Initial telephone contact and access to clinical triage** – access to the service is restricted to telephone booking only, to:

- identify people with Covid-19 symptoms, at risk /self-isolating people to signpost to appropriate services.
- offer telephone/ video consultation and selfcare advice or provide signed orders remotely, where appropriate
- offer face to face appointments with optometrist following telephone/video consultations for those who are presenting with urgent and higher risk symptoms (observing PPE guidance and social distancing advice)
- Signpost to emergency services, as appropriate.

**Urgent Eye Care** – see CUES Risk Stratification, Conditions and Service Pathway Table. The service might typically include people presenting with a red or painful eye, foreign body, sudden change in vision, or flashes and floaters which might suggest retinal detachment, who would otherwise present to general practice, hospital services and A&E.

Patients can self-present (by telephone) or be referred / redirected from other services for clinical assessment and management.

- The service will utilise current clinical capability within optical practice
- Should a local optical practice be closed, a recorded telephone message will redirect the caller to the nearest optical practice, acting as an urgent eyecare hub.
- By accepting redirected referrals from HES for assessment / continued care
- The service will recognise that where available, optometrists with higher qualifications (independent prescribing and glaucoma qualifications) will be able to manage a broader scope of eye conditions, initiate treatment and deliver care as necessary, as well as supporting other practitioners with advice and guidance as required.

- It is accepted that in some areas, referrals to ophthalmology may require clinical discussion first (or by email if not urgent) with an ophthalmologist to explore alternative management options thereby reducing the need to attend hospital, provide additional advice and guidance, or agree a collaborative approach for patient management.

### 1.1.2 Inclusion criteria

People presenting with recent onset / urgent eye conditions and for advice to support self-management of a less complex eye conditions.

Presenting symptoms typically include: loss of vision (Sudden or Transient) / Visual distortion / Painful eye / Flashes and floaters / Red eye / Double vision

### **CUES Risk Stratification, Conditions and Service Pathway Table:**



COVID-19 CUES  
Risk Stratification C

## **2. Care pathway**

**See CUES Patients Pathway flow diagram:**



COVID-19 Urgent  
Eyecare Services CUE

### **2.1 Referrals / entry points**

- Patient telephones the practice directly (This will be the majority of referrals and telephone triage occurs immediately)
- Referral from GP, care navigator or local referral management service /trriage
- Referral from Pharmacy deflection
- Referral from A&E / MIU / HES deflection
- Patient redirected by another ophthalmic practice, or allied health professional
- Signposting by NHS111

2.2 Telephone triage - Short initial telephone assessment to identify: service eligibility criteria, screen for COVID-19, potential red flag check list, and understand if the patient is already under the hospital eye service.

Where the patient calls the practice directly, the telephone triage occurs immediately.

Where the referral is received in any other way (e.g. email from GP; telephone from HES transferring care) telephone triage will usually be delivered by the practitioner to allow for remote consultation to occur concurrently, if necessary. A call to the patient will be made within 2 hours of the referral being received by the practice.

Where the practitioner is delivering the telephone triage, and identifies the need for a remote consultation, it is expected that this will be offered at the same time. Where a team member is

delivering the telephone triage, and identifies the need for a remote consultation and the practitioner is available, the remote consultation will be offered immediately.

Outcomes of telephone triage:

- Identify people with COVID -19 symptoms, at risk /self-isolating people and signpost to appropriate service (or offer a remote consultation if appropriate)
- Identify patients calling for other reasons and address appropriately (i.e. trying to book a routine sight test or for advice following a postponed outpatient appointment)
- Identify patients who are eligible for a sight test under GOS essential care and offer an appointment (as set out in NHS England Publication approval reference: 001559)
- Identify patients who have an urgent eye care need, offer and book a telephone/ video consultation with an optometrist / suitable team member (may result in the offer of a face to face appointment)
- Identify “red flag” symptoms and signpost to emergency services, as appropriate (It may be necessary to first speak with an Optometrist and / or book an immediate remote consultation).

Where the remote consultation is separate to the telephone triage, an appointment is booked, and email or SMS confirmation is sent to the patient which includes time and date of the consultation and includes the link to the video conferencing facility and/ or confirming the telephone number the practitioner will call on.

