NHSEI NATIONAL EYE CARE RECOVERY & TRANSFORMATION PROGRAMME

RECOMMENDATIONS TO OPTIMISE EXISTING LOCALLY COMMISSIONED EXTENDED PRIMARY CARE OPTOMETRY CONTRACTS IN YEAR TO AID RECOVERY.

DRAFT Guidance

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Version Control

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Contents

THIS DOCUMENT IS INTENDED FOR: COMMISSIONERS AND PROVIDERS INVOLVED IN THE COMMISSIONING AND PROVISION OF EYE CARE SERVICES (OPHTHALMOLOGY & OPTOMETRY).

1. EXECUTIVE SUMMARY

Along with many specialties, eye care services in England are under significant pressure. They must optimize all service provision to meet the needs of our population safely and sustainably.

The pandemic has compounded these pressures, with the need for immediate action to support the recovery of services and reduce the risk of severe visual loss in patients. This is especially true for long-term conditions like glaucoma, where existing hospital eye services struggle to meet follow-up needs and patients are at greater risk of avoidable sight loss. There is also an opportunity to transform eye care and enable service providers to meet the needs of our population with a focus on improving access and addressing health equity.

Service provision should be aligned to the Long-Term Plan (LTP) and the Planning guidance 2022/23 to support timely access to primary care and enable integrated working at neighbourhood and place level care settings. Primary eye care provides a coordinated and comprehensive service as part of the broader eye care delivery system, reducing pressure on the hospital eye services and benefiting patients and the wider NHS and should be utilised to support eye care services to meet local population needs.

The purpose of this paper is to request commissioners of eye care services and secondary care providers to review existing extended eye care contracts with primary care optometry and take actions, including variations to contracts that allow optimisation of current arrangements to assist with ***both in-year and future*** sustained recovery and enable a system approach to support delivery of eye care in appropriate patient care settings.

2. OPTIMISATION OF EXISTING CONTRACTS.

Improved utilisation of primary eye care provides a more convenient and accessible setting for patients. It helps manage the growing demand sustainably and mitigates the increasing strain on hospital eye services. It gives the patient greater continuity of care and improves patient experience and opportunity for self-care. This approach to supporting recovery makes optimal use of an existing sizeable primary eye care workforce, utilising first contact practitioners to manage low-risk patients with long-term conditions.

Most commissioning bodies in England already commission services that utilise the skills of primary care practitioners, that provide services beyond the sight testing service to support, manage and prioritise eye care patients. Many of these commissioned services are not fully utilised. Establishing new contracts for primary eye care services is time-consuming, but there are opportunities to improve the utilisation of the many existing contracts with little effort. With care navigation, referral triage and redirection, signposting, and discharge into the current primary

care provision, capacity can be released rapidly from Hospital Eye Services and general practice with an opportunity to deliver immediate system benefit.
"A fundamental shift is required so that patients with suitable eye conditions are managed within primary care optometry; care is navigated away from other parts of primary or urgent care or redirected from hospital eye services, and only seen in / referred to the hospital if clinically necessary. This includes patients who are currently on regular follow-up plans within the hospital but who can be safely transferred to a service closer to home". (LOCSU)

Where existing contracts permit, commissioners are requested to:

- work with referrers, those directing patients to services (urgent and routine), and patients, to optimise use of first contact and referral filtering services in primary eye care.

- work with secondary care providers to:

1. Ensure risk stratification of patients has taken place to identify clinically appropriate patients suitable for transfer to qualified primary eye care providers for ongoing monitoring and, where appropriate, management.

2. Ensure transfer takes place at the earliest opportunity.

3. RECOMMENDED IMMEDIATE ACTIONS

1. **Review existing primary eye care contracts:** Ensure current contracts are fully serviced and utilised. Also, ensure pathways and signposting for the following areas are in place where extended primary care provision is contracted.
- Urgent Eye Care Services
- Cataract Pathway (both Pre- and Post-Operative)
- Glaucoma Filtering services (Repeat measures and Enhanced Case Finding)
- Glaucoma Monitoring

2. **Confirm current activity levels with primary eye care providers:** Work with primary eye care providers to understand current activity and work with primary eye care leads to ascertain possible scope for increased capacity and activity.

