

Bristol Eye Hospital and the enhanced multidisciplinary team – a case study

Bristol Eye Hospital (BEH) is one of the UK's oldest eye hospitals (founded 1808) and has been at the forefront of expanding the role of the ophthalmic multidisciplinary team for many years. This case study describes some of the work they have been doing and how they are continuing to move forward.

Overview of the unit

BEH is part of University Hospitals Bristol NHS Foundation Trust but is a standalone specialist eye hospital situated at a separate site from the main acute hospital buildings such as the Bristol Royal Infirmary and the Royal Bristol Children's Hospital. The trust has an excellent reputation and has an outstanding rating from the CQC. The eye hospital has 27 ophthalmology consultants (increasing to 29 in the next 6 months, and not including 2 locum consultants) providing general and specialist ophthalmology care to a core catchment population of approximately 350,000 people in central, south Bristol and the north of North Somerset, and also specialist care to the wider Southwest region. It sees around 110,000 outpatients per year, performs around 9,000 procedures, including around 4500 phaco operations and 1500 vitrectomies, delivers more than 15,000 intravitreal injections per year and runs a walk-in eye A&E. The main eye hospital building was built in the 1980s, is attached to the original older building which now houses offices, and has four floors with a floor dedicated to paediatrics, a retinal floor and four theatres. There is also a productive clinical research facility in the building running mainly industry sponsored trials.

The eye hospital also delivers some ophthalmology services in South Bristol Community Hospital, Weston General Hospital, and the Cribbs Causeway mobile retinal unit.

The hospital uses an ophthalmic EPR to record clinical information electronically including consent forms, prescriptions and tracker identification of drugs and consumables. All data is electronically auditable and regular audits are performed on adherence to guidelines and outcomes. The unit now runs regular multidisciplinary clinical governance meetings where elective work is cancelled, to review audits and drive quality improvement for the service.

Optometrists

The original move to expand the roles of the non-medical healthcare professional (HCP) team began in 1996 with the expansion of hospital optometry roles in the glaucoma service. In 2008-9 the optometrists also began expanding their roles in medical retina (MR), anterior segment and urgent care. At this point, there are 36 optometrists (\approx 23 WTE) and the optometrist workforce capacity is split into approximately:

- 20% core optometrist work (refractions, paediatric, low vision aids, contact lens)
- 40% glaucoma extended role
- 35% MR extended role practice
- 5% anterior segment and urgent extended role.

Each of these areas of extended role work has a lead optometrist who is an experienced extended role practitioner in this area overseeing all the specialist optometrists working in their subspecialty

and who organises the training programme, designed with relevant consultants, and manages the training and career progression for optometrists in their subspecialty service.

Glaucoma

The optometrists provide a huge proportion of the glaucoma capacity, seeing 85-90% of all follow up cases. They see patients mainly at the BEH site but with some work at the community hospital sites. Glaucoma clinics are divided into new patient clinics, suspect glaucoma (glaucoma suspects and ocular hypertension which cannot be discharged back to community optometrists), stable clinics, and complex patient clinics; some of the low risk follow up (suspect/OHT and more recently stable glaucoma) is now delivered virtually. By separating the clinics into the different types of patients, this allows an efficient approach to the on-the-day journey – all patients in any one clinic will be having the same set of tests rather than mixing up new and follow ups where only some will need pachymetry, gonioscopy etc. In other words, for any one session, there will be a standardised set of tasks per patient. Patients have individual decisions on their level of risk taken at the previous clinic (or referral triage) which determine which clinic type they should be in, in line with NICE guidance, and this will be reassessed at each visit. Nurses, HCAs and technicians undertake the visual acuities and visual fields, imaging etc. Each optometrist will have a list of 9 follow up patients, or 7 new patients, or 8 complex patients per morning or afternoon session. There will be a consultant working alongside the optometrists in new clinics and complex clinics but, for the other clinics, there usually will be a consultant available on site to discuss cases; if not, notes are held and discussed later. In all types of clinics, optometrists are able to see all types of cases and are trained to work as independently as possible but to understand the limits of their experience and expertise and discuss cases with a more senior optometrist or the consultant as they feel is required, eg when listing for procedures or very complex cases. For virtual clinics, nurses/HCAs and technicians will assess any changes in symptoms or drop difficulties/compliance, perform visual acuities, visual fields, Goldmann tonometry, pupil dilatation and optic disc photos. The data will then be reviewed later on the EPR system by a glaucoma optometrist, who will make the decision as to follow up timing and which clinic type and write to the patient and the GP. They will seek help from a more senior optometrist or consultant colleagues only if they feel it is required.

