

SCI Gateway referral form updates community optometry information session- Transcript

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HC

Helen Court (NHS GOLDEN JUBILEE) 0:07

Well, good evening everyone and welcome to tonight's information evening, SCI Gateway referral form update evening. My name is Helen Court and I work alongside Janet Pooley within the Eye Care work stream as part of CFSD, that's the Centre for Sustainable Delivery.

This evening we have a jam packed agenda in the next hour. We're going to start off with giving you some context around the updates to the SCI referral forms. Also provide some background about the process, alongside timelines of when things will occur. But quite importantly, we've got a number of speakers this evening to give you some idea about the different perspectives from the hospital side and from community Optometry about the new forms, and all these people have been involved in the process of updating the forms. And then at the end we are going to have a time for question and answer and we welcome questions and hopefully we'll have a great discussion at the end.

Before we sort of launch into this evening, a little bit of housekeeping. So you may be aware as you're sitting there or standing there that your mics are off. We've had to do that this evening just due to the sheer number of people to try and help reduce any technical difficulties.

However, as I've said, we really do welcome questions. So if you turn your attention to the chat box, you'll notice that that's the space you can put in questions. If you do that during the evening, what I'll ensure is that towards the end, when we've got that last little bit of time, I'll field as many of those questions as possible to the panel. Also, you are very welcome to switch on your camera this evening if you feel comfortable. It's always nice to see people's faces. And also, we really welcome the use of reactions on the toolbar. Again, it just helps create a bit of a sense that there are people out there and that we're actually connecting with one another.

The session this evening is being recorded. That will allow anybody to go back and re-watch what we've said tonight, but also particularly gives access to anyone who's unable to attend this evening, and the recording will be available in the next week or so.

Finally, if you do have any technical issues this evening, could I encourage you, the first thing to do would be to leave the webinar. So if you just press the little red telephone icon and then re-join. If you're still having problems, do feel free to put a little comment in the chat. I'll try and sort it out. But again, if it's not possible, then as I say, we are recording the session tonight and you'll be able to watch it at a later date.

So, without further ado, I'd love to introduce Doctor Janet Pooley, who I'm sure is familiar to most of us. Janet works as Chief Optometrist Advisor for the Scottish Government and is going to provide a bit of the current context in Scotland around eye care services at the moment and how that relates to the update of the SCI Gateway referrals. So, I'll pass over to you, Janet, if that's okay.

 **Janet Pooley** 3:15

Great, thanks ever so much, Helen. That's really kind. It's super to see so many of you on the call. It's very impressive, actually, for a Thursday night. We were discussing this earlier, and honestly, my comment was you lot should all get out more and do more things. But seriously, I'm delighted that you're here, really delighted. It's great to have so many of you on.

So as lots of you will be aware, we are having huge challenges in our hospital eye services with waiting lists. This is not just ophthalmology, all our specialties are really challenged with waiting and the demand for services within the NHS. And the big government targets now are around reducing as many waits as possible so that patients are not waiting for the treatment that they require. So from an Optometry input, clearly ophthalmology is a service which has a huge number of outpatients, huge demand for our services, and a lot of patients waiting for surgery. And largely the big waits that we record are cataract surgery, and we've got a huge number of patients still waiting, and that backlog goes right back to the pandemic and the time when we had stopped services and were not providing cataract services. So lots of

demand and struggling very much, we are struggling to meet that demand. So from an Optometry point of view, what can we do to help? Well, clearly, we are the professionals who largely refer into ophthalmology. So it's so vitally important that we get our referrals right. And the one thing that I hear when I go around the country to different ophthalmology departments is how impressive the referrals are. So pat yourselves on the back because it is it's a really positive story.

And the number of patients we're referring has reduced because we're managing more patients in the community. So we're looking after them with the acute eye conditions that we're managing. Those of you who are independent prescribers are providing huge amounts of help. Those of you who are just providing help Optometrists, all optometrist first port of call is providing extremely convenient care to your patients and largely that's providing a lot of support in the community and so patients do not need to be referred. But it's very important that where we do need to refer patients, then the information that we provide on those referral forms is as comprehensive and helpful to the ophthalmology who are making the decisions about which patients need to be seen and when. So the huge amounts of work that's been going in over the last few months, actually probably longer than that, Helen, I think, isn't it? A long time that we've been working on developing the template. So these are the templates that we refer in and lots of work has been going on to update them all. So over the next few months across the country, you'll see these changes in these new templates. And I'm really grateful to all of the professionals who put a lot of time into upgrading these referral forms. The information you'll be providing be incredibly helpful when they arrive in the hospital. But it'll be the information that you've already collected and that you are already discussing with your patients. So it shouldn't be anything new that you're not discussing with your patient, but it may be new to add it on to the referral form. So that will be something that will be very different. I suppose the big two changes are around the cataract referral form and the glaucoma referral form. So those are the two that you'll notice the biggest changes, but there are some really important changes on the others as well. So it's all incredibly positive. And one thing I would say about the cataract referral form, if you can please use the aide memoir, you can find that on the eyes.nhs.scot website and that will help you when you're claiming your 3.9 code and do take advantage of that supplementary code. That's just to make sure that your patient is absolutely sure they want to be referred, that they know what they're going to, they're being referred for, they understand what's going to be involved. You may