3. **Enabling all relevant eye care needs directed to primary care optometry service**: Where service provision exists, ensure first contact for all appropriate eye care-related problems is directed to the primary care optometry service. Ensure all care navigation and signposting services are aware of service provision and pathways and will direct suitable patients.

4. **Through risk stratification enable clinically appropriate patients to transfer to primary eye care**: Where there are monitoring and management services in primary eye care which are suitable for low-risk patients currently seen in the hospital eye care services, commissioners should work with

hospital eye service providers to support their clinical teams to risk stratify their current patients to identify all clinically appropriate patients suitable for transfer to primary eye care. Care should be taken to ensure equity of access and quality of services.

5. **Enable rapid transfer of patient care:** Once patients suitable for transfer to primary eye care are identified, commissioners, hospital eye care services operational managers, and primary eye care providers should work together to ensure transfer of patients without delay.

6. **Support collaborative approach for primary eye care services and hospital eyecare services:** Monthly reviews of activity in extended primary eye care services should take place along with further regular identification of patients in hospital eye care services suitable for transfer to primary eye care.

7. **Enabling a single point of access approach**: Investigate implementing a Single Point of Access for eye care referrals as early as possible at the system or locality level. This may not be feasible within the current financial year; however, commissioners who do not already have this in place should consider the possible benefits to maximise the use of existing primary eye care contracts and locally available hospital eye care services capacity.

4. DETAILS OF KEY AREAS FOR FOCUS

4.1 Urgent Eye Care Services. (MECS, CUES, PEARS or local equivalent)

There is comprehensive coverage for England for these extended optometry services but only limited utilisation of the full available capacity. A recent local audit of 14 established services in one of the regions within NHS England indicated that approximately 50% of primary, urgent eye care services were not delivering as much appropriate activity as they could, indicating that there is significant opportunity to increase activity appropriately through care navigation, signposting and referral triage/redirection into the optometry service.
This, in turn, will help to realise optimal outcomes for the system and patients.

If the service already in place is not being fully utilised, commissioners should work with their local optical committee, primary eye care service leads, and hospital eye care services to:

1. Agree on a process for care navigation and referral triage / redirection to the primary eyecare urgent service from their hospital eye care services emergency departments, Minor Injuries Units, and A&Es.
2. Ensure the local NHS111 directory of services (DOS) team recognizes the primary care urgent eye care service provision and evidence signposting to the service within their DOS pathways.
3. Agree to pathways for care navigation and referral from general practice and non-participating optometry practices, general promotion of the optometry services.

4. Work with the local pharmacy committee to raise awareness of eye care service and agree to signposting arrangements from community pharmacies.
5. Agree on promotional material and information resources to support patient self-care and self-presentation to the primary eye care urgent service, where appropriate.
6. Ensure that the local pathway supports the management of postoperative complications (e.g., following cataract surgery) within primary eye care where clinically appropriate, to avoid a referral to the hospital eye care services / surgical provider or attendance at an A&E or eye casualty service. All complications should be reported to the surgical provider and arrangements for co-management and/or referral, where required.
7. Ensure all Optometrist Prescribers have access to FP10 NHS prescription forms.

The other, often overlooked, opportunity for improvement within a locally commissioned urgent eyecare pathway is maculopathy referral filtering. For services already utilising OCT and image sharing, patients typically presenting or referred to the hospital eye care services medical retina or urgent eye team for suspect wet AMD can be redirected to the local primary eyecare urgent service. Service evaluation suggests that 50% of people with suspected wet AMD would avoid a hospital appointment through urgent optometry service OCT referral refinement, releasing significant hospital eye care services capacity for those most in need of specialist intervention.

