The IP Optometrist and the NHS

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Current prescribing trends by CCGs

Support a case for issuing FP10s to IP Optometrists
Objectives

- Identify ophthalmic preparations prescribed through CCGs that could be prescribed by IP (Independent Prescribing) Optometrists
- Help to support a case for issuing FP 10s to IP Optometrists
- Not designed to have all the answers
- Promote discussion
- Main objective is to start the ball rolling
- Ultimate goal, FP10s for all IP Optometrists
Introduction

- 211 CCGs in England
- Many ophthalmic preparations prescribed nationwide
- 275 registered IP Optometrists in the UK (Source GOC)
- Very few have access to FP10s
- Many NHS patients needing eye drops go via GP and/or Eye Casualty
• Lord Howe (DH) was approached about independent prescribing by optometrists

• The DH stock response was to approach CCGs individually

• The general feeling is that we should be setting up a nationwide system
  - Better use of resources
  - Standardised model
  - NHS principle of “Do once and share”

• DH response?
The problem

- Newly acquired IP skills largely under-utilised
- Limited access to FP10s
- NHS patients unable to pay privately will need to collect their prescription from the GP
- Overburdened GPs and eye casualty departments
- There needs to be evidence-based research to support this case
The solution

- Research current prescribing trends within CCGs
- Identify groups of ophthalmic preparations which can be prescribed by IP Optometrists
- Present evidence-based research to NHS England
- Issue FP10s to IP Optometrists
Methodology

• Prescribing data from the last quarter of 2013 was extracted from HSCIC via iView\(^1\) (October to December 2013)

• Only ophthalmic preparation data was collected

• 6 different categories of ophthalmic preparations were listed

• Data from each CCG was adjusted for population

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\(^1\) HSCIC: Health and Social Care Information Centre
iView: A tool which allows the data to be extracted from HSCIC and edited as required once you have registered as a user
Categories

- Ophthalmic Preparations
  - Anti-Infective Eye Preparations
  - Corticosteroids & Other Anti-Inflammatory Preparations
  - Local Anaesthetics
  - Miscellaneous Ophthalmic Preparations
  - Mydriatics and Cycloplegics
  - Treatment of Glaucoma
The objective was to identify ophthalmic preparations prescribed through CCGs that could be prescribed by IP Optometrists in primary care.
## Results

<table>
<thead>
<tr>
<th>OP</th>
<th>Totals OP Across all CCGs</th>
<th>(%)</th>
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</thead>
<tbody>
<tr>
<td>Al</td>
<td>574,963</td>
<td>11.81</td>
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<tr>
<td>Steroids</td>
<td>480,842</td>
<td>9.88</td>
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<tr>
<td>Misc</td>
<td>1,628,484</td>
<td>33.45</td>
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<tr>
<td>Mydriatics</td>
<td>19,531</td>
<td>0.40</td>
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<tr>
<td>Glaucoma</td>
<td>2,164,761</td>
<td>44.46</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4,868,581</strong></td>
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</tbody>
</table>
That’s a staggering 20 million ophthalmic preparations per annum!
Results

Most OP Used (%)

- Glaucoma: 33.45%
- Al: 44.46%
- Steroids: 9.88%
- Misc: 11.81%
- Mydriatics: 0.40%
Results

• Glaucoma medication was found to be the most used
• Can only be prescribed autonomously with an accredited glaucoma qualification, excluded
• Miscellaneous came second...
• However, breakdown not available, excluded
• Anti-infectives came third
• Steroids follows
• Mydriatics and cycloplegics are routinely used for diagnostic purposes, less so as part of a treatment regime, excluded
Summary

- Broad range of anti-infectives and anti-inflammatories available to IP Optometrists
- Many more infective and inflammatory eye conditions could be diagnosed, treated and managed by IP Optometrists if issued with FP10s, leading to:
  - Improved accessibility for patients
  - Shorter waiting times for patients
  - Reduced burden on GPs and Eye Casualty departments
- Overall, a more convenient service for patients and a significant financial saving for NHS England
Conclusion

This research shows that there are a large number of ophthalmic preparations currently prescribed by CCGs that could be prescribed by IP Optometrists if they had access to FP10s.
Discussion points

• Initiate political discussion with stakeholders
  o GPs
  o Local Eye Health Network (LEHN)
  o NHS England

• Optometry is evolving, can the current model support IP optometrists?

