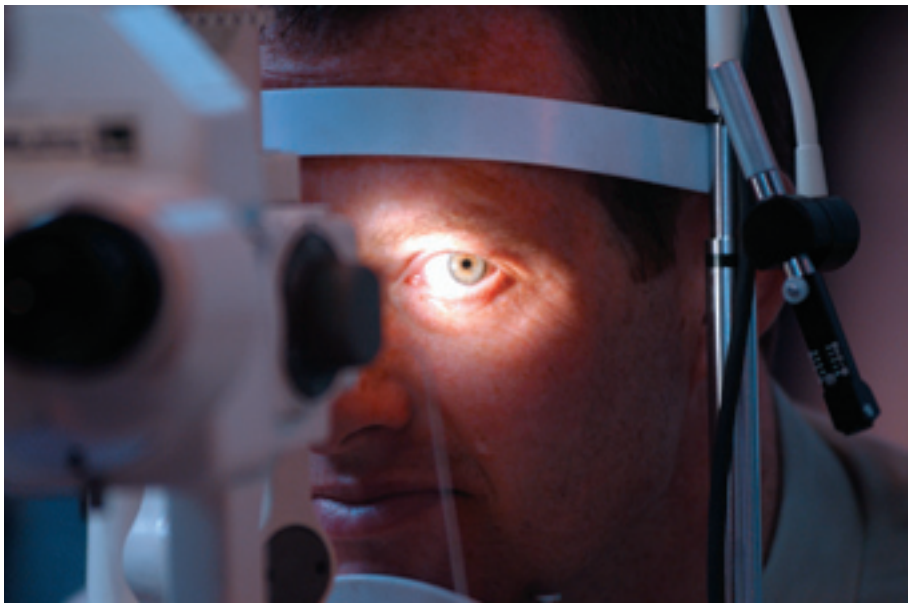
AT THE REQUEST of the Department of Health two proposals were developed within the health community, one led by East Devon PCT in partnership with the optical adviser and local optical committee and the other by the West of England Eye Unit (WEEU) within the Royal Devon and Exeter NHS Foundation Trust in partnership with the three PCTs.

The East Devon PCT proposal included the innovative option of a mobile solution for patients who could not access the hospital eye service (HES) or the community option. The WEEU proposal had a wider scope as it was across all three PCTs that support the HES to move glaucoma follow-up patients from the HES to the community.

When all parties found that there had been duplication, all agreed to support the successful proposal as the PCT executives and clinicians were enthusiastic.



Glaucoma follow-up

The East Devon proposal was successful with the proviso that the funding for the mobile solution was ring-fenced until a detailed 'scoping exercise' had been undertaken to assess the need and value for money for this solution, and an option appraisal paper prepared for review by the Department of Health.

The East Devon PCT bid was given the go-ahead in May 2004 to pilot a glaucoma follow-up scheme within a rural area, with particular emphasis on a mobile option. **Nicky Lavender** describes the issues particular to the East Devon pilot and describes how the project has developed

PROJECT AIMS

The aims of the pilot were to move so-called 'stable' glaucoma follow-up patients from hospital care to the community, under the care of appropriately skilled professionals, which in our case were community optometrists. This would, we hoped, provide the following:

- Introduce a community eye care service of specially glaucoma trained community optometrists distributed at population centres within optometrists' premises throughout the East Devon community, providing a primary care setting with state of the art technology for glaucoma and ocular hypertensive follow-up care
- Introduce a mobile eye care unit, available to patients unable to travel to the WEEU or community optometrists service, due to physical, mental, social, financial or other such hardship
- Establish a centralised glaucoma register, for use by primary, community and secondary glaucoma care providers.

In reality, this meant that we were increasing the capacity in the system, which would ensure patients were reviewed appropriately in a timely manner with easier access to the local community service.

DEMOGRAPHICS OF ACCESS

The geography and demographics of East Devon PCT played a role in deciding the desired proposal model, as the majority of the population are based within seven conurbations of which five are situated on the coast with good road access. The A30 runs through the PCT, but does not link with all coastal towns, so making planning based on providing as equal access for the whole PCT challenging.

To ensure that the locations of the service met local needs, the project GP representative asked all GPs to provide the numbers of patients they had registered at their practice with a diagnosis of glaucoma. This information was then mapped across East Devon and the sites chosen to ensure those areas with a population with highest numbers of glaucoma patients had easy access to a location.

The second consideration was to enhance disability access; once we had made it easier for patients to travel to a location, we did not want them to find they could not enter the premises. This had always been a criteria for service provision, but community optometrists highlighted that many of the local practices were in very old buildings and some with stairs. This started a discussion on where we should site the service, as East Devon has six community hospitals. We agreed that, because it was a pilot site, we should pilot both models. One service would be sited in a community hospital but staffed by a community optometrist, and the other within a practice that could demonstrate a high standard of disability awareness and access.

The final model was four locations but with a choice of sites, giving six locations as follows:

- Exmouth – Two community optometrist practices
- Sidmouth – One community optometrist practice and Sidmouth Hospital
- Axminster – Axminster Hospital
- Ottery St Mary – Ottery St Mary Hospital – due online in Jan/Feb 06.

Another issue was funding. Although the funding for the project was adequate, to provide the 'gold standard' service as laid out in our proposal required a lot of expensive equipment (Humphrey Field Analyser, slit lamp with tonometer, HRT II and digital camera). We quickly came to the conclusion that we needed to rationalise and the compromise reached

was to choose a different community hospital. This was not in the ideal location for access, but it was already partially equipped with ophthalmic equipment because the HES had an out-patient clinic there.