4.2 Cataract pathway

Pre-operative pathway

All people identified with cataracts should have a sight-test and assessment in primary eye care before considering referral for surgery. This will enable up-to-date refractive and ocular medical status information to support referral, if warranted. This ensures that patients benefit from optimal refractive correction and that they engage with an eye care professional as part of shared decision-making, covering the risks and benefits of surgery and addressing key questions.

Where there are extended services in place: consideration need to enable a more detailed ocular examination, risk-benefit discussion, and shared decision-making discussion may occur, enabling further reduction in unnecessary referrals and providing a risk-stratified basis for direct listing from optometry referral.

Most cataracts are identified during a sight test. However, there are referrals for cataract surgery from other routes that would benefit from redirection into the primary care optometry service for referral refinement.

If arrangements for redirection are not already in place, commissioners should work with their Local Optical Committee, GPs, and local surgical providers to agree to a process for:

- redirection of non-optometric referrals into optometry for a sight test if there are no extended services
- access into the extended optometry service from all referrers where there are extended services,

Post-operative pathway

Existing services show that up to 85% of all cataract operations are suitable for primary eye care and do not need hospital eye care services post-operative appointments. These are patients with no significant intraoperative complications and no unstable serious ocular comorbidities that need an extra post-operative hospital eye care services appointment.

Key action points relating to optimising current services:

- Clarify what percentage of patients are currently discharged to primary eyecare following cataract surgery and seek to increase this percentage. The NECRTP believes 80% is a realistic target for most trusts.
- There should be a mechanism for the return of the key postop data for the national NOD audit i.e., best correct visual acuity and refractive error, to the surgical provider.
- Ensure the local pathway supports the management of postoperative complications (e.g. following cataract surgery) within primary eye care where clinically appropriate, to avoid a referral to the hospital eye care services, either within an extended post-operative cataract service or through the optometry urgent eye care service.
- All significant post-operative complications should be reported to the surgical provider and arrangements in place for co-management and / or referral, where required.

4.3 Glaucoma pathway

Referral filtering

The NICE guidance for glaucoma NG81 recommended referral filtering in primary eye care to deflect avoidable referrals to the hospital eye care services. Repeat readings (RR) pathway allows the sight testing optometrist to repeat diagnostic tests to confirm the risk of disease, and enhanced case finding (ECF) allows an enhanced level of case-finding, including assessment of the optic nerve for people not suitable for RR. For areas with a simple RR service alone, commissioners should investigate incorporating into the contract* the added benefit of glaucoma ECF, as recommended by NICE, to further improve referral filtering to encompass most patients.

The ECF pathway can receive referrals for:

- Raised IOP / suspect visual fields found at sight test by a practice not participating in the local RR service
- Suspicious signs/damage to the optic nerve head

Key action points relating to optimising current services:

- Commissioners should work with local providers and clinicians to agree to a process for redirecting referrals into the locally commissioned primary eyecare glaucoma filtering service.
- Enable redirection of referrals following Diabetic Retinopathy Screening (Glaucoma-ECF-in-Leeds-case-study_final.pdf (locsu.co.uk)).
- Where RR & ECF are commissioned, determine whether this includes referrals following DRS and, if not, work with the LOC and local trust to understand how many hospital eye care services appointments this intervention might save locally.

The data from Leeds is based on low activity but found 82% of referrals from the DRS were avoided.

*Note: the clinical workup within ECF is significantly greater than RR, and a reasonable fee would need to be agreed. If further evidence is required locally to justify this, since ECF is deliverable on optometrist core competency (2. Competencies and Qualification Summary Table 211021 Final - Eye Care Hub - FutureNHS Collaboration Platform a pilot pathway could be implemented at pace to build the evidence base for the local case for change.

4.4 Glaucoma Monitoring

People with a diagnosis of glaucoma (or glaucoma-related condition) with a low risk of progression can be appropriately managed in Optometry.

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, while 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.

