NHS

Case Study

Optometry First Toolkit

To be added

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Introduction

Eye care services in England are under pressure and must urgently innovate if they are to meet the needs of our population safely and sustainably. This is especially true for long term conditions like glaucoma where existing services are struggling to meet follow-up needs and patients are at greater risk of avoidable sight loss.

Optometry First is a service commissioning and design principle to help manage this growing demand in a sustainable way by establishing a co-ordinated and comprehensive primary eye care service as part of the wider eye care delivery system, reducing pressure on the hospital eye service (HES) and benefiting patients and the wider NHS. It covers primary eye care's contribution to both recovery and the transformation of eye care services to meet need.

Optometry First makes optimal use of the existing primary eye care workforce as first contact practitioners and to manage low risk patients with long-term conditions, to broaden the scope of care delivered in primary care beyond the sight testing service. It aims to improve the efficiency and accuracy of case-finding, reduce the need for hospital attendances and improve patient experience and opportunity for selfcare.

The fundamental shift is that patients with suitable eye conditions are managed within primary care optometry; care navigated away from other parts of primary care or redirected from

hospital eye services, and only seen in / referred to the hospital eye service if clinically necessary. This includes patients who are currently on regular follow-up plans within hospital but who can be safely transferred to a service closer to home. In addition, the care is delivered more flexibly, with less emphasis on separate clinical condition care pathways (e.g. urgent care, cataract care, glaucoma care etc) so that the level of examination and management is simply that which is appropriate to the patient need at that time.

Cataract: Potential 20% reduction in first outpatient appointments and up to 85% of all cataract surgery suitable for follow up in Optometry First

Glaucoma: Over 30% reduction in first outpatient appointments and a significant contribution for glaucoma follow up care

Medical Retina: A 30% reduction in first outpatient appointments and a significant number of AMD follow up appointments delivered in Optometry First

Urgent care: Up to 50% of all urgent referrals

As experience and confidence in these services build up and primary care contractors respond to demand, an even greater proportion of eye care patients could be managed under Optometry First on an ongoing basis. enabling the HES to meet the demand of more complex patients whose needs can only be met within the hospital setting. This can ease the need for significant investment in new hospital or community diagnostic estate/facilities/equipment and workforce by making fuller use of existing primary care practice resources and workforce. Some infrastructural investment, such as in IT connectivity, governance, and commissioning at ICS level, will be required to permit this system to function smoothly at scale and allow patients to receive significantly more eye care delivered close to home with equivalent or better outcomes (through fewer delays) and with a lower NHS carbon footprint.

Primary eye care can be flexible and ICSs (or their precursors CCGs) should hold focussed discussions with established local provider networks to learn from them, discuss priorities and mobilise primary eye care services integrated with secondary and community eye care as soon as possible.

Background

Our people

Optometry First will help achieve transformation through care closer to home and the best use of the existing >13,000 optometrists, 5,700 dispensing opticians and their teams operating through a network of primary care practice sites to bring a wider range of services to patients in a coordinated way across communities.

The Optometry First approach utilises the core competencies of optometrists, supported by their

practice teams, and higher qualified primary care practitioners and the multidisciplinary hospital ophthalmology team where necessary, across a network of local optometric practices and the HES.

The NHS primary eye care workforce and facilities are high quality and flexible and can respond to patient and commissioning needs, intentions and plans outside the constraints of central NHS planning. Making better use of this capacity will improve the efficiency and accuracy of case-finding, reduce the need for hospital attendances and improve patient outcomes by reducing overall waiting and journey times, and experience.

Using optometrists' core skills and clinical decision-making capabilities for most patients, Optometry First does not require optometry higher qualifications for rapid initial deployment.

Workforce Matrix – [Available from August 2021]

Service evolution and innovation

Optometry First is distinct from the NHS General Ophthalmic Service (GOS) and private sight testing services, although it draws on the same clinical workforce, premises and facilities. It brings together a suite of established primary eye care pathways as a single service offering at place and system level. When referrals to secondary care are needed, patients will benefit from direct, usually electronic, referral to hospital and discharge back again in a seamless process without the need for duplication of information or diagnostic tests.

Patients can be referred into this service from a sight test or via other routes, including self-presentation. Integrated with the hospital eye service, and higher qualified optometrists, and supported IT connectivity - such as electronic eyecare referral systems (EeRS) [see the Digital Transformation toolkit and Eye care digital playbook - NHSX] - the service will incorporate advice and guidance, image sharing, virtual review and support for primary care management as needed.