## 2.3 Consultation

### 2.3.1 Remote consultation

The service aims to deliver care safely and remotely wherever possible, avoiding the need for the patient to leave their home / place of isolation.

The consultation will be delivered in line with *College of Optometrists Remote consultations during COVID-19 pandemic guidance* <https://www.college-optometrists.org/the-college/media-hub/news-listing/remote-consultations-during-covid-19-pandemic.html>

The appointment will be delivered by telephone and/or video link and risk-prioritised on the basis of clinical need. Same day appointments will be offered if the patient reports symptoms suggestive of a sight threatening condition that would require an urgent referral.

All remote consultations will occur within 48hours of telephone triage.

For people who are hard of hearing or have communication needs, the patient should be able to nominate a support person/advocate who can also be invited to the consultation to support the patient.

The remote consultation will include the following, as appropriate:

1. Confirm with the patient that the consultation will only be able to discuss symptomatic urgent eye care needs and ensure that the patient happy to proceed on this basis.

2. Complete full online consultation, which will likely include (but is not limited to) capturing patient details, presenting symptoms and recent history, current medication, current health and past ocular history.
3. If appropriate, use video-conferencing facility to permit a gross external examination of the eye (as far as practicable).
4. Analyse findings and discuss and share the working diagnosis with the patient.
  - i. Where available, it might be necessary to seek advice and guidance from an ophthalmologist / optometrist with higher qualifications, who will be able to support with decision making relating to both diagnosis and the establishment of an appropriate management plan.
5. Discuss and agree a management plan with the patient which may include self-care advice, therapeutic recommendation, face to face consultation (identifying the optical practice hub with the appropriate equipment and practitioner available), or urgent referral to the Hospital Eye Services as per local protocols. Verify patient's understanding of management plan.
  - i. If a face to face appointment is offered, as much clinical detail as possible will be gathered during the remote consultation to minimise the face to face contact time.
  - ii. The appointment will be booked with an Optometrist with the appropriate level of qualification and equipment and/ or access to ophthalmology A&G to help ensure the patient is fully managed within the service.
6. Where a 'virtual care and management plan' or 'self-care' plan has been agreed, a follow-up consultation may be arranged with the patient where appropriate and required.
7. Provide patient information by SMS, email and/or post, to support the individual management plan. This will include information on how to contact the service and/or other services if the condition fails to improve.
8. Ensure that the patient's clinical records are completed/updated as appropriate, and update the patients GP and original referrer by email / post (A copy should be offered to the patient).

### 2.3.2 Face to face consultation

Appointments will be prioritised on the basis of clinical need. Same day appointments will be offered if the patient reports symptoms suggestive of a sight threatening / urgent condition.

Practitioners will follow general advice from NHS England & NHS Improvement, Public Health England and Department of Health and Social Care on appropriate COVID-19 measures.

Practitioners will also follow advice from the College of Optometrists (and where appropriate RCOphth) on measures for restricting clinical activity in all eye care services, and for appropriate use of Personal Protective Equipment (PPE); mitigating risk of infection to patients and staff.

People who are vulnerable / house bound / shielding should not be offered a face to face consultation (Case-by-case basis. It is unlikely the risk of sight loss outweighs the risk to general health – seek consultant advice if uncertain).

<https://www.gov.uk/government/publications/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19>

The level of examination should be appropriate to the reason for referral.

Contact time with the patient should be kept to a minimum and performed by a single practitioner. (e.g., reduce practitioner-patient contact time by making use of Imaging and OCT in place of direct ophthalmoscopy and slit-lamp bio microscopy (with shield), where appropriate, and discussing the outcome remotely following the consultation).

All procedures are at the discretion of the practitioner and undertaken as deemed clinically necessary after assessment of the *patient's* History and Symptoms, appropriately mitigating for risk of infection.

Practitioners will work within their own competency and experience. Where available, they may seek advice and guidance (A&G) from an ophthalmologist / optometrist with higher qualifications, who will be able to support with decision making relating to both diagnosis and the establishment of an appropriate management plan.

