With a rapidly growing elderly population, the role of optometrists will become increasingly important in meeting the burgeoning demand for eye care services. This is at a time when the NHS is facing enormous budgetary challenges and substantial spending cuts, while still trying to maximise efficiency and productivity. This first article of a six-part series addresses shared care pathways in the UK, the historical background to how referral and shared care pathways have come to exist, and gives an overview of the relevant legislation. This is in order for the practitioner to appreciate where we have come from, in terms of professional development, where we are now, and where this may lead in the future.

**Course code C-30397 | Deadline: April 5, 2013**

**Learning objectives**

Be able to work within a multi-disciplinary team, knowing the roles of other health care professionals including knowledge of local and national shared care schemes (Group 2, 2.2.2)

Be able to work within the law and within the codes and guidelines set by the Opticians Act, GOC and the College of Optometrists (Group 2, 2.2.3)

**About the author**

Chris Steele is consultant optometrist, head of optometry at Sunderland Eye Infirmary (SEI). Over the last 19 years he has developed a wide range of extended roles involving hospital optometrists undertaking cataract, anterior segment, diabetes, glaucoma, paediatrics and medical retina case loads. He has authored over 50 publications on topics including glaucoma, diabetes, specialist medical contact lenses, refractive surgery and clinical risk management, and has undertaken many presentations both nationally and internationally. Mr Steele was a member of the NICE Glaucoma Guideline Development Group from 2007 to 2009, which produced the NICE glaucoma guidelines published in 2009.

Visit www.optical.org for all the information about Enhanced CET requirements

**BAUSCH + LOMB**

Academy of Vision Care

My Academy

A unique online resource, offering personalised education to meet individual needs and interests.

Find out when CET points will be uploaded to the GOC at http://www.optometry.co.uk/cet/upload-dates | For the latest CET visit www.optometry.co.uk/cet
From April 2013, the new GP-led clinical commissioning consortia/groups (CCGs) will be handed 80% of the NHS budget to spend as they see fit for the benefit of patients locally. These will replace the primary care trusts (PCTs) which existed prior to these changes. If undertaken properly and appropriately, expanding roles for community optometrists has the potential to reduce the burden on the hospital eye service (HES) and improve the quality of care received by patients in both primary and secondary care.

Referral, shared care and effective communication

One of the biggest daily challenges facing the community-based optometrist is appropriate referral of patients who require medical advice and/or treatment. According to the Optical Confederation, 4% of patients were referred following eye examinations in 2011, while studies have shown that approximately 75% of optometrists’ referrals are appropriate. Optometrists need to ensure that referrals are always appropriate and directed to the right place, especially where shared and co-managed care pathways are in operation; optometrists involved should know clearly when it is necessary to refer patients back for further specialist medical input.

Effective communication between all those involved is an essential element in making shared care schemes function effectively. Firstly, roles and responsibilities of each health care professional involved should be clearly defined and continue to be re-defined as training and levels of experience develop by all participants with time.

Optometrists participating in shared care schemes must be competent in accurate and legible data collection and possess the necessary expertise and skills to execute their shared care role effectively. Communication between all parties involved in eye care services may require some enhancement in order to provide best practice services to all patients at all times.

Feedback from medical colleagues (for example ophthalmologists) on referrals is very important as this helps to enhance optometrists’ clinical decision making. This applies equally to basic referrals from primary to secondary care, through to specialist optometrists co-managing complex cases within a shared care pathway or in a hospital consultant-led clinic. Ongoing discussion between all healthcare professionals involved should ensure that necessary changes to patient pathway protocols always ensures optimum patient care.

From a patient’s perspective, it is also essential that they clearly understand who is responsible for each aspect of their care and that they are given the opportunity to choose if they wish their care to be shared between the ophthalmologist and optometrist. Healthcare professionals must act in the best interests of their patients at all times and keep their patients fully informed of alternative surgeons, treatments and treatment centres.

Professional obligations regarding referral

The obligation to refer patients when appropriate and clinically necessary to do so has been in existence since 1910. Before 2000, it was the optometrist’s duty to refer all patients with signs of ocular disease or abnormality to secondary care. From January 1 2000 new General Optical Council (GOC) rules (under sections 31(5) and 5A of the Opticians Act 1989) came into existence, which enabled optometrists to use their discretion in deciding when it was “clinically necessary to refer a patient.” The reality was that most optometrists had been doing this anyway for a considerable period of time. Simultaneously General Ophthalmic Services (GOS) regulations were also amended so that referrals only needed to be made “when appropriate”.

The Opticians Act 1989

From the early 1900s, various attempts were made by members of the optical profession to obtain legislation to properly establish and control their profession. Medical opposition to opticians continued to focus on the belief that non-medical practitioners were not competent to test eyesight and detect ophthalmic problems and that it was not ‘desirable to combine in one person the professional function of prescribing, with
the commercial one of selling spectacles.\(^6\) The fact that so many optometrists are now working within structured, shared care and co-managed schemes in order to provide enhanced services to patients is testament to how this attitude has certainly changed over the years and how the level of training and clinical competencies have greatly improved.

