

PEARS in Bradford

Chris J. Davey, secretary of Bradford LOC and an optometrist, examines the methodology, results and outcomes of a rapid access ophthalmology clinic at Bradford Royal Infirmary

IN BRADFORD and Airedale, the existing enhanced services have proved to be successful in monitoring ocular hypertension, cataract choice referral, and referral refinement.¹

In light of this, the local optical committee (LOC) wanted to investigate the feasibility of running a primary eye care assessment and referral service (PEARS). In order for the service to be feasible, a need has to be recognised, and it has to demonstrate a potential cost saving for the local clinical commissioning group (CCG). There have been a limited number of audits

published on similar services with slightly varying methodologies,^{2,3,4} although all have concluded that the services satisfy their respective specifications and aims.

The remit and protocol of a PEARs are given in detail by the LOC support unit (LOCSU) pathway.⁵ The aim of the service is to investigate and treat appropriate minor eye conditions in primary care (optometric practice) instead of the limited investigation available to GPs or referral to secondary care (ophthalmology departments).

These patients can self-refer to the

service or may be referred by their GP or a different optometrist. With this in mind, a PEARs would be expected to reduce the number of patients being seen and managed for acute eye problems by both GPs and by the hospital eye service. The introduction of the independent prescriber (IP) diploma for optometrists allows prescribing rights to prescription only medicines for therapeutic use. As a result, a service using IP optometrists could independently manage a greater

proportion of eye conditions within primary care.

The aims of this audit were to evaluate what mix of pathologies are routinely seen by the rapid access clinic (previously known as eye casualty) at the ophthalmology department of Bradford Royal Infirmary, and to ascertain what proportion of these patients could have been seen and managed in primary care by: a PEARs according to the LOCSU protocol; and an IP optometrist in primary care.

The methodology

A retrospective audit was performed on the clinical records of all patients who attended the rapid access clinic over nine sessions (4.5 days) between August 13–19, 2013. The following information was recorded – the pathology diagnosed by the ophthalmologist including whether the patient was new, what treatment or further investigation was required, and whether the patient was discharged.

Data collection was performed by the author. On the basis of the pathology, investigation and treatment, the patient episodes were categorised as being appropriate for a PEARs, an IP optometrist within primary care, or a secondary care ophthalmology department. All other data were simply descriptive, therefore no analysis was required.

The results

A total of 103 patients were seen over the nine sessions, of which 55% (n=57) were new and 45% (n=46) were attending for review appointments. In total, 44% (n=45) were discharged at that appointment, while 56% (n=58) needed another appointment. A very wide variety of pathologies was seen (see Table 1) and the severity varied greatly within each pathology classification.

Pathology	n	%*
Blepharitis/dry eye/epitheliopathy	15	15%
Microbial keratitis	13	13%
Conjunctivitis	9	9%
Uveitis	9	9%
Abrasion/insult/foreign body	9	9%
Vitreoretinal	7	7%
Post-operative complications	6	6%
Posterior vitreous detachment	6	6%
Abrasion/trauma/foreign body	5	5%
Disc abnormality (non-glaucoma)	4	4%
Wet age-related macular degeneration (AMD)	3	3%
Lid lesion	3	3%
Episcleritis	3	3%
Cataract	2	2%
Binocular vision	2	2%
Other	7	7%

Table 1 Pathologies seen by the rapid access clinic at Bradford Royal Infirmary (* % rounded up to the nearest decimal place)

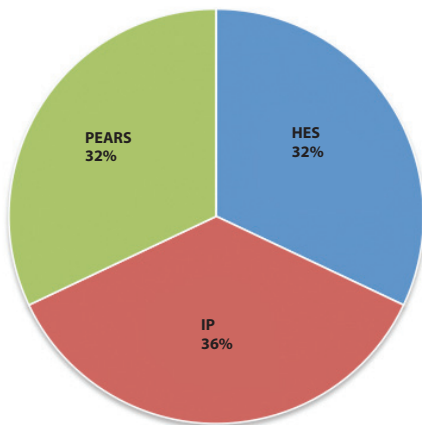


Figure 1 The proportion of patients who could have been seen and managed by a primary care PEARS, IP or could only have been managed in secondary care (HES) (n=103)

