Proposed Glaucoma Pathway

1. Patient attends community optometrist (CO)
   • Sight test, IOP over 21 (applanation tonometry) and/or
     visual field defect and/or excavated discs
   • Patient/optometrist makes appointment with optometrist
     with special interest in glaucoma (OSI) or OMP

2. Patient attends OSI or OMP
   Full history and assessment carried out according to protocol
   • Decision taken as to whether patient has ocular hypertension (OSI/OMP reviews) or can be discharged (return to CO) or has glaucoma (treat or refer to HES)
   • Patient advised, given information etc and further appropriate appointments made if needed

3. OSI/OMP relays data to HES
   • HES reviews data, advises OSI/OMP regarding management and sets up review at HES if needed

4. OSI/OMP manages patient in community setting
   • Regular reviews set in place
   • OSI/OMP relay data to hospital if significant progression for HES review if needed
Delivering the Vision
The East Devon Community
Shared-care pilot project

Daniel Byles, Consultant Ophthalmologist
Jane Hitchcock, Matron – Glaucoma service

West of England Eye Unit
Exeter
• The host unit and setting
• Aim of the project
• Recruitment / sites
• Training
• Capacity / activity
• Quality control
• Challenges
• Advantages and disadvantages
• What we have learnt
The host unit and setting

- Royal Devon and Exeter Hospital
- Pop 380,000
- Rural / urban
- 11,000 glaucoma appointments yearly
Glaucoma care in Exeter

- Glaucoma new-referral clinic
- Glaucoma monitoring clinic
- Glaucoma specialist clinic
- Surgery

General clinics
Glaucoma care in Exeter

- General clinics
- Glaucoma new-referral clinic
- Glaucoma monitoring clinic
- Glaucoma specialist clinic
- Surgery
Glaucoma new-referral clinic

All referrals
Glaucoma practitioners

- Identify patients with glaucoma or at high risk
- ESTABLISH A BASELINE

Normal
OHT / Suspects
Glaucoma
Glaucoma care in Exeter

- Glaucoma new-referral clinic
- Glaucoma monitoring clinic
- Glaucoma specialist clinic
- General clinics
- Surgery
Glaucoma Monitoring clinic

- In-house practitioner-based monitoring clinics
- All patients (glaucoma / suspects)
- 6 monthly review (yearly for OHT / susp)
- Protocol
  - Sympts / VA / IOP / Discs / Fields
  - Minor change? recheck in 2/12
  - Confirmed / major change? back to consultant clinic

DETECT PROGRESSION
Glaucoma care in Exeter

- Glaucoma new-referral clinic
- Glaucoma specialist clinic
- Glaucoma monitoring clinic
- Surgery
- General clinics
Aim of the pilot project

• To establish an optometrist-based shared-care glaucoma monitoring service in East Devon and to assess the need for a mobile service for those not able to access hospitals / practices
Project committee formed

- Matron
- Optometrists
- LOC representative
- Nurse glaucoma specialist
- GP
- Consultant ophthalmologist
- PCT manager
- PCT accountant
- IT representative
- Patient representative
Sites
Sites
Sites
Sites
Sites
The Mobile Service

- Scoping exercise
  - GP practices
- 50 suitable patients in PCT area
- Dedicated van / mobile unit too expensive and not appropriate for these individuals
- Domiciliary service offered by 2 of participating optometrists
  - (Hx, VA, IOP, exam)
Recruitment

- Adverts via LOC / PCT
- Application form including preferred site of work (eg practice/hosp, where)
- Interviews
- Contracts directly with PCT
Recruitment

• Appointed:
  – 4 optometrists to work in community hospital sites
    • 3 Sidmouth
    • 1 Axminster
  – 3 optometrists to work in own practices
    • 2 Exmouth
    • 1 Sidmouth
Training

• Whole group meeting
  – Theory – diagnosis, signs, tests, treatments, monitoring

• Clinic attendance
  – Clinical skills – applanation IOP, 90D ophthalmoscopy, field interpretation

• In-house shared-care clinic attendance
  – Protocol, use of equipment, proformas, evaluation of glaucoma follow-ups

• ‘Competency-based’ assessment
  – Self assessment
  – Practice assessment
Model of care for the shared-care service

- Glaucoma new-referral clinic
- Glaucoma specialist clinic
- Glaucoma monitoring clinic
- Surgery

General clinics
Capacity / Activity

Community shared-care
• First patients January 2005.