• Why are we negotiating to do what we are already competent to do?

• Are we happy to refer to each other?

• Should there be a separate umbrella group for IP Optometrists? Would this strengthen our case?

• Then there is the question of funding
  o Central government and NHS England
    • Modified GOS?
    • Fresh start?
  o Locally by CCGs
The IP Optometrist and the NHS

Thank you for listening

Questions?
Nicholas Rumney
MScOptom FCOptom DipTP(IP) FAAO FIACLE FBCLA
• Why are we here?

• International Comparison

• Current state of play
  o Community NHS

• Future

• Discussion
Number of ophthalmologists per 10K of population*
• Acute pressure on 2\textdegree{} care

• The current Payment By Results system
  
  o encourages HES to accept unnecessary referrals
  
  o acts as a perverse incentive against improved triage of referrals using electronic retinal imaging
  
  o encourages unjustified follow up in HES
  
  o encourages failure to discharge patients
Primary care in Ophthalmology

- 1st point of contact, no referral required
  - GP, A&E, Optometrist, Pharmacist
- Assess diagnose and treat to conclusion
  - closest to patient
  - identifying more serious conditions and referring
- GP
  - 1.5-3% of GP consultations
  - 50 per 1000 per year
  - 95% symptomatic
- Casualty
  - 22.7 per 1000 per year (91% new)

Concordance

- 50% GP diagnoses wrong

**Conclusion:** Agreement between optometrists and consultants, in glaucoma clinical decision making, was at least as good as that between medical clinicians and consultants. Within an appropriate environment, optometrists can safely work as part of the hospital glaucoma team in outpatient clinics.

**Extended report**

**The accuracy of accredited glaucoma optometrists in the diagnosis and treatment recommendation for glaucoma**

**Conclusions:** Community optometrists trained in glaucoma provided satisfactory decisions regarding diagnosis and initiation of treatment for glaucoma. With such additional training in glaucoma, optometrists are at least as accurate as junior ophthalmologists but some cases of glaucoma are missed.
UK History

• UK Optometric therapeutics have been a reality for over 50 years
  ○ Held back by an obligation to refer (1961)

• Obligation to refer was rescinded in 2000
  ○ Opened door to treatment
  ○ Unlike other jurisdictions the UK saw little organised medical opposition

• Enhanced therapeutics (AS & SP) 2005 (IP) 2008

• Problem solved?
  ○ maybe....
Optometrists to get independent prescribing powers

Health Minister Dawn Primarolo today announced that optometrists will be able to train to prescribe medicines. Patients will soon be examined, diagnosed, and get a prescription during one trip to the opticians. Optometrists, also known as ophthalmic opticians, are health specialists trained in all aspects of eye health.
looks good? But only 275 as of October 2014
Growth in IP

scratching the surface
AOP Survey 10/2013*

- 214 optometrists on IP & AS register
- 108 responses (48% of all Registered)
  - 69 England, 37 Scotland, 2 Wales, 2 Northern Ireland
- What's going on?

*Jane Bell; with help from NJRumney, K Wallace, R Gilmour, T Sivapalan, E Spofforth, P Hampson
How do you Rx?

- Via electronic records
- NHS prescription pad
- Private prescription
- Via GP
- Via ophthalmologist
How many Rx’s a month

• Criticism
  o Q should be “clinical decisions” because high proportion of diagnoses do not require treatment & many require GSL or P preparations
If you have an NHS prescribing pad (FP10), how is this budgeted?

- Coded to GP practice
- HES prescribing
- Personal budget
- Other budget (e.g. district nurse)
- Not applicable
Future?

Should there be another tier of GOS enabled at national level which encompasses IP, including national PEARs & prescribing?

