The challenges of rural optometry and how independent prescribing has helped

BY IAN ROUGH

Why move from a busy professional independent Aberdeen optometry practice over 200 miles to one of the most remote places in the United Kingdom? I could talk about the professional challenge of supporting a rural community, or the chance to use my prescribing skills to their full potential. But the honest answer was that my wife wanted to go home and bring up our young family on the Isle of Lewis where she was raised. In the end the decision was very easy when the opportunity arose for me to become a partner in a practice in Stornoway.

I became a fully qualified optometrist in 2001, working in community practice in Aberdeen. Eyecare in Scotland is different from the rest of the UK, and in Aberdeen (NHS Grampian) even more so. All patients have NHS funded eye examinations [1] and we can recall and review patients, refining our referrals and supporting our patients. All practices have fundus cameras; we dilate almost all our over 60s and contact tonometry is standard before referral. Optometrists are the first point of contact for any eye care emergency and, from the earliest opportunity, I was prescribing via local GPs following strict protocols and phone contact with ophthalmology [2]. In this environment, it is easy to see why patients liked the community setting; it was typically a quieter environment than a hospital Accident and Emergency Department (AED), there were convenient time allotted appointments and we had evening and weekend clinics.

Lewis is the most northern of the Outer Hebrides or Western Isles. R Doig Optometrists consists of two practices: one full-time in Stornoway, the main town on Lewis, and a second part-time practice in Balivanich on the Isle of Benbecula, south of Lewis. Between our practices we serve a population of 27,400 with three full-time optometrists and one part-time with a support staff of 13. An optometrist on average will do 2000 eye examinations a year, which means we are stretched, trying to service the eye health needs of the Western Isles. There are just two other part-time practices on the Island.

The Stornoway practice is well connected to the mainland by ferries to the Highlands or by air to the cities of Inverness, Aberdeen, Edinburgh and Glasgow. Our second practice in Benbecula involves a four-hour journey by road and ferry, this is softened by the Outer Hebrides' best known features of scenic beaches, Harris Tweed, Stornoway black pudding and Harris Gin!

To support optometry, we have three ophthalmologists who cover six days a month in the Outer Hebrides. This basically means we have two to three weeks a month without cover other than flights or ferry transportation to the mainland for emergencies. Sometimes the weather hinders transportation off and onto the islands so ophthalmology days are delayed or shortened. AED or general practice refer cases they feel are beyond their capabilities directly to optometry, which can sometimes lead to getting called out at various times of night. My patients are also geographically widely spread and I'm not always on the same island as the patients, so some diagnoses must be done via phone. This can particularly be the case when they've limited transport or when the weather conditions prohibit travel. Perhaps surprisingly, the main challenges of rural optometry are very like that of everything within the NHS just now. There's not enough time, not enough staff and not enough funding.

I also have the challenge of seasonal tourists, especially on the large cruise ships. Many of these patients are elderly and need an emergency eye examination before departing again within a few hours. This puts a greater burden on clinics during the summer months.

Essentially there are three things that make life as a rural optometrist so much easier. These are the direct phone contact and email to ophthalmology for advice on pathology related problems and updates on post-surgical reviews. This helps greatly when it comes to formulating treatment and management plans. Secondly, I get copied into every referral and review appointment result; something that my mainland colleagues can only dream about! And finally, my independent prescribing qualification. This enables me to implement treatment straight away, either from my own diagnosis or via discussion with the on-call ophthalmologist. All three have ensured that I'm not referring patients unnecessarily. This is clearly a benefit to both my patients and to the ophthalmology clinics. It also allows cases to be referred out of the hospital system into the community again when it is appropriate.

I became an independent prescribing (IP) optometrist in 2012. Dr June Crown led a review of Prescribing, Supply and Administration of Medicines in 1999 [3,4]. It recommended that certain non-medical groups, including optometrists, be given the legal authority to prescribe. It stressed patient safety should be paramount in extending the roles, but that patients should benefit from faster access to care including the medicines they need, whilst using the skills of a range of healthcare professionals. The legislation to allow optometrists to become IP trained was passed in 2008 [5]. Optometrists have always had exemptions from the restrictions imposed by the Medicines Act, 1968 for the sale and supply of drugs [6]. This includes diagnostic drugs for use in practice and for the treatment of basic eye conditions, but the new legislation

allows a far greater role in treating and managing patients.