• 8 practitioners
• 6 in community hospitals
  – All except 1 do 2 sessions per month
  – 6 patients per session
• 2 Practice optometrists make own arrangements

• Total Capacity 88 appts per month (1056 yearly)
• Currently 70 patients per month seen
Capacity / Activity

In-house shared-care

- 7 practitioners
- 10 patients per session

- 330 per month capacity (3960 yearly)
- (Increasing to possible 476 per month with proposed changes to clinic running)
- Numbers seen:
  - 327 per month (2006)
Quality control

- Open-access telephone advice
- Email responses to queries
- Feedback on all patients referred back
- Yearly clinic attendance for practitioners
- Audit
## 05/06 audit

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<th>Total</th>
<th>In-house</th>
<th>Community</th>
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<tr>
<td>Number seen</td>
<td>2766</td>
<td>2192</td>
<td>574</td>
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<tr>
<td>‘Stable’</td>
<td>2562</td>
<td>2041</td>
<td>521</td>
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<tr>
<td>Referred back</td>
<td>204 (7%)</td>
<td>151 (7%)</td>
<td>53 (9%)</td>
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05/06 audit: agreement with consultant

<table>
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<tr>
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<th>Total</th>
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<th>Community</th>
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</thead>
<tbody>
<tr>
<td>Number audited</td>
<td>190</td>
<td>105</td>
<td>85</td>
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<tr>
<td>Clinical decision agreed</td>
<td>161 (85%)</td>
<td>97 (92%)</td>
<td>64 (75%)</td>
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‘Challenges’

• Training commitment
  – Burden on hospital
  – Funding for hospital + participants
  – Agreeing standard to be met

• Clinical supervision commitment
  – Burden on hospital
  – Funding needs building in

• Working between organisations
  – Who is responsible for each aspect of the service?
  – No agreement to purchase electronic record despite allocated in project bid

• Information flow
  – Paper records / copies / disc photos
  – Electronic record ideal

• Disc imaging
  – How to transfer data between HRT instruments
  – electronic record
Advantages/disadvantages of community shared-care by optometrists

**Advantages**
- Local service
- No delays (although capacity limited at present)
- Improves expertise of small group of optometrists

**Disadvantages**
- Clinical isolation of practitioners
  - No access to second opinion
  - Poor educational supervision
- Training / assessment / communication issues
- Record transfer difficulties
- Less efficient use of expensive equipment (if too many sites)
- Political issues
  - Use of practice sites not favoured by our LOC
  - Balance of care and commerce – ongoing local issues with this
- Cost? No current allowance for secondary care supervision / review time.
What have we learnt?

• Glaucoma shared-care works (with a range of professional groups)
• Any community shared-care service needs to have full integration between 1° and 2° care
  – Up and running in-house shared-care service
  – Same model / standard of care applies to both
  – Same audit clinical governance applies to both
  – Seamless movement of patients between sites
  – Practitioners working in both 1° and 2° sites would help communication / education issues
• Practitioners should see enough patients to develop and maintain skills
• Need electronic record system for clinical governance / quality control, tracking patients / appointments, audit of practitioners
• Schemes need central coordinator (records, maintaining central database, make sure clinics filled, audit, quality control)
• Schemes need designated points of contact in hospital unit
  – ?senior practitioner
  – Recognised time commitment for responding
• Need national / regional shared-care practitioner training courses
• User group involvement and feedback useful
  – Preference for particular sites / satisfaction survey / support group
Thank you

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