Depending on availability, A&G may be delivered at the time of the consultation (by video link) or a later time (by NHSmail or telephone) and the outcome communicated to the patient remotely (telephone or video call).

### 2.3.3 Consultation outcome

It is expected that the patient will have one of the following outcomes following consultation:

- The practitioner decides to manage the condition and offers the patient advice and/or prescribes/recommends medication. Management may include a minor clinical procedure e.g. foreign body removal. A remote follow-up consultation may be necessary.
- The practitioner refers the patient for an eye casualty / emergency consultation at the local hospital eye service, contacting the service in advance of referral to confirm appropriate referral management and booking if accepted.
- The practitioner determines the condition (and subsequent referral) is non-urgent and can be safely delayed until following the pandemic. A further appointment is recommended e.g. 4-6 months.
- The practitioner has concerns that the patient may have a systemic condition and makes a referral to their GP.
- The practitioner refers the patient non-urgently for further investigation and/or treatment in line with local referral pathways and protocols. Managing the patient expectations relating to appointment availability in the current pandemic.
- Where appropriate, the patient should also be directed to the College of Optometrist resources to help patients with their self-care and understanding.

<https://lookafteryoureyes.org/eye-conditions/>

### 2.3.4 Access to treatment

Supply & Use of Medicines following consultation:

- Where a medicine is required, this will normally be supplied or prescribed by the optometrist, as part of the consultation, through the issue of a signed order for supply by the community pharmacist of the patient's choice; or by directly supplying or selling (where appropriate), "Pharmacy only" (P) medicines and General Sales List (GSL) medicines, and the following POMs: chloramphenicol, cyclopentolate hydrochloride, fusidic acid and tropicamide.
- Independent optometrist prescribers will ideally have access to FP10 prescription, for dispensing by a community pharmacist.

An approved list of medicines will be agreed. All participating clinicians will only prescribe, supply or issue signed orders for medicines included on the approved formulary, unless there is a clinical reason not to do so.

#### **Example Formulary:**



Formulary.pdf

Where patients are eligible for free NHS prescriptions a written order with a pro forma claim form will be provided to the patient to take to the pharmacy to have dispensed and the Pharmacy will claim their fees from the commissioner.

#### **Example Written order template:**



Written Order April  
2019.docx

It should be noted that many recommended therapeutic drugs will be available over the counter (OTC) and in line with NHS England Guidance should be purchased where appropriate. However, it should be noted some preparations such as Chloramphenicol maybe a POM classification for conditions other than bacterial conjunctivitis and as such cannot be purchased OTC and a written order or FP10 is required for patient access from pharmacy.

Some OTC recommended products will be available for purchase by the patient from the optical practice acting as the urgent eye care hub – thus minimising onward contacts with other healthcare settings where possible.

Where an optometrist has independent prescriber (IP) status the commissioner will enable them to receive an FP10 prescribing pad and assign an additional prescribing budget for IP optometrists to enable greater care to be delivered in primary care within this service.

The clinical lead Optometrist and ophthalmologist will work together with pharmacy colleagues to explore routes to remote prescribing locally.

## The use of medicines

Providers will be expected to:

- Maintain their skills and knowledge with regards the use of drugs
- Demonstrate continuous professional development in line with their professional requirements
- Inform patients of the any adverse reactions prior to application and provide them with the appropriate information
- Record all batch numbers and expiry dates of drugs in the patients notes
- Ensure that all drugs are stored according to the manufacturer's instructions.

### 3. Days and hours of operation

The service will be available across the week from across a network of optical practices, acting as urgent eye care hubs. It is expected the majority of appointments locally will be between the hours of 9am and 5pm. Same day appointments will be available which will include evening and weekend provision to meet patient needs following telephone triage - subject to current COVID-19 related challenges, changes in workforce and/or government strategy.

### 4. Records & Patient information

#### 4.1 Record keeping

Complete and accurate records will be held for each patient to include clinical information by the provider in either paper or electronic format and stored securely. Information within records should be processed with regard to the principles expressed in the Data Protection Act 2018.

