Optometry Wales

PRESCRIBING, SUPPLY AND ADMINISTRATION OF MEDICINES BY OPTOMETRISTS IN WALES

BACKGROUND[1]

The Review of Prescribing, Supply and Administration of Medicines led by Dr June Crown and published in 1999 recommended that the legal authority to prescribe should be extended to certain non-medical groups. In July 2000 the NHS plan endorsed the Review's recommendations. The key principles of the extension of prescribing responsibilities are:

- patient safety is paramount;
- patients should benefit from faster access to care, including the medicines they need; and
- making better use of the skills of a range of healthcare professionals.

There are now several legal mechanisms by which an optometrist can prescribe, supply or administer medicines to patients:

- Independent Prescribing (IP);
- Supplementary Prescribing (SP);
- Medicines Act Exemptions:
  - additional supply (AS); and
  - entry level; and
- Patient Group Directions.

Independent Prescribing, Supplementary Prescribing and Additional Supply Medicines Act exemptions, all require specialist training and registration with the General Optical Council before an optometrist can practise in these areas. Entry level Medicines Act exemptions can be practised by all registered optometrists. Patient Group Directions permit named authorised registered optometrists to supply or administer drugs as part of treatments provided by or on behalf of NHS bodies.

Independent Prescribing

Independent Prescribers take responsibility for the clinical assessment of the patient, establishing a diagnosis and determining the clinical management required (including prescribing where necessary). Legislation to allow optometrists to train as Independent Prescribers came into force in June 2008.

[1] College of Optometrists website; Accessed January 2011

Supplementary Prescribing

Supplementary Prescribing is defined as 'a voluntary partnership between an Independent Prescriber and a Supplementary Prescriber to implement an agreed patient-specific clinical management plan with the patient's agreement'. The plan sets out how much responsibility should be delegated and refers to a named patient and to the patient's specific condition.

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Medicines Act Exemptions

There are exemptions granted to certain groups of health professionals from the restrictions imposed by the Medicines Act on the sale and supply of particular Prescription Only Medicines (POMs), Pharmacy (P) medicines and General sales list (GSL) medicines.

Entry Level

Exemptions from the general rules laid down in the Medicines Act are permitted for all registered optometrists. These allow optometrists to use various diagnostic drugs (including mydriatics, cycloplegics and local anaesthetics) and to use and supply specific therapeutic POMs, such as chloramphenicol and fusidic acid. Furthermore, legislation that came in to force in April 2005 also allows optometrists to sell GSL or P medicines. A recent survey of the scope of Optometrists' therapeutic practice commissioned by the College of Optometrists[2] indicated that significant numbers of practitioners were regularly managing common non sight-threatening conditions using this exemption route.

Additional Supply

Since June 2005, appropriately qualified optometrists have been able to access a further list of POM exemptions, termed 'Additional Supply'. The rationale behind Additional Supply exemptions is to provide optometrists with access to medicines to allow them to manage a range of common non-sight threatening disorders including:

- infective conjunctivitis;
- allergic conjunctivitis;
- blepharitis;
- dry eye; and
- superficial injury.

These medicines can be sold or supplied by the Optometrist directly to the patient in an emergency, or routinely obtained by the patient from the Pharmacist, against a written order signed by the Optometrist.

Patient Group Directions

A Patient Group Direction (PGD) is a legal mechanism that allows named optometrists to supply and/or administer medicines that are not on the

[2] Needle J J, Petchey R and Lawrenson J G; 2008; A survey of the scope of therapeutic practice by UK optometrists and their attitudes to an extended prescribing role; Ophthalmic and Physiological Optics; 28; 193-203.

exemptions list, to patients that fit a predefined criteria. It is not a form of prescribing. PGDs are used in situations where patients may benefit from having a medicine supplied and/or administered directly to them without their safety being compromised[3].

PGDs should be drawn up and signed by a multi-disciplinary group involving a doctor, a pharmacist and a representative of any professional group and/or clinical governance leads expected to supply medicines under the PGD. A senior person in each profession should be designated with the responsibility to ensure that only fully competent, qualified and trained professionals operate within directions[4].

Comprehensive arrangements for the security, storage and labeling of all medicines in the practice must be made. Ideally medicines should be supplied in pre-packs made up by a pharmacist. In particular there must be a secure system for recording and monitoring medicines use from which it should be possible to reconcile incoming stock and out-goings on a patient by patient basis. Names of the health professionals providing treatment, patient identifiers and medicine provided should all be recorded[4.]

Generally, a PGD should be reviewed every two years along with clinical governance arrangements and an assessment of whether the PGD remains to most effective way of providing the relevant services[4].

PGDs are inflexible in terms of professional judgement in that, when supplying and/or administering a medicine under a PGD, the patient must fall exactly into the criteria determined; otherwise, the patient must be referred Therefore they are not ideal for the wide variety of clinical scenarios that may be encountered in optometric practice.