I undertook the training part-time over three years. The University course at Glasgow Caledonian University includes distance learning and taught modules. My 24 practical sessions were all undertaken at the Aberdeen Royal Infirmary and I learnt huge amounts from a supportive team in ophthalmology. A final professional written examination confirmed my ability to prescribe, but it was only when I was issued with an NHS prescription pad [7] that I could fully utilise my skills. My ability to prescribe suddenly became useful and I could start diagnosing and treating.

The main conditions I have prescribed for are:

- blepharitis
- dry eyes
- abrasions
- conjunctivitis; bacterial, allergic and viral
- uveitis
- marginal keratitis
- epi-scleritis.

The main conditions I have prescribed for in conjunction with an ophthalmologist are:

- scleritis
- closed angle glaucoma
- post-surgical complications.

Unsurprisingly, my most commonly prescribed medications are for dry eyes, accounting for 80% of my prescribing. I issued 180 NHS prescriptions in 2014 and this has risen slightly to 263 in 2015 and 270 so far this year.

Practising on Lewis, relationships between optometrists, GPs and ophthalmologists must be good, as often ophthalmology are having to trust our assessments. Being an IP optometrist has helped this situation greatly as now instead of requesting a GP or AED colleagues to prescribe something for me, I can do this myself. It means in already time-constrained practice, we can be more efficient.

Two examples of how therapeutic prescribing has helped my patients

1. Acute anterior uveitis

I see one or two cases of uveitis a week between initial onset and follow-up reviews. Being a prescriber allows diagnosis and management in most cases, except when it is a first presentation, where I discuss diagnosis and get ophthalmology approval [8]. If the patient presents too late to get a prescription from the pharmacist or medication is out of stock, I must chase the on-call hospital pharmacist to get the prescription dispensed. Regularly treating uveitis has increased my confidence in diagnosis and management. I have developed an understanding of when I require more expert advice and further interventions. Most importantly, I am always acting in the best interests of my patients, to support their ophthalmic care.

2. Acute glaucoma

Unlike mainland optometrists, I diagnose patients with acute glaucoma and then seek approval from ophthalmology by phone to start treatment.

The alternative would be for these patients to fly by air ambulance or on the next commercial flight with a possible overnight(s) stay and chaperones. This is expensive for the NHS. An IP optometrist allows a very inexpensive and safe alternative, with access to the same medications that the ophthalmologist would prescribe. There is also the advantage that in most cases, I can review frequently to check on progress. My patients can be safely managed until ophthalmology has an available clinic.

Along with the ability to prescribe come the following obligations: I have a more onerous Continuing Professional Development (CPD) requirement, I keep a prescribing log-book to reflect on practice, I work to a local formulary to use the most appropriate medication but also to stay cost-effective, and I conduct personal audits to review my performance, supporting continual improvement. All these extra responsibilities unfortunately do not give any more remuneration. This is an issue that I hope will be addressed when we can prove prescribers are both efficient and cost-effective. Otherwise I fear optical businesses will not want prescribers who will not generate as much profit.

For my ophthalmology colleagues who fly regularly from Raigmore Hospital in Inverness to undertake their clinics, rural ophthalmology has several challenges. Back in Inverness, they are very reliant on those of us based on the island to provide good, clear and helpful information over the phone to support the diagnosis. Telemedicine is key to providing the best possible care for patients. When they do examine patients, there is no option of short-term follow-up unless the decision is made that the case is serious enough to fly them to Inverness and admit them; ophthalmologists must rely on those of us on the island to provide that follow-up and report back.

Especially in the winter, flights are often delayed or cancelled. Not only can there be difficulties getting to Lewis, there can also be problems getting back. This has knock on challenges for clinics back in Inverness. Recruitment continues to be an issue in ophthalmology, and while several posts have remained unfilled, the community optometrists and particularly prescribing optometrists have become another avenue to deal with the increasing number of patients.

Hopefully partnerships between optometry and ophthalmology can continue to develop for the benefit of patients. With more optometrists becoming prescribers, then we can keep more eye conditions out of the hospitals. Progress with these pathways will also help facilitate the safe discharge of patients into the community for monitoring. I suspect to achieve this, optometry will gradually become a two-tier profession with practices that are involved in more advanced care and practices that are not. Ultimately, we need a healthcare system that will provide safe, high quality and affordable eyecare in an appropriate setting to support our patients. On Lewis, we are achieving this by fully utilising the skills of our eyecare professionals both on and off the Island.

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