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>Response Count</th>
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<tbody>
<tr>
<td>Yes</td>
<td>72.2%</td>
<td>78</td>
</tr>
<tr>
<td>No</td>
<td>7.4%</td>
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<tr>
<td>Not sure</td>
<td>20.4%</td>
<td>22</td>
</tr>
<tr>
<td>please comment</td>
<td></td>
<td>18</td>
</tr>
</tbody>
</table>

answered question 108

Comments

- A national framework would reduce the time taken to set up schemes, reduce post code lottery and inequalities in health care.
- Stop chasing extended contracts and renegotiate GOS nationally.
- Would love it if there was a nationally agreed PEARs type scheme, properly funded for eligible Pxs
Scotland 11/2013-04/2014

- 1606 Rx
- 61 Optometrists
  - Grampian not included
  - Glaucoma SIGN not enacted
How Optometry succeeded in the USA

- Malpractice rates lowest of any healthcare profession
- No bills ever reversed
- Access is always the issue
  - 34K OD’s and only 12K Ophthalmologists
- Training + Personality + Grassroots = Success!
  - A tendency to pareto 80:20 rule
- No Ophthalmology education
- Optometrists barred from AmAcOph meetings
Australia/NZ

- Investigated scope of practice 1983
- Teeth of extreme opposition
- No Hospital Optometrists
- No Ophthalmology teaching optometry
- Adopted USA outreach programmes
- Victoria first state

- Utterly convinced professional bodies with the vision this was NOT elitist but aspirational
Jim Kokkinakis

• Sydney based Optom
  ○ First course 1991 (not recognised)
  ○ Next 1996 (VCO, Melbourne) recognised in Vic.

• 1996-2007 Worked with Ophthalmologists who wrote scripts under supervision
  ○ Legislation Victoria 1999
  ○ Legislation NSW 2007

• Reckons an 80:20 rule
  ○ 20% optoms do 80% TPA activity
  ○ Minimum 10 per week viability of exposure
  ○ Medicines privileges once qualified
Peter Larsen MD Specsavers Australia

“Taken as routine treating conditions”

“CL complications remains bulk of work”

“About 2% of primary optometry, ophthalmologists are pretty accessible here”

No controlled or parenteral

Most glaucoma is co-management

Often alongside non-glaucoma opthal.
By Comparison with the UK

• Overwhelming confidence that IP is properly the province of every optometrist not the dedicated few
  o Universities, Professional bodies and practitioners
• USA, Australia, NZ, Canada
  o NEVER funded outside profession!
  o Always started with existing practitioners conversion courses
• Fast uptake
  o Victoria, Australia <5 years 90%+ IP qualified
• Undergraduate entry only
  o Extend training
  o No longer any conversion courses
• NOT just a clinical issue, POLITICAL VISION!
Why are we so slow?

- UK is progressing too slowly
  - Overwhelming concentration on clinical aspects
  - Confidence & Encouragement lacking?
  - Laziness, Lack of imagination, Leadership?
  - Inadequate placements?
  - Dominance of corporate sector?
- Contact lenses are a big risk factor in A&E
  - So it's our responsibility!
- Relationships between IP Optometrists and Ophthalmologists better than the professional bodies think
  - Understand our competence and taking responsibility
- Fear of Litigation
  - Evidence in USA and Australia lower risk
Why are we so slow?

Intentions of training in TPA

- No Intention of training
- Not actively considering training
- Training (AS/SP)
- Waiting (for IP)

Survey reveals desire for further training

Most eye care professionals have the appetite to take on more training to further their career, latest findings suggest. According to the Optician, 21 per cent of optical assistants, and 30 per cent of optical technicians, were keen to train as DOs. This compared to the 10 per cent of optical assistants and 7 per cent of optical technicians who wanted to train as audiology, while 35 per cent had no interest in any further training.

Other industry roles were also explored by the survey. Twenty-one per cent of them had trained in or were interested in independent prescribing.

The research, sponsored by Specsavers, found that 53 per cent of optical assistants and optical technicians to qualify as dispensing opticians. Results showed just 2 per cent of practitioners were planning to train as joining an optical body. Further results from the survey will be published in next week's Optician Workplace 2013 supplement.
Public consultation (MLX 334): Proposals to introduce independent prescribing by optometrists

MLX 334 sought your views on proposals to enable optometrists to become independent prescribers. This would be achieved primarily by amendment to the Prescription Only Medicines (Human Use) Order 1997 (the “POM” Order) and consequential amendments to NHS regulations, and Rules made by the General Optical Council. This consultation document was jointly produced by the MHRA and the Department of Health. It was also made available in Wales, Scotland and Northern Ireland. The deadline for comments was 27 October 2006.