There is a very well defined training system for the glaucoma role. All extended role optometrists are initially employed at Band 7, unless they have both previous experience of glaucoma management and monitoring and relevant specialist higher qualifications. The training program has 3 components. First they are given a short period of observation watching ophthalmologists and extended role optometrists undertaking clinics. This is particularly important for some who are recruited from elsewhere with no previous experience as hospital optometrists. Secondly, they will start undertaking some clinical assessments of patients in outpatients but in a supernumerary role. They will need to undertake 60 of each of the various clinical assessments (IOPs, Van Herick, gonioscopy, disc assessment etc) and these will be audited for reliability (taking into account known peer to peer test variability) in what they term "measurement reliability assessment" by the Glaucoma Service Lead Optometrist, or Head of Optometry, and the optometrist then signed off as competent for data collection. The final stage is that the optometrist will actively contribute to seeing patients and undertake complete assessments of patients, recording their decisions on care but must discuss every patient with an expert optometrist or consultant in clinic to confirm their assessment and management plan was correct. The Glaucoma Service Lead Optometrist or Head of

Optometry will audit all these decisions and interventions for a period until confident of performance. On completion of this in-house training, each optometrist is encouraged to commence undertaking the College of Optometrists Higher Qualifications in glaucoma if not already doing so and this requirement is formalised as an objective at subsequent appraisal. Optometrists may move to a Band 8a on completion of the professional diploma. Those optometrists who lead a subspecialist service are on Band 8b.

All glaucoma services including the virtual clinics are considered consultant-led and charged at the usual new or follow up tariff. Staff monitor a list of patients pending (ie waiting list and times patients are waiting, generated from PAS) for each type of clinic and this is discussed at monthly multidisciplinary performance meetings with managers and admin team, and the ratio of the different kinds of clinics varied to maintain capacity where most needed.

There are standardised protocols for stable and suspect glaucoma in terms of tests, standardised follow up intervals and treatment recommendations, which reflect the NICE guidance. However, these are for all staff seeing glaucoma patients and there are no specific optometrist glaucoma protocols. Specialist optometrists are treated in a similar way to the medical staff in terms of autonomy of decision making and independence, and understanding one's own limitations and when to ask for support.

In terms of community referral refinement, there is a community-based *Repeat Measures* (repeat IOP and fields) scheme in place, operated and commissioned by the local CCG, to which the hospital team gave advice on the original set up but over which they now have no involvement in terms of training, operational processes or clinical governance. The hospital team feel that this scheme is not effective enough in failing to prevent false positive referrals and up to 30% of new glaucoma referrals to the hospital service are discharged after one visit. There is also a CCG commissioned LOCSU supported step-down *Community Monitoring Scheme* for ocular hypertension, glaucoma suspects and low risk stable glaucoma but only for patients in the Bristol Central CCG area, rather than the entire primary catchment area of the hospital. Again, this is not governed in any way by the hospital team and is delivered by approximately 20 accredited community optometrists who underwent WOPEC training. Suitable patients are discharged with all the relevant clinical information and imaging and a clinical management plan as advice to the community optometrists from the hospital team as to how to manage the patient and what are the criteria to re-refer. Patients choose which optometrist to visit and there is some concern that there is no failsafe process for these patients to ensure they do attend and keep attending. The hospital team is actively exploring how to join up the community pathway, make it accessible to a wider population of patients and support virtual care.