Records will clearly state where a remote consultation (telephone or video consultation) has occurred (as appropriate) because of the COVID-19 pandemic.

*The Information Commissioner's office has stated that practitioners need to consider the same kinds of security measures for home working that would be in use in normal circumstances*

<https://ico.org.uk/for-organisations/data-protection-and-coronavirus/>

#### 4.2 Patient information

At the end of the consultation the practitioner will summarise and discuss their findings and recommendations with the patient. Information, relevant to their condition, will be provided in order to promote their active participation in care and self-management.

A copy of the consultation report will be forwarded to the patient's GP within 48 hours. Where applicable, a copy will be sent to the original referrer and offered to the patient.

The patient will be provided with both oral and written information and offered a copy of any letters between healthcare professionals regarding their care (ideally by email, alternatively by post).

The primary source of information to support patients with their self-care and understanding will be College of Optometrist resources:

<https://lookafteryoureyes.org/eye-conditions/>

## 5. Clinical Governance

### 5.1 Workforce

The service should have effective clinical leadership with principles of training, clinical governance and clinical audit central to this.

The service will recognise current capability in optical practice and will not require any additional accreditation for service delivery.

The initial telephone triage may be delivered by optical practice staff, working to an agreed protocol, under the supervision of an optometrist.

Remote consultation, and/or face to face consultation will be delivered by appropriately trained Practitioners, who have:

- Registered with the General Optical Council (GOC)
- Registered on the NHS England Performers List (Optometrist only)
- Have an enhanced DBS check (or application in progress)
- Have completed Safeguarding Level 2 (Adults), and Safeguarding Level 2 (Children)
- Appropriate levels of Indemnity (including Medical Negligence insurance)
- Have completed GOC continuing education and training requirements to demonstrate up to date competency.

For optometrists, existing accreditation processes enable the optometrist to revisit core learning and demonstrate that their core skills are up to date. At this current time, all practical skills assessments have stopped. For the purposes of this proposal, optometrists who haven't already completed the accreditation process will be able to deliver the service, but will be expected to self-assess. All Optometrists will be expected to:

- Recognise their own learning needs and identify appropriate resources to meet these needs. All DOCET / WOPEC distance learning is still available.
- Work within their own competency and experience.
- If required, on a case-by-case basis, make use of the mentorship and guidance available within the network of local primary care optical practice and through advice and guidance processes delivered by optometrists with higher qualifications.
- Make use of Ophthalmology advice and guidance, on a case-by-case basis, where available

For CLOs, the MECs accreditation process delivers new learning beyond core competency. CLOs without MECs accreditation can still deliver care within a MEC service if supervision is provided by a MECs accredited Optometrist.

The service will utilise Optometrists with higher qualifications, where available.

### 5.2 Premises and Equipment

#### 5.2.1 Premises

All participating practices need to be providers of General Ophthalmic Services. As such, they are required to complete the "Quality in Optometry" toolkit <https://www.qualityinoptometry.co.uk/> which includes:



- Taking steps to improve accessibility for people with disabilities
- Providing a safe, secure, clean & warm environment which protects patients, staff, visitors and their property; and the physical assets of the organisation
- Ensuring patient privacy and confidentiality, protecting patient details (written and on the computer) are not accessible to members of the public
- Conducting patient consultations in private and ensuring any diagnostic tests, performed outside of the consultation room are not undertaken within the view of other patients
- Ensuring that cleanliness levels in clinical and non-clinical areas meet NHS standards for clean premises; and that staff are aware of correct handwashing procedures
- Meeting requirements for safety of equipment and disinfection

This 'Quality in Optometry' clinical governance toolkit will be the benchmark used for the service. Each participating practitioner must adhere to the core standards as set out in the toolkit and be able to provide evidence of this to the CCG if requested to do so.

<https://www.qualityinoptometry.co.uk/>

All locations delivering the service are subject approval by the Commissioners in advance of service commencement and should include the following:

- Enclosed reception and/or waiting facilities (provision of seating as a minimum)
- Suitable private room for assessment and treatment

### **5.2.2 Equipment required**

Providers delivering the service will be expected to have appropriate equipment available for the safe and effective delivery of the service. This should be used, maintained, calibrated and cleaned in line with industry standards and up to date infection control requirements that will continue to be updated throughout the COVID-19 pandemic.