It was not until after the introduction of the National Health Service (NHS) in 1948 that the feasibility of a regulatory body for the ophthalmic profession was investigated.\(^7\) A private member’s bill was presented by Ronald Russell, Member of Parliament for Wembley South, which eventually passed through both Houses of Parliament, receiving Royal Ascent in The House of Lords in 1958 and the Opticians Act became law.

The main purposes of the Opticians Act were to establish the following:

1. A body with the purpose of promoting and maintaining high standards of professional education and professional conduct (this being the GOC – see later)
2. Registers of all optometrists, dispensing opticians and contact lens opticians. This was the first responsibility of the newly formed GOC
3. Disciplinary powers and procedures
4. Restrictions on sight testing, contact lens fitting, sale and supply of optical appliances and use of titles and descriptions
5. Organise inspections of training institutions and examining bodies
6. That ophthalmic opticians (optometrists) should “receive training from medical men in certain subjects and be allowed to have further clinical training by the medical profession in appropriate hospital departments.”

The Opticians Act 1989 was a consolidation act based upon the original Opticians Act 1958. It addressed many of the changes in the profession which had occurred during the previous 30 years. The Opticians Act 1989 provides the primary statute for the ophthalmic profession today, following some amendments again in 2005.

**The General Optical Council (GOC)**

The GOC is one of 13 organisations in the UK known as health and social care regulators.\(^8\) These organisations oversee the health and social care professions by regulating individual professionals. The GOC is the regulator for optical professionals in the UK. It currently registers around 23,500 optometrists, dispensing opticians, student opticians and optical businesses. It has four core functions as specified in Section 1 of the Opticians Act 1989:

- Setting high standards for optical education and training, performance and conduct (essential for shared care pathways)
- Approving qualifications leading to registration (now also including higher specialist qualifications, for example independent prescribing)
- Maintaining a register of individuals who are qualified and fit to practise, training or carry on business as optometrists and dispensing opticians
- Investigating and acting where registrants’ fitness to practise, training, or carrying on business, is impaired

In 1989 the GOC set up the Optical Services Audit Committee with a remit to carry out a wide-ranging review of the roles, functions and responsibilities of the GOC. This set the agenda for the GOC to reform regulation in the public interest. As a result, in 2005, a number of extensive changes were made to the legislation. These included the introduction of mandatory continuing education and training (CET) for full registrants, and the introduction of registration for student optometrists and dispensing opticians. CET and continuing professional development (CPD) are essential for any optometrist wishing to participate in shared care or co-managed care schemes, whether community-based or within the HES.

The Government White Paper – Trust, assurance and safety: the regulation of health professionals – set out a number of measures designed to modernise and enhance health regulation.\(^10\) One of these is revalidation, whereby all registrants are checked to ensure that they remain competent in the areas in which they practise most. For those involved in co-managed or enhanced eye care services, this will become increasingly important in order to meet all the necessary clinical governance requirements which are already commonplace in secondary care.

Under the GOC’s new enhanced CET scheme, peer review has become an important part of improving clinical competencies, addressing different ethical scenarios and improving standards of record keeping and communication skills. These aspects will also influence the way shared care schemes develop in the future.
General guidance on referral
When referring patients, full records should be kept and locally agreed protocols followed. If referring patients through a local referral centre, it is important to ensure that the centre has a mechanism to check that the practitioners to whom it refers are registered with a statutory regulator.

Patients have a right to be fully involved in decisions regarding their care. Some may refuse to be referred, in which case the reasons need to be documented and the consequences of not referring fully explained to the patient. Wherever possible, obtain the patient’s signature on a declaration that they do not wish to consult a registered medical practitioner and keep this in their notes. The GP should always be kept informed, provided the patient consents to this.

Referral letters should always be clearly written and contain all relevant information about the condition, reason for referral and appropriate level of urgency (depending on College guidelines and/or local protocols – see later). It is good practice to offer copies of referral letters, or other written information, to patients to keep them informed of the referral process. It is essential to maintain patient confidentiality at all times so precautions should be taken to protect patient identity when sending patient information via electronic means.

If an optometrist decides not to refer a patient, the following must always be recorded:
1. An adequate description of the condition
2. The reason for deciding not to refer on this occasion
3. Full details of advice and/or treatment given to the patient.

College of Optometrists’ guidance
The College has published Clinical Management Guidelines (CMGs) to assist appropriately qualified optometrists in their professional practice (including prescribing practice for those with therapeutic qualifications). These provide a reliable source of evidence-based information on the diagnosis and management of over 60 eye conditions which present with varying frequency in primary care. Although they make recommendations for best practice, local referral protocols should be followed when making referral decisions.

Optometric Independent Prescribing
In March 1999, the final report of the Review of Prescribing, Supply and Administration of Medicines by Dr June Crown recommended that optometrists should be granted independent prescribing responsibilities. From 2007, the Department of Health (DoH) and the GOC worked to achieve the legislative changes necessary to implement optometric independent prescribing and the new GOC registration rules, making this a reality, came into effect on 11 August, 2008.