IP OPTOMETRISTS IN WALES

Independent Prescribing in Optometry is a new concept in Wales with only five known IP optometrists working in Wales. This number is likely to remain small as the training course is only available in England and has to be wholly funded by interested optometrists with no support from the Welsh Assembly Government (WAG) or NHS Wales.

Around 2-4% of GP consultations have been found to be regarding patients with ocular symptoms[5,6]. The four commonest diagnoses are bacterial conjunctivitis[5,6,7] allergic conjunctivitis[5,6,7] meibomian cyst, and blepharitis[5], and these accounted for more than 70% of the consultations[5].

Most GPs have expressed confidence in diagnosing and managing common eye conditions despite more than half of the general practitioners indicating that they did not feel confident with Ophthalmology generally[8]. The most

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[3] Patient Group Directions: A practical Guide and framework of competencies for all professionals using patient group directions; National Prescribing Centre; 2009

[4] Patient Group Directions in the NHS; The Medicines and Healthcare products Regulatory Agency (MHRA).

[5] McDonnell PJ. 1988; How do general practitioners manage eye disease in the community? Br J Ophthalmol.;72 (10) 733-6.

[6] Sheldrick JH, Wilson AD, Vernon SA, Sheldrick CM. 1993, Management of ophthalmic disease in general practice. Br J Gen Pract.;43 (376) 459-62.

[7] Sheldrick JH, Vernon SA and Wilson A; 1992, Study of diagnostic accord between general practitioners and ophthalmologist. BMJ; 304, 1096-1098.

[8] Featherstone PI, James C, Hall MS, Williams A. General practitioners'

commonly confused conditions were infective and allergic conjunctivitis, blepharitis, and dry eyes[7]. General Practitioners false positive referral rate for lid/tear duct/conjunctival conditions, the most common basis for referral by General Practitioners, has been found to be higher than that of Optometrists[9].

Treatment in over-stretched Ophthalmology departments, should be avoided where possible in order to improve the patient experience through shorter journey times to and prompt appointments in community practices, save hospital resources[10] and allow Ophthalmologists to concentrate their efforts on those patients who require surgical and sub specialist level input.

A significant number of patients who attend ophthalmic A&E departments have non-urgent conditions that could be managed satisfactorily in a primary care setting by Optometrists outside the hospital casualty department[11]. Indeed optometrists who have been exposed to further training in dealing with the presentation of more complex ocular conditions have shown a high level of agreement with Ophthalmologist colleagues[12]. Independent Prescribing Optometrists could complement GP practices allowing GPs to treat patients with non-ocular conditions who require the input of a physician.

One Wales[13] aspires to "a world-class health service that is available to everyone, irrespective of whom they are or where they live in Wales, and at the time when they need it." This essentially means that a patient with an eye problem currently falling under the remit of a casualty doctor's care should not have to travel to a distant hospital accident and emergency department and wait for an urgent assessment. It also means that patients with conditions that can be assessed and treated in the community should be seen in the community.

Currently, the Welsh Eyecare Service (WECS) accredited Optometrists manage a range of grade ocular conditions within primary care. Those patients whose management involves medication that is not on the exemption list usually requires a referral to secondary care. Independent Prescribing Optometrists would complement and extend the possibilities of the WECI system, which has been shown to have good equity of access[14]. This would allow patients with a wider range ocular conditions to be assessed, managed and treated appropriately at a more convenient location, while freeing capacity in secondary care and reducing the administrative burden required to arrange appointments.

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confidence in diagnosing and managing eye conditions: a survey in south Devon. Br J Gen Pract. 1992 Jan;42(354):21-4.

[9] Pierscionek TJ, Moore JE, Pierscionek BK. Referrals to ophthalmology: optometric and general practice comparison. Ophthalmic Physiol Opt. 2009 Jan;29(1):32-40.

[10] An outpatient appointment currently costs between £100 and £150.

[11] Hau S, Ioannidis A, Masaoutis P, Verma S. 2008 Patterns of ophthalmological complaints presenting to a dedicated ophthalmic Accident & Emergency department: inappropriate use and patients' perspective. Emerg Med J ;25(11):740-4.

[12] Hau S, Ehrlich D, Binstead K, Verma S. 2007; An evaluation of optometrists' ability to correctly identify and manage patients with ocular disease in the accident and emergency department of an eye hospital. Br J Ophthalmol.;91(4) 437-40

[13] http://new.wales.gov.uk/about/strategy/publications/onewales/?lang=en

[14] Sheen NJ, Fone D, Phillips CJ, Sparrow JM, Pointer JS, Wild JM. 2009 Novel optometrist-led all Wales primary eye-care services: evaluation of a prospective case series. Br J Ophthalmol. 93 (4) 435-8

RECOMMENDATIONS

The Welsh Government should consider working with other disciplines – Pharmacy to issue PGD's where appropriate so that patients can access services in their community without having to seek care from their GP

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