MOBILE SCOPING EXERCISE

The next stage of the project was to undertake the scoping exercise into the need for and the value for money of the mobile lorry. The original proposal had discussed using a vehicle equipped with appropriate equipment that would drive around East Devon to patients who could not access either the HES or the community service.

The scoping exercise was undertaken using the data from the GPs. When we had first asked for the numbers of patients with glaucoma, we also asked how many patients they had registered who were wheelchair or bed bound. To collaborate this information we wrote out to all residential and nursing homes asking for the same information. Both came up with very similar data of around 56 patients within the PCT.

Clinically it was agreed using the lorry for this vulnerable frail client group was not an option. Firstly, they would find accessing a lorry, even if equipped with a hydraulic lift, as difficult or impossible as accessing the HES. Secondly, a lorry of the size that would have been required to ensure sufficient space for all the equipment required, would have found visiting many of the patients in rural locations impossible because of narrow and steep roads. Lastly, although the equipment is technically mobile, many instruments require calibration and the effect of vibration on this delicate equipment was unknown.

It was proposed that we would set up a domiciliary service as it would enable us to meet the limited need within the population of patients who are bed bound, or for whom accessing health care is difficult. It would also release funds that could be reinvested into a sixth location – Ottery St Mary – thereby increasing access to the whole service to ensure a fair, equitable service across the whole of East Devon.

The domiciliary service would be equipped with hand-held equipment in the form of a Tonopen and ophthalmoscope. We initially budgeted for a hand-held slit lamp as well, but two members of the project board were very experienced community optometrists who specialised in domiciliary practice. They pointed out that through experience, if a patient was very infirm and bed bound, they would be unable to use a hand-held slit lamp.

The domiciliary service began in September 2005. To ensure the service was not overwhelmed with referrals, as many patients would prefer a home visit, an algorithm was devised to ensure only appropriate patients were referred to this service. This was thought especially important as the clinical gold standard of glaucoma follow-up care was to be examined with a range of equipment to determine whether the condition was 'stable' or deteriorating. Unfortunately the domiciliary service only uses two pieces of equipment. Owing to the restrictions of the patient's disability and illness, it was thought best to only see patients within this service who would not benefit from the 'gold standard'.

PATIENTS' VIEWS

One of the small risks to the project was that patients would not wish to be seen by non-medical staff. To ensure that patients were adequately informed of this development and offered the choice of location as well as gaining consent to transfer them to the community service, the HES wrote to all identified as meeting the parameters of the 'glaucoma follow-up' protocol, asking them to identify where they would like to be seen. They all chose the community service, giving strong indication that they thought this was a step in the right direction.

Anecdotal feedback from patients via the participating optometrists in both community hospitals and practices was that they were delighted to be seen on time – both for review and at their appointment time, and preferred being seen close to home.

The next stage of the project is to more formally obtain patients' views through questionnaires and coffee mornings. This will enable us to substantiate the anecdotal evidence and use information from patients to further develop our service around their needs.

SUCCESS FACTORS

The enthusiasm of the initial seven community optometrists was a key benefit to the project. Fortunately, all optometrists were prepared to work in all the required locations across East Devon and undertake domiciliary work.

The willingness of the HES to take on the work of both training and supporting the new service has also added to its success. The HES has had the role of offering advice to clinical questions and directing patients back to appropriate HES clinics. As the HES is working without the electronic patient record, the hospital staff have had to identify appropriate patients and photocopy all the relevant notes. Optometrists are not at present linked to the IT network. The HES is also unable to send patients' notes to a community optometric practice as they need to be accessible at all times in case of an emergency.

OPTOMETRIST SUPERVISION

To ensure the clinical aspects of the service were equal to that provided by the HES, we built in regular clinical supervision opportunities, both via email and at the end of project meetings. This has been further formalised in two ways, though both are only in the planning stages.

Initially 50 per cent (reducing to 10 per cent) of all patient notes of those who are not referred back to the HES will be audited for both quality of documentation against the protocol requirements and clinical decision-making. In the first instance, one of the HES ophthalmic registrars will undertake this. It is planned that in due course it will become regular peer review by all participating in the scheme. This review will include all patient records seen within a glaucoma shared-care scheme, including the HES and that set up within Mid Devon PCT.

Secondly, we are planning to run bi-annually a clinical supervision and teaching session within the HES, run by the HES. This will consist of all health-care professionals involved in the shared care glaucoma service across all PCTs, examining and documenting four patient examinations. The ophthalmologist specialising in glaucoma then reviews the findings against the protocol. Feedback will be given both privately on a one-to-one basis, and common themes captured and presented back for open discussion to ensure common learning.

PROJECT FACTS

The project has seven trained optometrists, with four more commencing training, six sites in four locations within East Devon, and we are seeing on average 60 patients per week with the number increasing week on week.

THE FUTURE

The HES has already rolled out the scheme to Mid Devon and Exeter PCT using health professions, and wishes to continue supporting and extending the service within East Devon to increase patient numbers to meet patient need. The HES will examine in the future the possibility of developing glaucoma screening as well as follow-up in the community. It is already looking to develop another Eye Care Services pathway – Low Vision and Rehabilitation Service by working in partnership with community optometrists and social services rehabilitation officers for the visually impaired.

◆ *Nicky Lavender is matron/service manager, Royal Devon and Exeter Hospital*