Implementing effective care navigation and referral management, via an ophthalmic single point of access (SPoA), can help to ensure people are directed to the most suitable care setting with the appropriate level of urgency.

Care Pathway - Optometry First Contact Care: Pre Hospital

Optometry First is delivered flexibly and not restricted by the individual clinical condition care pathways. The level of examination should be appropriate to the reason for referral and patient need and should make optimal use of the service and the clinical expertise available across a network of practices and the wider primary care workforce. *For example, a patient may present for a routine post-operative cataract assessment but, if postoperative complications are identified, should then receive care within the urgent care pathway under an IP optometrist / remote prescribing and advice from the hospital or within a practice with OCT. Prompt access to*

treatment would be supported by community pharmacy. However for ease, the individual components of the service are outlined below.

Direct referral

When referrals to community / secondary care are needed, patients will benefit from direct electronic referral (see examples in NHXS Eyecare digital playbook) to hospital and discharge back again in a seamless process without the need for duplication of information or diagnostic tests.

All patients assessed in Optometry First who require a referral will be directly referred to the most suitable care setting, whether that is another optical practice, a community eye service or the hospital eye service, without the need for the patient to see the GP or for a GP referral.

The GP will be notified of any referral.

Within Optometry First, there will be a mechanism for the optometrist and/or HES to obtain information from the summary care record. Where there is uncertainty about the need to refer, or a need for guidance from colleagues to be able to manage higher risk or more complex cases in primary care, advice and guidance will be obtained from the hospital or primary care optometrist with higher qualification.

There will be a direct urgent referral system for patients with suspected wet maculopathy; patients can be referred to an urgent eye care service in primary care (Urgent eye care or macular referral filtering) with a fast-track to HES, for those who need it, or direct to the HES.

All referrals to another optical practice, community or hospital should result in feedback directly to the referrer, with a copy to the GP. The referrer should continue to receive copies of reports for ongoing care by another provider.

In primary eye care, the referrer will usually be an optometrist, but other practitioners may also refer e.g. dispensing optician, GP, OMP or other health care practitioner. Within primary care, a multidisciplinary team approach will allow best use of the whole workforce.

Acute and urgent eye care management (currently known as CUES)

Optometry First Urgent Eye Care Service (currently known as CUES) is suitable for people presenting with recent onset / urgent eye conditions. Presenting symptoms typically include: loss of vision (sudden or transient) / visual distortion / painful eye / flashes and floaters / red eye / double vision.

Practitioners will undertake an enhanced assessment and management of the patient. This will be supported by advice and guidance and, in some cases, remote prescribing, from higher qualified primary care optometrists or the hospital eye service. See the Urgent eye care How to Guide for more details of urgent and emergency eye care pathways.

Low risk and minor eye conditions management (often known as MECS)

Optometry First is suitable for people presenting / referred for advice to support self-management of a less complex but symptomatic / troublesome eye condition. (e.g. ongoing management of dry eye disease or blepharitis). Current low risk and minor eye conditions management is often known as MECS.

Practitioners will undertake an enhanced assessment and management of the patient. This will be supported by advice and guidance and, in some cases, remote prescribing, from higher qualified primary care optometrists or the hospital eye service.

Support for patient self-care

WHO state: "Self-care is the ability of individuals, families and communities to promote health, prevent disease, maintain health, and cope with illness and disability with or without the support of a health-care provider."

All NHS services and health care providers are responsible for supporting people to lead healthier lives and to take better care of their health.

Providers of Optometry First, (the practices, professionals and wider teams) can help to promote self-care in a number of ways:

- Providing information, advice and support to help people manage minor eye care needs through self-care, usually without the need for an appointment.
- Signpost to over the counter medications where appropriate in line with NHS guidance

NHS England » Conditions for which over the counter items should not routinely be prescribed in primary care: Guidance for CCGs

- Through brief interventions to support general health and wellbeing – see Optometry First Brief interventions

Brief interventions / signposting via the Healthy Living Optical Practice Framework

The Healthy Living Optical Practice (HLOP) Framework is focused on improving the health and wellbeing of the population and helping reduce health inequalities. At its simplest level, HLOP involves brief interventions and signposting to appropriate services via conversations supported by leaflets/websites. It is not a standalone service but delivers added value to any area already delivering the primary eyecare service pathways.

This could include signposting to local stop smoking services or a very brief intervention to both identify and assess potential risk factors for falls and then support access to local provision, or signposting to advice on management of diabetes and high blood pressure.