Medical retina

Optometrists are also working in the medical retina (MR) service providing clinical assessments in outpatients but have not developed into the injecting role. There is a very well defined training system for the MR role. All extended role optometrists will start at Band 7. As for the glaucoma training, optometrists initially undertake a period of observation: watching ophthalmologists and extended role optometrists undertaking clinics and again this is considered particularly important for those who are recruited from the community with no previous hospital experience. They are then

trained in the virtual clinics to begin with and will begin making assessments recording two distinct pieces of information which are audited for reliability:

- 50 cases of key feature recognition: It is necessary to be able to recognise key features on OCT and fundus photography as well as slit lamp lens funduscopy. *Note that this does not cover fluorescein angiography and ICG interpretation.*
- 50 cases of management decision: The decision is usually dichotomous (treatment with anti-VEGF injection or not) but, more recently, as treat and extend protocols become common, this also includes the decision on how long the interval period should be until the next injection.

The Service Lead Optometrist for Medical Retina oversees audit on all these decisions and interventions for a period until confident of the practitioner's performance.

Once optometrists have completed this phase of the training they undergo an exit test where they are presented with ten cases and asked to make a decision, these decisions are then discussed with the MR Service Lead Optometrist. The purpose of this is to check that the decision making process is competent and that they are aware of their own clinical boundaries. Once they have completed this they can work autonomously in AMD and virtual clinics, but these clinics will always have a consultant or senior MR ophthalmologist present whom the optometrists will consult for a second opinion where necessary. They will also be working towards the College of Optometrists MR certificate.

Once staff have worked successfully in AMD clinics for a number of years they can progress to working in triage clinics and general medical retina clinics and the training is performed by working alongside a consultant. The clinical decision in these clinics are more complex and staff need to be working at band 8a level and have or be making good progress towards gaining the medical retina certificate.

As the number of optometrist and the number of sites across which they work have expanded, the unit is assessing how to ensure appropriate monitoring of ongoing clinical performance. The Head of Optometry and the Clinical Lead are developing an online test that can be performed every six months and will allow them to check more accurately decision making across the medical and optometry team. The tests will be similar to the exit test based around clinical vignettes, and will more provide more accurate audit information of clinical decision making.

As the Head of Optometry pointed out, one limitation for optometrists expanding their roles in MR is the legal limitation of the independent prescribing (IP) rights, which excludes the prescribing of any "injectables" so that they cannot prescribe intravenous drugs, subconjunctival injections or intravitreal injections; nurses are able to undertake this (note currently orthoptists cannot become independent prescribers). The inability to prescribe intravitreal injections is a limiting factor in their fully independent practice in MR clinics. The Human Medicines Regulations 2012 (214(5)) specifically exclude all medicinal products which are 'for parenteral administration' (i.e. injecting directly into the body)) from optometrist independent prescribers (see appendix for wording).

External/corneal and urgent care

Optometrist involvement in extended roles for this area of care delivery has been ongoing since around 2010 but has not expanded as rapidly, partly due to some staff, once trained, leaving to work elsewhere - but is recognised as the next area of likely expansion. There are four specialist optometrists working 1-2 sessions per week each, seeing patients in extended roles in primary care clinics (general front of the eye referrals and eye casualty follow ups), postop cataract clinics and eye casualty. Because of the wide range of conditions, and the lack of College of Optometrists Higher Qualifications in this area, the training is less defined and the entry level for optometrists higher. All are expected to already be independent prescribers and recruitment is usually internal from experienced extended role applicants from other the extended service areas primarily. Training is informal alongside the consultants, with a supervision period of around 50 cases which are always discussed and management decisions reviewed with the consultant. After that, once mutually agreed, practice can be more independent with discussion as the practitioner feels appropriate, but an ophthalmologist is always present in these clinics. Formal competencies are being developed.

Other

There is one specialist paediatric optometrist who works alongside the paediatric consultant ophthalmologists with their own list of patients and an apprentice-style training occurs similar to that for external, with sign off after a supervision period.

