

1What is your name?

Enter your name here *(Required)*

Josephine Mullin

2What is your email address?

Enter your email address here *(Required)*

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3What are the first three or four digits of your postcode?

Enter the first three or four digits of your post code here (these will help us to analyse results on a local and regional basis) *(Required)*

4Are you providing a response as an individual, or on behalf of an organisation?

(Required)

- As an individual
- On behalf of an organisation

5If you are responding on behalf of an organisation, which organisation is it? (400 characters)

The College of Optometrists
Local Optical Committee Support Unit (LOCSU)
Optical Confederation

6Which of the following areas of healthcare are you representing? (please tick all that apply)?

(Required)

- Commissioners of healthcare services
- Acute services
- Mental health services
- Primary care services
- Community based care
- Patients and service users
- Other
- None

If you ticked Other, please specify which organisation you are responding on behalf

7Do you believe that the current system of urgent and emergency care in England needs to change and improve?

(Required)

- Yes
- No

8 Have you read the full Urgent and Emergency Care Review evidence base?

(Required)

- Yes
- No

9 Do you agree with the evidence base presented for self-care and self-management (section 5 of the evidence base)?

- Yes
- Mostly
- Partly
- No

10 Do you agree with the evidence base presented for telephone care (section 6 of the evidence base)?

- Yes
- Mostly
- Partly
- No

11 Do you agree with the evidence base presented for face to face care (section 7 of the evidence base)?

- Yes
- Mostly
- Partly
- No

12 Do you agree with the evidence base presented for 999 emergency services, accident and emergency departments, and access to back-up services (sections 8 and 9 of the evidence base)?

- Yes
- Mostly
- Partly
- No

13 Do you agree with the evidence base presented for emergency admissions (section 10 of the evidence base)?

- Yes
- Mostly

- Partly
- No

14 Do you agree with the evidence base presented for urgent and emergency care workforce (section 11 of the evidence base)?

- Yes
- Mostly
- Partly
- No

15 Do you agree with the evidence base presented for urgent and emergency care networks (section 12 of the evidence base)?

- Yes
- Mostly
- Partly
- No

16 Do you have any other comments on the evidence base, or is there any further evidence that you would like to offer to support improving the urgent and emergency care system in England?

Insert your comments here

We mostly agree with the evidence base but would like to take this opportunity to highlight the role that appropriately trained optometrists can play in improving the quality and availability of urgent care, particularly in the community as part of the primary care workforce (in partnership with other eye care professionals such as ophthalmologists). In many CCGs, patients cannot access urgent eye care through community optometrists and we believe expanding this service across the country would benefit patients and the healthcare system.

Urgent eye care is provided by GPs, optometrists, A&E departments, minor injury units, eye casualty departments and rapid-access outpatient clinics. An urgent eye condition is any eye condition that is of recent onset and is distressing or is believed by the patient, carer or referring health professional to present an imminent threat to vision or general health. However many patients treated by the urgent eye care service have non-urgent conditions, particularly patients who self-refer to eye casualty.

Most hospital urgent eye care services report that they struggle to keep pace with demand. Demand for hospital eye emergency services is thought to be increasing. Evidence from London, shows that over a five year period up to 2011, demand at two major eye casualty units increased by seven and ten per cent year on year¹ and eye emergencies are estimated to make up 1.46-6% of accident and emergency attendances². However, most urgent eye conditions are non-acute and relatively straightforward to treat³. As many as 78.1% of cases attending eye casualty are deemed 'non serious'⁴, with 50-70% of cases not constituting either an accident or an emergency⁵, a figure supported by patient feedback⁶.

To make services more accessible and reduce pressure on hospital eye casualty, a significant proportion of patients can be diagnosed and managed in a primary care instead by a healthcare professional with a slit lamp (which allows you to see the front and back of the eye in detail and is needed to diagnose most urgent eye conditions) and the skills and experience to use it. GPs do not usually have slit lamps or enough experience of using one, but community optometrists do and are

well placed to promptly diagnose, triage and treat patients with urgent eye problems safely and efficiently.

Across the UK, innovative services are already in place to provide urgent triage and treatment for eye conditions in the community. Wales and Scotland have national contracts that enable patients to use community optometrists as the first port of call for all urgent eye problems, whereas provision across England is patchy across different CCGs. Below are examples from Wales and Grampian showing how access to emergency eye care can be improved without harming patient safety, and potentially improving efficiency at the same time.