Glaucoma referral filtering

The pathway will improve referral quality, reduce the number of avoidable referrals and ensure all referrals to HES for glaucoma meet NICE NG81 recommendations on investigations and case-finding.

This pathway is suitable for people who are found at sight test to have a suspicious glaucomatous clinical sign (raised IOP, suspicious optic nerve head, glaucomatous visual field defect), or referred from elsewhere for glaucoma case-finding.

Core service – level 1 **Glaucoma Referral Filtering** through repeat measures/ repeat readings or enhanced case-finding in primary care optical practices this level of care will allow optometrists to repeat tests to confirm abnormal test results detected by a sight test and refine the decision to refer.

Enhanced service – level 2 **Referral Refinement** (as defined by NICE 81). Glaucoma Referral Refinement provides a validation of clinical findings following assessment within a Glaucoma Repeat Readings (GRR) or Glaucoma Enhanced Case Finding service (ECF). The pathway also allows for the diagnosis of OHT and suspected glaucoma and the formulation of a management plan.

See Glaucoma How to Guide for more details on glaucoma pathways.

See Paper on Manchester glaucoma scheme cost savings

Macular referral filtering

The **Maculopathy Referral Filtering** pathway aims to improve the efficiency and accuracy of case-finding for AMD, for both new and review patients, to improve the speed at which people are diagnosed and treated within the HES, to help prevent loss of sight.

This pathway is for people who have symptoms or signs suggestive of wet maculopathy including blurred/reduced central vision, distortion of straight lines, difficulty with specific tasks especially reading and recognizing faces. Patients may self-present, including those with AMD who have identified a change following self-monitoring, or be referred following a sight test or from another health care professional.

The pathway will support improved case-finding for all forms of suspected maculopathy and these patients should not be excluded.

Within Optometry First, the patient will be directed to a practice with an OCT.

The optometrist will undertake an enhanced assessment including slit lamp dilated fundus examination, dilated macular imaging including photography and OCT.

A decision is taken on triage and management by:

- an experienced optometrist with support through virtual assessments and advice and guidance (A&G) from the HES.
- the HES based on the clinical data and images obtained by the optometrist in a virtual clinic model.

See AMD How to Guide for more details on macular pathways

Cataract care

Optometry Cataract integrated care:

Pre-operative:

All people identified with cataract should have a sight-test before referral for cataract.

Suitable people for referral through this pathway are identified through a sight test. This will not include people with cataract who are primarily being referred for other co-pathology e.g. glaucoma or age-related macular degeneration (AMD).

Referrals will be direct to the surgical provider from the optical practice, copied to the GP. Patients will be referred for a surgical assessment if they have a significant cataract affecting their vision and daily life and they would like to be considered for surgery.

Core service – level 1. All patients will undergo a simple shared decision-making process addressing key questions so that patients who do not want or are unlikely to benefit are not referred for surgery.

Enhanced service - level 2. Patients may also undergo an enhanced pre-operative cataract assessment , with dilated assessment as required, to identify ocular co-morbidities, factors in the patient's medical or ocular state that will increase the risk or complexity of surgery of the choice of anaesthetic, more detailed provision of information, counselling (e.g. on refractive outcomes) and provision of written information supplied by the surgical provider. This assessment should not be duplicated by the surgical provider but will help to streamline care within the hospital pre-assessment.

Post-operative:

The College of Optometrists and the Royal College of Ophthalmologists have released a **Joint statement on post-operative cataract care** of recommendations to discharge patients following routine uncomplicated cataract surgery.The recommendations aim to help rapidly increase hospital capacity to see patients with urgent, complex or sight-threatening disease and recommend that people who have had routine, uncomplicated cataract surgery are discharged to primary care.

There are 2 options for post-operative care:

Core – level 1. All patients will be advised to attend an optical practice of their choice for a routine sight test approximately 4-8 weeks after uncomplicated surgery (1-2 weeks after completing their eyedrops) - wit return of the postop data (vision, refractive error) for audit.

Enhanced – Level 2. All patients will be referred to a named optical practice for a detailed post-operative assessment 4-8 weeks following surgery (including post-operative history and symptoms, drop compliance, assessment for post-operative complications, refraction and VA) and outcome reporting. The outcome and the dataset required to complete the National Ophthalmology Database (NOD) national cataract audit will be reported back to the surgical provider, as recommended by NICE NG 77.

For both levels of post-operative care, people following advice issued by the surgical provider at discharge may present earlier if they have symptoms and will be assessed within the urgent care pathway. This will be a small number of patients (estimated at 3-7%).