Cataract

Bristol Eye Hospital optometrists are not involved in pre-operative part of the cataract pathway. Traditionally, post-operative cataract surgery review was undertaken by nursing staff. However, until the relatively recent past optometrists have undertaken large volumes of post-operative follow-up visits predominantly on an ad-hoc basis when appointment demand exceeded supply in nurse-led clinics. Due primarily to both space resource limitations, this was usually undertaken outside contracted working hours on weekends and evenings, with optometry staff undertaking working autonomously without direct supervision, supported by a protocol and reviewing 12 patients in one clinic session. Individuals without specialty independent prescribing registration were able to supply one named topical steroid, and one named NSAID as appropriate for common post-operative complications using approved Patient Group Directions written specifically for this purpose. Individual optometrists undertaking this role required assessment as competent at assessment of anterior chamber activity anterior to work in these clinics, if this had already been undertaken for their contracted role. In 2016/7, cataract pathway revision reduced the demand for these ad hoc clinics as post-operative review by community optometrists was commissioned by the local CCG. Similar to glaucoma community repeat measures and OHT monitoring schemes, whilst BEH was integral to designing this scheme, it is not actively involved in its oversight or training.

Nursing

There are 11 whole time and 10 part time nursing staff in the outpatients department.

Medical Retina

Nurses have been delivering intravitreal injections since 2015 and there are now seven band 6 nurse injectors (as well as two orthoptic injectors, see below). Non-medical HCP provide most of the injecting capacity, particularly at the outreach sites and the mobile unit. In the main BEH unit, doctors contribute to the injections usually only to cover nursing sick leave except that they do also

provide several injections over the lunchtime period every day to keep the flow going whilst the nurses have a lunch break.

There have been several models of clinic trialled where nurses inject, including one-stop PRN, injection only and treat and extend. One stop PRN clinics have created difficulties in terms of very unpredictable demand for injections and, in line with many others, the central unit has moved towards the treat and extend model, which creates a much more predictable number of injections as the patients are always going to be injected at each visit but the timing of the visit varies. There are also virtual clinics, in which there is data collection by nurses, HCAs and technicians, with later reporting by optometrists and ophthalmologists. Virtual clinics run for both active and stable patients, with decisions regarding treatment and follow-up arranged as required.

Currently, the mobile unit provides injections and assessment on the same day, i.e. one-stop clinic. The rate limiting step here, due to space, is the single injection room. There are two assessment rooms. Consideration is being given to converting one of the assessment rooms into an injection room and then to utilise a 'reverse one-stop clinic' model for some patients, whereby some patients will have VA and imaging recorded and will be given an injection on the day, with a decision on when they are to be followed up for next injection being made at a later date via the virtual clinic. The remaining patients will be treated in a one-stop fashion. Combining the one-stop and reverse one-stop models will reduce room space required for assessing patients on the day, thus allowing for possible conversion of an assessment room to a treatment room. Nurses on average see 15 patients per session, although depending on the model of clinic not all of these necessarily receive an injection. This is in line with the average of 16 found by GIRFT for AMD injection clinics.

Nurse injectors have a training programme involving an external course for most, although this is optional (Bayer Masterclass Nurse Education course, internally directed learning can also be undertaken) and a development period during which they observe, then perform, supervised injections and are signed off after 50 injections, using cascade training by other extended role HCPs and overseen by the lead nurse educator. There are protocols on how to check and inject patients (WHO checklist & SOP). Every year there is further education update and an annual observed assessment and sign off of the injection performance. Nurses perform up to four injection sessions per week but currently are not clinical assessors for virtual or outpatient assessment of AMD or MR patients. However, to keep the role interesting and expand capacity, a training programme for this is being developed.