Example one - the Grampian Eye Health Network

The walk-in service at Aberdeen's eye department was increasingly being used by the public for non-urgent eye problems. The level of walk-ins was at 6,000 annually and increasing, leading to long travel times and waits for patients, a chaotic environment and specialist resources being used to treat non-urgent cases. An audit demonstrated that only 9% of patients coming to the eye department required referral to the hospital eye clinic; over 90% could have been treated by someone other than a hospital doctor.

Following input from all stakeholders (Local Board Advisory Groups, Community Health Partnerships, Community Forums) and to enable partnership and patient involvement, the Grampian Eye Health Network was formed which includes all optometry practices in Grampian and Shetland.

A 24 hour telephone Eye Health Network Clinical Decision/Support Line was established, staffed by specialist nurses and doctors. Afternoon consultant-led eye-assessment clinics were established and optometrist-led support sessions were formed to ensure continuous learning, high quality care. Patient Group Directives enabled more efficient prescribing of medications.

The outcomes of the Scheme have been encouraging:

- There has been a significant shift of care from hospitals to community services
- Only patients who require referral to the hospital eye clinic are booked into the eye assessment clinic
- Patients are now seen as locally as possible
- Lengthy travel times and waits are avoided
- Valuable NHS resources are now used more effectively

Example two – Wales PEARS (Primary Eyecare Acute Referral Scheme) model⁷

PEARS is an optometric primary care intervention service to facilitate the early assessment of acute ocular conditions. Patients are seen within 24hrs of making an appointment and are self-referred or directed to the service by a GP. Optometrists are paid under an enhanced contract to detect, and in some cases manage, urgent conditions. Many GPs lack the equipment, experience and skills to diagnose and treat eye condition so taking advantage of community optometrists can enable patients to remain in primary care and potentially free up some GP resources.

Costs per consultation:

- PEARS £38.00
- GP consultation £22.00
- Hospital eye service (HES) consultation £69.80

Overview:

- Of 4881 PEARS examinations, 3692 were self-referred
- 1416 had a presenting symptom of unilateral red eye (1276 of these were managed in optometric practice or in conjunction with the GP)
- 986 had the presenting symptom of 'ocular discomfort'
- 601 had the presenting symptoms of 'flashes and floaters'

Outcome of referrals to hospital eye service from PEARS:

- 392 patients were referred
- 295 (75%) were judged to have been appropriately referred by the optometrist
- 284 (72%) were judged to have been correctly diagnosed by the optometrist
- 49 of 97 (51%) of 'inappropriate referrals' were for posterior vitreous detachment (PVD)
- 45 of PVD referrals were correctly diagnosed, but 27 had been referred solely on the basis of local protocols
- 34 had non sight-threatening problems
- 14 were normal.

Equity of access

Of 6432 individuals 87.4% travelled less than 5 miles to an optometrist.

Workforce and hospital eye casualty

A better workforce mix is important to improve capacity and efficiency within eye casualty settings. For example, optometrists and nurse practitioners have shown good agreement with ophthalmologists with diagnosis, treatment and management strategies in eye casualty settings^{8,9, 10, 11,12}. Many cases can be managed without the input of an ophthalmologist^{13, 14,15,16,17} and optometrists can be supplementary prescribers or independent prescribers and can also operate under a PGD.

17Have you read the full Urgent and Emergency Care Review emerging principles?

(Required) Yes

No

18Do you agree that any improvements and changes to the urgent and emergency care system need to be based on the emerging principles?

Yes

No

19Do the system design objectives outlined allow the emerging principles for the future delivery of urgent and emergency care to be met?

Yes

Mostly

Partly

No

20Do you support the identified possible implementation solutions?

- Yes
- Mostly
- Partly
- No

21What type of things would help with implementing the possible solutions? Please tick all that apply.

- Improved IT and information sharing
- Increased focus on clinical outcomes
- Urgent and emergency care networks
- Closer working across organisations
- Closer working between GPs and secondary care clinicians
- Wider range of skills and increased training
- Common commissioning framework
- Better alignment of incentives/commissioning levers
- Other

If you ticked Other, please specify (max 2,000 characters)

Tackling variation in the availability of access to primary urgent eye care by commissioning community urgent eye care schemes in parts of England where this is not yet available. See answer 16 for further details.

22What type of things might prevent implementing the possible solutions? Please tick all that apply.