See the Cataract How to Guide for more details on cataract pathways.

Other first contact care pathways - people with learning disabilities and/or autism.

Commissioners should consider specific optometry pathways for people with learning disabilities and/or autism, so there is equitable access to eye care for this high risk group.

People with Learning Disabilities - Provide individualised care for patients with moderate to severe learning disabilities by using the skills of primary care optometrists and dispensing opticians and aims to improve local access to eye care for all people with learning disabilities. Patients with a learning disability are more likely to need, but less likely to be able to access, high quality eye care.

Children's Integrated Eye Care service and Diagnostic Pathway Following Vision Screening - Allows for early intervention and management of poor vision including amblyopia, providing an alternative to the hospital children who have been referred, or are already under the care of, the HES for poor vision. Child vision screening - GOV.UK (www.gov.uk)

Low Vision Care allows people with sight loss, often elderly patients, to access services easily and nearer to home. The pathway is specifically designed to make best use of the skills of primary care low vision practitioners (optometrists and dispensing opticians), working alongside rehabilitation officers and third sector partners to provide a fully integrated service for high-quality low vision assessment, information and clinical support and, where appropriate, low vision aids (LVAs) and daily living aids. This will include referral to support services for all conditions which can lead to visual loss (e.g. glaucoma and retina conditions) including habilitation and rehabilitation, sight loss support including Eye Clinical Liaison Officer (ECLO) services and counsellors, in line with CCEHC SAFE Low Vision, Habilitation and Rehabilitation Services framework and the RNIB ECLO framework and support guidance.

Care Pathway - Optometry Plus (Continuing Care): Post-Hospital

Diagnostic request / assessment to support hospital management

Individual requests for patients who are under the HES are directed to the service for diagnostic assessment only, to support continued care under the hospital (usually by remote consultation), avoiding the need for the patient to attend the hospital, including patients who are delayed for their review.

Examples include:

IOP (intraocular pressure) only (history & symptoms, drop compliance and applanation tonometry) for glaucoma

IOP and imaging (history & symptoms, drop compliance, IOP and imaging of the optic nerve head) for glaucoma

AMD stable (visual acuity, fundus photography and OCT)

This could include patients who present for their routine sight test and identified as “lost to follow-up” or known to be delayed for their HES review. In this scenario the optometrist should contact the HES and invite co-management, which may result in a request for diagnostic assessment within the optometry first service and/or an appointment within the HES.

Cataract postop care and NOD audit data return

Post-operative care:

The College of Optometrists and the Royal College of Ophthalmologists have released a j**oint statement on post-operative cataract care** to discharge patients following routine uncomplicated cataract surgery. The recommendations aim to help rapidly increase hospital capacity to see patients with urgent, complex or sight-threatening disease and recommend that people who have had routine, uncomplicated cataract surgery are discharged to primary care.

There are 2 options for post-operative care:

Core – level 1. All patients will be advised to attend an optical practice of their choice for a routine sight test approximately 4-8 weeks after uncomplicated surgery (1-2 weeks after completing their eyedrops) adn return of key audit data (corrected vision, refractive error).

Enhanced – Level 2. All patients will be referred to a named optical practice for a detailed post-operative assessment 4-8 weeks following surgery (including post-operative history and symptoms, drop compliance, assessment for post-operative complications, refraction and VA) and outcome reporting. The outcome and the dataset required to complete the National Ophthalmology Database (NOD) national cataract audit will be reported back to the surgical

provider, as recommended by NICE NG 77.

For both levels of post-operative care, people following advice issued by the surgical provider at discharge may present earlier if they have symptoms and will be assessed within the urgent care pathway. This will be a small number of patients (estimated at 3-7%).

Monitoring and management of patients with glaucoma

People with a diagnosis of glaucoma (or a glaucoma related condition) with a low risk of progression can be appropriately managed in optical practice within the Optometry First service.

The lowest risk patients (those with a diagnosis of glaucoma suspect or ocular hypertension [OHT]) can be monitored by primary care optometrists following a management plan, whilst those with a higher risk of progression can be managed autonomously by optometrists with the relevant qualifications (where available) or within a consultant-led service utilising remote / virtual review of clinical data.

In-house HES-based virtual clinic models exist in some hospitals, however expansion is limited by physical space, workforce capacity and there is little advantage for patients as they still have to travel to the hospital for their appointments.

LOCSU Glaucoma Monitoring

See the Glaucoma How to Guide for more details on glaucoma pathways.