However, 68% (n=70) were deemed to have been manageable within primary care, 32% (n=33) by a PEARS and 36% (n=37) would need an IP (see Figure 1). Of the patients seen, 39 (n=40) required prescription-only drugs, 17% (n=18) required over the counter drugs, 19% (n=20) required advice only and the remaining 24% (n=25) required hospital specific investigation or surgery (see Figure 2).

Outcomes and learning

A PEARS would be able to manage about one third of the patients seen by this rapid access clinic. However, an IP would be able to manage an additional third. Although there are complex cost and capacity implications – as each new hospital appointment costs the CCG £115 and each follow up £67 – it may be possible for commissioners to make savings by keeping certain acute eye problems within primary care.⁶ This would also result in care being closer to home for the majority of patients and previous research has found they may find this less stressful.⁷

It is possible that some patients suitable for a PEARS appointment are already being seen in practice due to inappropriate usage of GOS funds. For example, a recent survey in the same area found that if a GOS eligible patient attended the practice complaining of flashes and floaters then 87% of optometrists would examine the patient and fund it by completing a GOS form

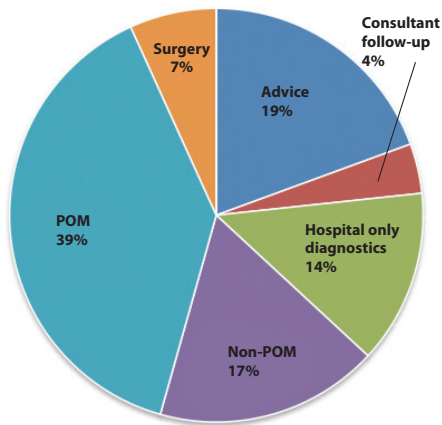


Figure 2 The outcomes of the rapid access clinic appointments. Prescription only medicine (n=103)

with a code.⁸ Other patients suitable for a PEARS appointment may currently be managed by GPs in their normal scope of practice. There is published literature on the eye problems referred to secondary care by GPs,^{9,10} but an audit of the eye pathology seen and managed by GPs without referral is required, in tandem with the present audit, to give a more complete picture of the need for a PEARS.

This audit is limited by a relatively small sample size and the fact that the classification of whether patients were manageable in primary care was done by only one person. Although this classification decision was based on published protocols where possible, ideally it should be repeated using a panel, including a consultant ophthalmologist.

In conclusion, this audit supports the introduction of a PEARS in Bradford and Airedale, and dependent on pricing, it could result in a saving for the CCG. Many more patients could be managed in primary care by an IP, therefore the effectiveness of the service could be improved if IP funding is made available, or alternatively a relationship with the GP is established whereby prescriptions are written at the request of PEARS providers. As with any enhanced service, it will be important for robust audits to be inbuilt to assess appropriate usage and on-going cost efficiency.

References can be found online at www.optometry.co.uk/clinical



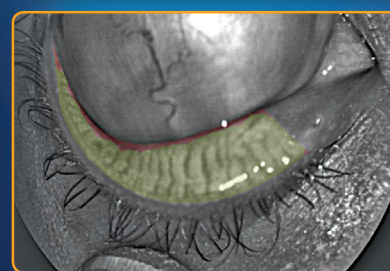
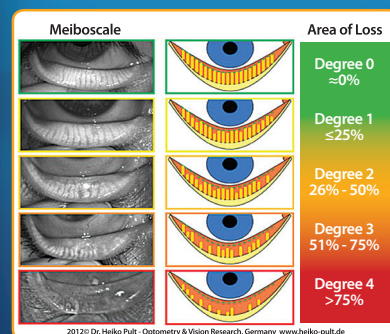
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