In addition to equipment already available for the delivery of GOS services, this should include:

- Access to the internet (for data reporting and referral system)
- Access to NHS.net
- Access to telephone/video consultation functionality
- Slit lamp BIO or indirect
- Slit lamp breath shields
- Applanation Tonometer (Goldmann or Perkins) or Icare
- Appropriate diagnostic ophthalmic drugs
  - Mydriatic
  - Anaesthetic
  - Staining agent
- Access to imaging / OCT
- Suitable Personal Protective equipment (PPE)
- Equipment for foreign body removal

It is the responsibility of the Provider to make available, maintain to a high standard and replace all relevant equipment required to provide the service.

### 5.3 Policies and procedures

Participating practices and practitioners will follow all relevant CCG policies and procedures as required. As a minimum, these will include:

- Serious untoward incidents
- Clinical audit
- Information governance

#### 5.3.3 Infection control

Service delivery must use robust infection control procedures, including:

- Using a breath guard on slit lamps. The Royal College of Ophthalmologists has advice on how temporary breath guards can be made
- Wiping clinical equipment and door handles after every patient, as well as other surfaces that may have been contaminated with body fluids using a suitable disinfectant such as an alcohol wipe. All surfaces must be clean before they are disinfected
- Sanitising frames before patients try them on. If a focimeter needs to be used on patients' spectacles, the patient should be asked to take them off and should be provided with a wipe to sanitise their frames before these are touched by the professional
- Supporting good tissue practice (catch it, kill it, bin it) for patients and staff by having tissues and covered bins readily available
- Ensuring that thorough hand washing techniques are adhered to.

**Personal Protective Equipment (PPE)** – national PPE guidance:

- COVID-19 Infection Prevention and Control (update 12 April 2020)  
<https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control>
- COVID-19 Infection Prevention and Control (update 12 April 2020)- Table 2 (primary care settings – possible or confirmed case)  
[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/878750/T2\\_poster\\_Recommended\\_PPE\\_for\\_primary\\_outpatient\\_community\\_and\\_social\\_care\\_by\\_setting.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/878750/T2_poster_Recommended_PPE_for_primary_outpatient_community_and_social_care_by_setting.pdf)
- COVID-19 Infection Prevention and Control (update 12 April 2020)- Table 4 (any setting – currently not a possible or confirmed case):  
[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/879111/T4\\_poster\\_Recommended\\_PPE\\_additional\\_considerations\\_of\\_COVID-19.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/879111/T4_poster_Recommended_PPE_additional_considerations_of_COVID-19.pdf)

#### 5.3.2 Disposal of clinical waste

This is the responsibility of the provider and should meet legal requirements.

### 5.3.2 Patient Complaints and Compliments

Practices will be expected to display information on complaints procedures and make them available to patients and to manage patient complaints in accordance with NHS complaints procedures. [www.dh.gov.uk/health/contact-dh/complaints](http://www.dh.gov.uk/health/contact-dh/complaints)

Patient compliments and feedback will be encouraged. To minimise contact collection of feedback should be facilitated remotely.

### 5.4 Service Evaluation and Audit

The single provider lead organisation will ensure all practices and practitioners meet the requirements and provide assurance to the commissioner of this.

A secure IT web-based platform will be used to provide the data required to demonstrate performance against the service KPIs and to facilitate regular audit.

The provider will ensure that all contract performance management requirements are met and will attend virtual performance monitoring meetings with the CCG contract manager as, as necessary. The Provider is expected to undertake regular internal clinical audit and review and to take action to implement any learning acquired during this process. The key findings of the clinical audit and actions taken from learning must be reported to the commissioner.

Where it is identified that the service is not delivering the anticipated activity levels and/or the service outcomes, then the provider will work with the CCG to identify, and address, the root cause.

The single provider organisation will report to the commissioner regarding quality and performance of the service at regular intervals as agreed with the commissioners – supported by a network of local and regional leads.