Accident & Emergency

Bristol has a busy walk in A&E service, seeing 26,000 patients per year. Nurses in A&E undertake triage, as is common, and in addition 15 nurses are working in extended roles where they are able to manage and treat specific conditions, so called "see and treat" – three nurses are in training at present and one technician is available in the department, equating to 14.53 WTE altogether. One is trained as an independent prescriber, the others can use PGDs for medications or can seek support from a prescriber for medications if required. Conditions independently managed include contact lens related keratitis, foreign bodies, corneal abrasions, conjunctivitis, simple anterior uveitis etc. At any one time in A&E there will be four to five extended role nurse practitioners undertaking this care. There are always at least two ophthalmologists to consult and support their role. Nurses

develop their skills through on the job training alongside ophthalmologists or more experienced nurses; they are signed off for each condition by seeing three cases successfully as assessed by their trainer to the level of independent practice, and some formal competencies for tasks (eg corneal scrape) are being developed. Nurses work at band 5 and 6 levels for these roles and again there is consideration of formalising the exact requirements and type of work which will map to these bands. Overall nurses independently manage approximately 17% of all attendances at the emergency department, however the independent prescriber nurse can increase this to 27%.

The nurses also perform a pivotal role of taking histories from all patients attending the emergency department and independently arranging all investigations they believe that patient may require including OCT scans, retinal imaging, visual fields, colour vision and blood investigations. These investigated patients are then passed to the doctors in the department. This greatly improves the patient flow and numbers able to be seen by individual doctors.

There are also currently four optometrists doing at least one session a week in the emergency department. Two are senior, requiring little direct supervision, and two are being trained. Training involves partnering with the Emergency Department consultant; initially all cases are reviewed then as competencies are achieved the supervision becomes less and optometrists are able to work within their own remit. Both training optometrists have previous experience of working in the anterior segment primary care clinics and are already quite experienced. There is no formal sign off for conditions to be seen, instead each optometrist has individualised feedback on performance and cases seen. Practical skills such as foreign body removal and corneal scrape are performed under direct supervision, until they are deemed competent. Initially optometrists are supernumerary on the rota, then come on to the rota as their skills and competence increases. All optometrists work alongside an ophthalmologist in the department. On the last internal audit, optometrists saw 8 patients per session, fewer than an ophthalmologist sees. Optometrists are encouraged to work within their confidence and self-select the cases. For example, they see fewer neuro-ophthalmology cases and more vitreoretinal and anterior segment cases than what would be expected by the average attendances for the Emergency Department.

Other

There are three to four clinical nurse specialists who support the inflammatory eye disease service. They counsel patients on medications including immunosuppressants, oversee the monitoring of drugs eg blood tests and their results, answer questions and are the first point of contact for patients with problems with their medication, side effects or problems with the eye or vision. They are able to perform slit lamp assessments and can undertake management including discharge, via a protocol, of low risk anterior uveitis including uveitis follow ups from A&E. They also support the paediatric uveitis clinics.

Nurses also undertake fundus fluorescein angiography (FFA) and photodynamic therapy (PDT). There was previously a nurse who performed YAG laser capsulotomy but with the individual member of staff leaving this has lapsed.

Orthoptists

There are 11.3 WTE orthoptists at BEH and there are two orthoptic intravitreal injectors who undertake both clinical assessments of patients in MR clinics and injections, and each spends one day per week of their timetable doing this. They work at a band 7 as that is the advice that BIOS have given. Their training for injections is the same as for nurses but they also receive training from working alongside the ophthalmologists and have signed competencies which are based on those from BIOS.

In addition to this, they run a number of extended role virtual services in terms of a children's epilepsy surgery preop assessment, a "skull base" clinic and a stroke clinic, involving visual fields and an expanded orthoptic assessment. They generate a report on the Big Hand digital system which is later reviewed virtually by the neuro-ophthalmologist

These are all charged at an orthoptist assessment tariff which is not reflecting the resource of the consultant review of the data and decision making which they would like to change.

The UKOA view of the BEH model

Bristol Eye Hospital has one of the longest established extended/advanced practice non-medical practitioner programmes in UK hospital eye services. They have been able to build this up over time, learn and improve, and to develop a framework for staff development and assessment which gives confidence to them, the trust and their patients, that non medical HCP staff are well trained, knowledgeable, competent and safe in their expanded scope of practice. The system is extremely well embedded and mature, and a bedrock of their service delivery. The whole department is signed up to and supportive of this and it is not driven by one or two enthusiasts but supported by all.