Outcome of consultation exercise MLX 334 - 28 August 2007

The proposals were considered in detail by a small working group of the Commission on Human Medicines (CHM) before consideration by the full Commission. CHM's recommendation was that suitably qualified optometrists should be able to prescribe any licensed medicine for ocular conditions, affecting the eye and the tissues surrounding the eye, within the recognised area of expertise and competence of the optometrist. CHM felt that patient safety is best served by concentrating prescribing responsibilities on the competence of individual prescribers – which is the practice now adopted for nurse and pharmacist prescribers – informed by clear professional guidelines. No optometrist will prescribe a medicine for other optometrists.

The responses received are available in the documents below:

- MLX 334: Responses received electronically
- MLX 334: Other responses

The Department of Health issued the following press release:

- Department of Health press release: Prescriptions from your High Street Opticians (external link)
Clinical Management Guidelines

- CMGs predate IP
- Need to establish overall safety of optometric diagnosis and treatment
  - Concern that formulary would seriously limit scope
  - “same standard of care”
  - Irrespective of who delivers; A&E, GP, Ophthalmologist, Optometrist.
- Other non-medical prescribing (nurses, pharmacists) developed around limited formularies for defined conditions without the autonomy optometrists need to manage their patients
- Remember why we are here
  - Ensure improved ACCESS, QUALITY and COST benefits
  - NOT to add another step.....
- As the consultation on scope of practice developed CMG’s were offered as means to demonstrate that optometrists would be able to deliver appropriate treatment based on the publicly available evidence
Evidence

- The CMG’s are a very carefully drawn up evidence base with regard to investigation, diagnosis, differential diagnosis, management and treatment, by whoever is competent to deliver it...
  - Although absence of evidence is not necessarily the same thing as evidence against
  - In some areas new methods of practice move ahead faster than evidence: blepharitis management
- There is **no** evidence provided with regard to pathways
  - The evidence available suggests optometric diagnostic concordance is high and IP more so
CMGs in practice

- No differentiation between IP/non-IP
- 56 Published
  - 42 entirely logical treatment pathway
  - 14 require referral
  - SAME AS NON-IP OPTOM!
- Post IP qualification
  - Largely ignored
  - e.g. HSK, AAU, steroid response
Assumptions

• HES care is accessible enough to be available on demand
  o Not always true

• HES care is uniform and always better than that provided by a therapeutically trained and competent prescribing optometrist
  o Consultant ophthalmologists will of course always have higher competence and experience but they are not in primary care except via a portal of A&E, GP...

• IP Optometrists are NOT trying to be ophthalmologists
  o In the community we see ourselves as the GP of the eye
  o The gatekeeper to ophthalmic services
  o IP Optometrist is properly equipped & specifically trained in eye disease
In my view the CMG are rarely a useful aid to clinical practice. They were however a very useful guide on what to revise for my IP. It is just an exam thing.

I treat within my confidence and with what I think is in the Pxs best interest.

I treat to resolution if I think the particular case is within my competence. I might also treat and refer or just refer depending on the situation.

We tend to treat everything, using the CMGs, but taking the ophthalmology position. That works well for me here, as I have a very good relationship with our "acute ophthalmologist"...
Treat stuff that I should refer on CMGs - obviously....

For instance I had a first-time severe bilateral AAU with systemic features recently on a Saturday morning with the nearest eye cas 50 miles away so I started treatment and got him seen locally Monday morning.

Err no! They are useless currently. I would do if they were any good as there isn't really any resource to tell you what to do. It should be the CMGs.
What next?

• Clinical aspects and competence is **not** the issue
  o Negativity is
• Indemnity is **not** an issue
  o AOP or FODO both cover declared scope of practice
• Main issues
  o lack of National Commissioning
    • See OC Call to Action
• Education and training
  o Widen encouragement
  o Should be an expectation for PEARS/MECS to grow into IP
  o Undergraduate courses should develop to qualify with AS
    • Now!
Discussion Points

• Political Communication with stakeholders
  o GPs
  o LEHN
  o NHS England

• Optometry is evolving, can the current model support IP optometrists?
  o Why are we negotiating to do what we are already competent to do?

• Are we mature enough to refer to each other?

• Should there be an umbrella group for IP Optometrists

• Funding
  o Central government and NHS England
  o Modified GOS?
  o Fresh start?
  o Locally by CCGs

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