Key action points relating to optimising current services:

Diagnostic requests

In areas where there is a commissioned ocular hypertension (OHT) / glaucoma monitoring service delivered in primary eyecare:

- Commissioners should work with their LOC and local trusts to explore the utilisation of this pathway for glaucoma (or other) “diagnostic requests.”
- The optometrist can review these, making a decision in line with hospital eye care services-advised parameters, or can be reviewed remotely by the hospital eye care services team if images and information can be shared.
- Optical practice acts as a local community diagnostic centre supplemented by remote consultations from the hospital eye care services as required.

Support recovery of service:

This approach is helpful in support of the hospital eye care services backlog of patients experiencing long delays for new or follow-up appointments but can also be incorporated into the ongoing delivery of glaucoma.

The local need will inform the request, but examples include:

- History & symptoms drop compliance and applanation tonometry only for glaucoma monitoring.
- IOP, visual fields, Van Herrick test (or anterior segment (AS) OCT where available), and imaging / OCT of the optic nerve for glaucoma first appointment
- visual acuity, imaging, and OCT of the optic nerve for stable OHT or glaucoma monitoring

Monitoring:

Where there are established primary eye care OHT and glaucoma monitoring services, these can be significantly underutilised, with the hospital eye service not robustly identifying a low-risk cohort from their caseload and making the transfer.

- Where these extended primary eye care glaucoma services exist, commissioners should work with local trusts and LOCs to ensure an agreed risk-based cut-off for identifying suitable patients and support trusts to review and transfer patients, with regular continuing review going forward.

4.5 Introducing a single point of access

There is an increasing range of locally commissioned extended services delivered by primary eye care professionals in their optometric practices. However, the uptake or usage is often not optimised. In several areas, commissioners, local optometrists, and trust teams have worked together to introduce a single point of access (SPoA). An SPoA provides a complete service of triage covering routine and urgent referrals supported, as required, by hospital eye care services.

Depending on the model chosen, some or all referrals are either encouraged or, in some cases, mandated to pass through the optometry-led SPoA.

Possible opportunities:

Appropriate referral approach: Referrals are received and triaged by primary care optometrists, using protocols agreed by the local lead ophthalmologist(s) and clinical lead optometrist(s), to assess and direct the outcome: booked into the appropriate clinic; rejected with advice (if unnecessary); or diverted to more appropriate community or primary eye care services, including the extended services described above.

Enable timely review: The triaging optometrists understand the local service availability in primary, community, and hospital eye care and use the agreed triage protocols and eRS to ensure, where a hospital appointment is needed, the timing and clinic type are chosen well to ensure timely specialist care.

Access for opinion and feedback: Local arrangements should be made to ensure access to ophthalmologist opinion for occasional uncertainties in triage, although suitable protocols eliminate the need for this to be very often. Triagers can develop their skills further through regular peer review discussions on decisions and regular data on outcomes of referrals.
For an SPoA to have an impact, there needs to be a minimum core extended primary eye care service available so that there is somewhere to divert referrals to – the minimum core being glaucoma RR, preoperative cataract assessment and urgent eye care.

Please See Case Study Paper sent with this Document.

For further information and support on please contact us on nhsi.eyecare-transformation@nhs.net

Key Stakeholders for Engagement and Areas for Consideration.

The following are key stakeholders for engagement and areas for consideration in pathway redesign and implementation of recommendations.

Patients

- Communications signposting to appropriate urgent eye care provision
- Communications about transfer of monitoring and treatment to primary care optometrists.
- Experience & feedback measures

Commissioning Teams.

- Contract Relationships
    - Commissioner/optical practice/secondary care providers

Secondary care providers.

- Eye care clinicians
- Operational managers
    - Cohort Identification through risk stratification
    - Transfer of care
    - Communications to patients
    - Transfer of records and management plan
- A & E Department
    - Clinicians
    - Support staff

Primary care

- General Practice / Care Navigators / Primary Care Network / Local Medical Committee
- Optometrists
- Optical Providers and primary eye care support staff
- Local Optical Committee
- Prime eye care provider (e.g. primary eyecare company)

Pharmacy / LPC

NHS 111

- Operational managers
- All care navigation staff

Minor Injuries Units