Learning points for other services:

Staffing

The programme was very optometrist focused originally, but has expanded to include many nurses. Orthoptists have been the least developed into expanded roles for the major high capacity disease areas (glaucoma, MR, acute, cataract) although they do undertake advanced roles which link directly to orthoptic practice, mainly neuro-ophthalmology and paediatric roles. There are more recently two orthoptic injectors.

Optometrists have often been the starting point for many eye units for outpatient clinic roles. Why is this? They already have excellent core skills and experience in slit lamp use and diagnostic expertise for eye disease and are used to making independent decisions in community practice. There are more optometrists available than for other ophthalmic professionals, with many thousands of optometrists in the UK; ophthalmic trained nurses are now less common than they were and there is a serious national shortage of orthoptists. For these non-optometrist HCP, therefore, numbers available to train and availability of backfill to their traditional roles can be a limiting factor. In addition, the College of Optometrists higher qualifications has provided a long standing clear route to education for expanded optometry roles. For Bristol, the additional factor is the inspirational Head of Optometry, Paul Spry, who has worked with his senior optometrist colleagues and ophthalmologists to develop and personally drive the programme of optometrist training, with many hours devoted to making this happen.

The picture in Bristol is reflective of the average picture nationally, in that the three professional HCP groups tend to fall naturally into certain expanded role areas. Optometrists are primarily utilised in outpatient care (at Bristol mainly MR and glaucoma, and in many other units also cataract). Nurses are used primarily in A&E and acute ophthalmology settings and in delivering invasive procedures especially intravitreal injections (and often minor ops elsewhere). Orthoptists tend to be utilised in their perceived areas of expertise ie children, adults with motility or neuro-ophthalmic conditions. This may reflect units tending to look to other units for inspiration and following established precedents for staff use, or may reflect traditional views that nurses are already well trained in urgent settings especially where there may be systemic disease issues and also are already used to administering invasive low tech procedures such as injections. It's worth remembering, however, that nowhere is this set in stone. When examining staffing and skill mix, especially if you have not got enough interested or suitable HCP professionals of one sort, that orthoptists and optometrists can inject and see acute patients; nurses can work autonomously in glaucoma and cataract and paediatric clinics. Units sometimes fail to look at the options as flexibly as they could.

Training and assessment

Bristol have made a lot of effort to have clear training programme, with staged assessments to move onto the next level for the high volume areas. There is also a clear introductory period where staff can familiarise themselves with the clinical practice whilst being supernumerary, which allows them to recruit less experienced staff from outside the hospital into advanced practice roles. They have also take advantage of existing external resources such as College of Optometrists qualifications and BIOS competencies. They also have clear rules for banding at various levels of expanded practice and the criteria for these (at least for most of their staff – more of this is in development for nurses). This is underpinned by clinical audits of practice and performance (to be signed off as independent initially and for ongoing annual reviews) as well as competency sign offs for specific tasks eg corneal foreign body removal. Career structure within the Optometry Department has been designed to ensure that staff understand that progress requires role-specific national Higher Qualifications to be achieved, with job descriptions and associated person specifications explicitly stating these requirements.

The greatest burden of training falls on very senior non-medical professionals to deliver, audit and assess practitioners. Much of the day to day training in the glaucoma and MR high volume areas is delivered by cascade training, that is experienced non-medical extended role trainers oversee and train those coming up behind them. Each professional group has a head of training/head of department who works with the consultant ophthalmologists to design the training but then takes primary responsibility for directing and signing off the HCP, and they have time in their job plan to do so. Audit on HCP practice and on performance in general in the unit is made much easier by the presence of an ophthalmic EPR with this function.

For other areas, where there is a wider range of conditions, more complex decision making, and less scope for very well defined treatment or management protocols (eg urgent care beyond the low risk common conditions, external, paediatrics, non AMD MR clinics) and less availability of formal external qualifications, the HCP work more alongside consultants as well as HCP senior educators, to gain a broad range of experience with a more apprentice-style development programme. To

minimise the risk, entry level for these roles is generally higher, recruiting those who are already experienced in hospital practice and/or are independent prescribers.