Monitoring and management of AMD

Wet AMD in particular has been identified as a major challenge for ophthalmology services (GIRFT Ophthalmology Report) and a priority for both recovery and transformation. The condition can develop quickly causing central vision loss, however, many cases are treatable meaning that early identification and fast track referral are essential.

Primary care optometrists are well placed to support the early identification and referral of people presenting with wet maculopathy but also for the routine monitoring of patients who have late stage disease. Patients with a diagnosis of late AMD (wet active) or late AMD (wet inactive) require regular monitoring. Patients considered suitable for monitoring in primary care by their referring ophthalmologist will be provided with an individual management plan, to include a date for the monitoring assessment.

Patients with late AMD who have identified a change following self-monitoring will also be advised to attend Optometry First if they identify a change in vision.

The routine use of OCT scans in primary care, will reduce the unnecessary hospital attendances significantly. The inclusion of OCT is also consistent with the NICE guideline on age-related macular degeneration (guideline [NG82] published Jan 2018) which advises that people with late AMD (wet active) should be offered ongoing monitoring with OCT for both eyes.

Maculopathy Referral Filtering and Monitoring - LOCSU

See the AMD How to Guide for more details on macular pathways.

Clinical Governance

Many aspects of clinical governance in optometric practice are enshrined in legislation or regulation as well as in the College of Optometrists' *Guidance for Professional Practice, the Association of British Dispensing Opticians Advice and Guidelines* and in other guidance documents. Optical practices will complete and be compliant with the Optical Data Security and Protection Toolkit (DSPT), hosted on Quality in Optometry

Primary eye care practitioners already practise in accordance with relevant NICE guidance, College of Optometrists Clinical Management Guidelines and LOCSU care pathways. They are regulated by the General Optical Council.

In Optometry First, optical practices, optometrists, dispensing opticians and ancillary staff will work together in local networks (place-based) to deliver the range of services required to meet local needs. Where necessary, this will be supported by advice and guidance and, in some cases, remote prescribing, from higher qualified primary care optometrists or the hospital eye service for more complex cases which can be safely managed jointly in the community.

To oversee service delivery, performance management and quality/safety, the service will appoint a named Clinical Lead Ophthalmologist and a named Optometrist Clinical Governance and Performance Lead (CGPL) from primary eye care, in accordance with the Joint College's Vision.

The primary care and secondary care clinical/governance leads will jointly manage system-wide pathway performance, outcomes, incidents, complaints, compliments, clinical audit, clinical governance and local accreditation or update sessions and learn from adverse events across the pathway. The CGPL will oversee the implementation and performance management of the service delivered in optical practices.

The clinical leads will report to the ICS eye care delivery group and regional eye care board to share learning and best practice across the region.

Service Aims and Objectives

Optometry First's aims and objectives are:

Deliver

- first contact eye care, management and discharge for the majority of NHS patients,

presenting to primary care optometry

- triage to the most appropriate practitioner / care setting / subspecialty clinic, avoiding duplication or rebooking
- better use of the primary care workforce (optometrist / optician / optometrists with higher qualification) equipment and estate
- timely access to care and reduce harm for patients with time sensitive conditions
- digitally supported integrated remote care (remote consultation, virtual diagnostics review, remote prescribing)
- data for future planning of eye care services
- the basis for building integrated care pathways in which more ongoing long-term care can be delivered in primary care optometry

Reduce

- referrals to hospital
- unwarranted variations in referral activity and outcomes
- unnecessary hospital attendances
- current levels of outpatient first visit discharge rates
- delays to care and 'on the day' waiting times
- GP attendances for eye issues and release GP capacity
- duplication of care

Improve

- patient experience and continuity of care
- access and choice for NHS patients and reduce the need for travel
- referral information and quality
- consistency of care and outcomes
- clinical co-management and timely discharge
- strength of relationships across optometry networks and between optometry and ophthalmology and between primary care and hospital.
- continual service innovation

Useful resources

- Clinical pathways for treating eye conditions provides the more detailed pathway delivery

guidelines for primary eye care, which are underpinned by the College of Optometrists Clinical management guidelines Clinical Management Guidelines

- Clinical Pathways for People with Learning Disabilities
- 202112241044 DRAFT in YEAR-Guidance for Optimising Primary Care Optometry Services. Version 1.3.pdf

Case Studies

Resources

Type	Name	Last Modified
Document	BMJ Impact of Manchester GERS 2019	9 Aug 2021
Document	Domiciliary eye care_Covid_Guidance_Update_August_2021_FINAL	2 Nov 2021

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