- Incompatible IT systems/data sharing issues
- Culture of silo working – not owning the whole pathway
- Lack of secondary care support for GPs
- Lack of awareness of how GPs can contribute to their patients care in hospital
- Inability to risk share/ double-run systems in transition
- Focus on process rather than outcome
- Insufficient skills mix across workforce
- Current Payment by Results structures
- Contractual focus on penalties rather than incentives
- Other

If you ticked Other, please specify (max 2,000 characters)

23Do you have any further comments about the emerging principles, system design objectives, or implementation solutions, or are there any other suggestions you would like to make?

We mostly agree with the objectives and implementation solutions but, based on the evidence presented above in answer to question 16, we would emphasise the importance of including optometrists as a vital part of the primary care workforce for urgent care.

24 Would like to be involved in further work relating to the Review?

(Required)

- Yes
 No

¹ Smith HB, Daniel CS, Verma S Eye Casualty Services in London Eye (Lond) 2013 Mar;27 (3):320-8 Epub 2013 Feb 1

² Flitcroft DI, Westcott M, Wormald R, Touquet R. Who should see eye casualties?: a comparison of eye care in an accident and emergency department with a dedicated eye casualty.. *J Accid Emerg Med.* 1995 12(1):23-7.

³ Bhatt R, Sandramouli S Evidence-based practice in acute ophthalmology. *Eye* 2007; 21(7):976-83. Epub 2006 Apr 28. Review.

⁴ Vernon SA. Analysis of all new cases seen in a busy regional centre ophthalmic casualty department during 24-week period. *J Roy Soc Med.* 1983; 76(4):279-82.

⁵ NHS Scotland (2008) Deliver better health, better care through continuous improvement: lessons from the national programmes.

⁶ Edmunds B, Francis PJ, Elkington AR. Communication and compliance in eye casualty. *Eye* . 1997;11(3):345-8.

⁷ Sheen NJ, Fone D, Phillips CJ, Sparrow JM, Pointer JS, Wild JM Novel optometrist-led all Wales primary eye-care services: evaluation of a prospective case series. *Br J Ophthalmol.* 2009; 93(4):435-8. Epub 2008 Nov 21.

⁸ Banerjee S, Beatty S, Tyagi A, Kirkby GR. The role of ophthalmic triage and the nurse practitioner in an eye-dedicated casualty department.. *Eye* 1998;12 (Pt 5):880-2.

⁹ Hau S, Ehrlich D, Binstead K, Verma S An evaluation of optometrists' ability to correctly identify and manage patients with ocular disease in the accident and emergency department of an eye hospital. *Br J Ophthalmol.* 2007 Apr;91(4):437-40. Epub 2006 Oct 31.

¹⁰ Bhatt R, Sandramouli S Evidence-based practice in acute ophthalmology. *Eye* 2007; 21(7):976-83. Epub 2006 Apr 28. Review.

¹¹ Jones NP, Hayward JM, Khaw PT, Claoué CM, Elkington AR. Function of an ophthalmic "accident and emergency" department: results of a six month survey. *Br Med J (Clin Res Ed).* 1986; 18;292(6514):188-90.

¹² Buchan JC, Ashiq A, Kitson N, Dixon J, Cassels-Brown A, Bradbury JA. Nurse specialist treatment of eye emergencies: five year follow up study of quality and effectiveness. *Int Emerg Nurs.* 2009; 17(3):149-54. Epub 2009 Jan 29.

¹³ Hau S, Ehrlich D, Binstead K, Verma S An evaluation of optometrists' ability to correctly identify and manage patients with ocular disease in the accident and emergency department of an eye hospital. *Br J Ophthalmol.* 2007 Apr;91(4):437-40. Epub 2006 Oct 31.

¹⁴ Bhatt R, Sandramouli S Evidence-based practice in acute ophthalmology. *Eye* 2007; 21(7):976-83. Epub 2006 Apr 28. Review.

¹⁵ Jones NP, Hayward JM, Khaw PT, Claoué CM, Elkington AR. Function of an ophthalmic "accident and emergency" department: results of a six month survey. *Br Med J (Clin Res Ed).* 1986; 18;292(6514):188-90.

¹⁶ Hau S, Ioannidis A, Masaoutis P, Verma Patterns of ophthalmological complaints presenting to a dedicated ophthalmic Accident & Emergency department: inappropriate use and patients' perspective. *S. Emerg Med J.* 2008; 25(11):740-4.

¹⁷ Buchan JC, Ashiq A, Kitson N, Dixon J, Cassels-Brown A, Bradbury JA. Nurse specialist treatment of eye emergencies: five year follow up study of quality and effectiveness. *Int Emerg Nurs*. 2009; 17(3):149-54. Epub 2009 Jan 29.