Supervision, autonomy and oversight

All the non-medical care delivery is performed in consultant led clinics with a consultant or senior ophthalmologist available at all times for advice and supervision as necessary. However the emphasis of the model is not to create routine exclusion criteria for patients deemed unsuitable for HCP or to create the necessity for ophthalmologist input frequently. Less experienced staff are placed in specific situations where there is training and supervision. More experienced staff signed off as independent are expected to behave as for non consultant medical staff such as SAS doctors or senior doctors in training, that is to practice autonomously, to make decisions, but to understand their limitations and know when to ask for support, which will be rapidly available. This empowers the HCP and allows them to develop their experience and scope of practice further. Safety of this model also relies on the regular auditing and performance review of established HCP – but this is time consuming to do.

Pathway models

Where possible, Bristol has tried hard to develop a suite of standardised pathways for delivering care in high volume areas. There is a widespread understanding that efficiencies are possible, and it can make it easier to employ HCP, if any given clinic has standardised process with repeated task set delivered in the same order for every patient,. To that end they separate out different groups of patients to be seen in clinics eg the new glaucoma patient clinic vs the low risk glaucoma suspect vs the virtual clinic. A similar approach is made for AMD and injection clinics, although there is some variability depending on which site this is being delivered. However everyone is aware of this and work is ongoing to develop and improve such models and to proactively assess and determine which is the best model, as is currently happening in the mobile retinal unit. This does require clear understanding of which patient is suitable for which clinic and to ensure there is a system which directs the right patient with the right risk profile to the correct clinic.

What more might be done?

The model is much less well developed for cataract pre and postop clinics, which is, for many other units, one of the earliest non-medical HCP pathways to be taken up, as the risks are generally deemed low and it is very amendable to standardised pathways.

The non-medical practice has concentrated itself in the hospital environment and has not expanded to the same degree into the community. This has some advantages in terms of managing risk, ensuring supervised and safe HCP led care, but does not take full advantage of the potential for preventing unnecessary low risk or false positive hospital attendances. Although there is a glaucoma repeat measures scheme, and a limited community glaucoma pathway, despite some initial input the hospital is not actively involved and this is therefore not a joined up system for the population. However the hospital are very keen to engage and build on the existing community schemes and with their track record and experience in non-medical care and virtual clinics, they would be in a fantastic position to set up a large regional glaucoma care system with consistent joined up

pathways and shared clinical governance and management protocols which would fit with GIRFT and HII recommendations.

A similar approach would be useful for community pre and postop cataract care to free up capacity on site.

Other areas to explore would be expansion of the orthoptic expanded scope and to move away from the traditional nursing and optometrist divisions in terms of expanded roles. Optometrists could be injectors; nurses experienced in A&E could be external eye disease clinic practitioners. In addition there is scope for more HCP involvement in procedures such as capsulotomy and glaucoma lasers.

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Appendix

[The Human Medicines Regulations 2012 \(214\(5\)\),](#)

- **UK Statutory Instruments**
- **2012 No. 1916**
- **PART 12**
- **CHAPTER 2**
- **Prescription only medicines**
- **Regulation 214**

Sale or supply of prescription only medicines

214.—(1) A person may not sell or supply a prescription only medicine except in accordance with a prescription given by an appropriate practitioner.

(2) A person may not parenterally administer (otherwise than to himself or herself) a prescription only medicine unless the person is—

- (a) an appropriate practitioner other than an EEA health professional; or
- (b) acting in accordance with the directions of such an appropriate practitioner.

(3) The following are appropriate practitioners in relation to any prescription only medicine—

- (a) a doctor;
- (b) a dentist;
- (c) a supplementary prescriber;
- (d) a nurse independent prescriber; and
- (e) a pharmacist independent prescriber.

(4) A community practitioner nurse prescriber is an appropriate practitioner in relation to a prescription only medicine specified in Schedule 13.

(5) An optometrist independent prescriber is an appropriate practitioner in relation to any prescription only medicine other than—

(a) a medicinal product that is a controlled drug; or

(b) a medicinal product that is for parenteral administration.