Independent prescribing status has been one of the most significant developments in the history of the profession. Qualified independent prescribers now take responsibility for the clinical assessment of a patient, establish a diagnosis and determine the clinical management required, including prescribing where necessary. Optometrist independent prescribers should be able to prescribe any licensed medicine for ocular conditions affecting the eye and adnexa, within the recognised area of expertise and competence of the optometrist. So far, there are approximately 200 independent prescribing qualified optometrists. In time, as this number increases, independent prescribing could have a very important impact on how enhanced eye care services operate.

The development of shared care, co-managed and enhanced eye care pathways
Over the years there has been an increasing need for the optometric profession to become...
more involved in the management of patients with both chronic and acute eye problems. Never before has there been such great potential for optometrists to progressively diagnose and treat more eye conditions in community practice, as well as co-manage a wide range of eye conditions which, up until now, have been in the domain of ophthalmology and the HES.

Any changes to eye care service pathways, however, should primarily be for the benefit of patients, ease the pressure on busy HES clinics, and increase productivity and efficiency. At the same time, these changes might provide a more rewarding career path for optometrists involved.

General Ophthalmic Service (GOS) review 2007

In 2007, a DoH review of the GOS in England concluded that a three-tier approach was appropriate for continued service planning. The three proposed tiers were:

1. Essential services such as NHS sight tests, commissioned by PCTs (now CCGs)
2. Additional services and domiciliary visits also commissioned by PCTs/CCGs
3. Enhanced services commissioned at the discretion of PCTs/CCGs. These enhanced schemes include for example: ocular hypertension and glaucoma referral refinement (including repeat measurements using Goldmann applanation tonometry – GAT15), primary care acute red eye presentations (PEARS)16 and direct cataract referral.17

This three-tier system adopted in England is in contrast to arrangements in Scotland and Wales. In Scotland, GOS eye examinations include additional key elements such as dilated slit-lamp biomicroscopy with patients over 60 years and those with conditions such as glaucoma, diabetic retinopathy and macular disease. In Wales, a more targeted approach to eye care services is used with schemes directly funded by the devolved Welsh Parliament under the Wales Eye Care Initiative (WECI) scheme.

Current care pathway schemes

According to the UK Eye Care Services Project18 there are approximately 50 published and unpublished, structured, co-management schemes involving optometrists identified and providing enhanced services to patients. These will be discussed in greater detail in later parts in this series. Currently, these schemes commonly occur in pockets around the UK within certain PCT/CCG areas (health board areas in Scotland). The financial restraints placed on local PCTs and their successors (CCGs) must be considered carefully. It will be interesting to see how these schemes develop in future and the extent to which they are collectively rolled out over larger areas.

Calculating the true cost of any such scheme will be complex and must assess five elements:19

1. The cost of each examination/appointment in terms of staff, equipment and administrative overheads
2. The cost of timely communication between the professionals who share the care
3. The cost of additional examinations which take place because there has been uncertainty about the significance of a particular result. Uncertainty may be more likely to occur if a practitioner sees fewer patients and consequently has less experience
4. The opportunity costs of losing the ability to deploy professional skills elsewhere
5. The cost of unnecessary examination of patients whose risk of sight threatening disease is so low that they should be discharged.

If sufficient care is taken to adequately govern shared care schemes in the community, there is no doubt that they can be safe and effective, but it may be that they will not represent the most efficient use of resources except, for example, in areas where travel to the HES is especially difficult.

Alternatively, a ‘hub and spoke’ model of care could be further developed. This is where HES capacity is significantly expanded by establishing more consultant-led, healthcare professional (for example, optometrists) run clinics which are held in a community setting. The healthcare professionals involved would be employed to undertake this work on a sessional basis in designated out-reach centres, not necessarily optical practices. Arguably this would have certain advantages, for instance enabling easier and more effective compliance with clinical governance issues overall, easier communication and avoiding conflicts of interest with the sale and supply of optical goods.

Conclusion

The functions of the optometrist have developed enormously, with many now involved in a wide variety of shared care roles. Shared care and co-management schemes have been demonstrated to be effective on a number of levels. However, there will be a continued debate regarding the extent to which such schemes could be applied more generally across wider areas and whether they really can be provided effectively at significantly less cost compared with current HES provision. Competing funding priorities of the new GP-led commissioning consortia will likely have the greatest influence in this regard.

MORE INFORMATION

References Visit www.optometry.co.uk/clinical, click on the article title and then on ‘references’ to download.

Exam Questions Under the new Enhanced CET rules of the GOC, MCQs for this exam appear online at http://www.optometry.co.uk/cet/exams. Please complete online by midnight on April 5, 2013. You will be unable to submit exams after this date. Answers will be published on www.optometry.co.uk/cet/exam-archive and CET points will be uploaded to the GOC on April 15, 2013. You will then need to log into your CET portfolio by clicking on “MyGOC” on the GOC website (www.optical.org) to confirm your points.

Reflective learning Having completed this CET exam, consider whether you feel more confident in your clinical skills – how will you change the way you practice? How will you use this information to improve your work for patient benefit?