also discuss with them the opportunity to have immediate sequential bilateral cataract surgery, which is often being provided now in our boards. So preparing your patients as best you can for that referral is so incredibly important. So I would really urge you to claim the 3.9, take advantage of that extra payment for take spending the time with your patient to make sure they absolutely do want to be referred. And I suppose the other thing to really emphasise is the glaucoma referral form. So that's now taking into account all the things that we are required to measure as part of the SIGN 144 guidance. And obviously we're all working towards that as part of the general Ophthalmic Services regulation. So that's obviously been in place for a while, but the form now reflects the requirements of that guidance. So thank you very much indeed for joining. As I say, I'm really interested to hear what our speakers have to say. Helen has worked incredibly hard to get everybody together, and I'm grateful for everybody to give up time to come and speak to you. So it's going to be an action-packed evening, I understand. So without further ado, Helen.

HC Helen Court (NHS GOLDEN JUBILEE) 8:27

Thanks, Janet. That's great. Thank you so much. So we will move on. I'm going to slightly build now on what Janet said and provide some more context around exactly the process that we've gone through to update these referral forms and also importantly, give you some sense of timelines about when changes will occur.

HC Helen Court (NHS GOLDEN JUBILEE) 8:46

From the diagram that you can hopefully see on your screen there, you'll see that e-referrals were launched nationally well over a decade ago now. And when they were launched across the boards, the majority of the boards were using the SCI Gateway system at that point, and five referral templates or referral forms, the same exact same ones were given to all the different boards.

They were cataract, glaucoma, wet AMD, paediatric and general. Now, as of today, if you, depends what board you're in, if you go into your SCI to make a referral, you might find you've got more than that. So certainly you would if you're working in NHS Greater Glasgow and Clyde. But in those additional referral templates, when you click in to make that referral, you'll find that actually what sits behind that referral is the general referral template. So everything's based on these original five. But as well

as you can see in the diagram, there have been some real key milestones in the last decade or so within community Optometry. As Janet said, a lot more pathology is being managed by community optometrist. And we've also had the introduction of different guidelines, such as the SIGN 144 guideline, as well as just new ways of working. So it really became evident over the last couple of years that it would really be a good time to take stock, to review the referral forms that we're all using at the moment and identify where there could be opportunity to update them so that they actually work more effectively for everybody in the pathway.

This is a quick attempt to sort of give you a sense of what happened. So as Janet suggested, this has actually been worked on now for over just over 2 years and it really is testament to an awful lot of hard work by a lot of people. So it has been a multidisciplinary effort and it's been very collaborative and involved people and representation from all of the health boards. And that's not just community Optometry, but also from the hospital eye service. And that includes many ophthalmologists, orthoptists, optometrists in the hospital, nurses and other hospital colleagues, in addition to important representation from Optometry Scotland. And what's been done is every single referral form that is used in all the different boards, and there have been changes made over time in different boards, they've all been reviewed and analysed in depth. And the final referral forms now that we're about to launch in the next few months are a real balance now of data in them that is clinically appropriate data. So they've been designed to all be clinically appropriate. No data on there or field that you fill out is a wasted field. But very much along the whole process, we've been very, very keen to ensure that there is ease of completion. And so we've tried many things. We've knocked on the door of SCI Gateway to try and do as many things as possible within SCI Gateway to enable the filling out of the forms to be quicker and easier. Some things we've been told are just not possible, but we've tried. So you will see there are some new functions that hopefully will just speed things up a little bit. And so having these new forms, really, there's two things that's worth knowing. First of all, they now do align with new ways of working and the new services that we that are now running. And also they do, as Janet's already alluded to, align with current guidelines such as the SIGN 144 glaucoma guideline. We have standardised the quality and consistency of referrals across all of the boards. This is going to help reduce unwarranted variation, and in particular, avoidable referrals. And so communication will be better. Vetting can be

more efficient. And what that will start to do is minimise delays in referral pathways for patients.

So what's the timeline? Well, all of the boards, almost all of the boards have already committed now to ensuring that these updated referrals will be in place on your SCI Gateway before, well, by the end of the calendar year. There's also, keep a lookout because you'll be receiving a PCA from Primary Care Scottish Government probably the end of next week that will provide you some more information as well. It's worth saying though that the implementation in your particular board, it was difficult to say because obviously we know it will be before the end of December, but it's going to not occur simultaneously in every single board. So please do make sure that you refer to updates from your local primary care team for information of when the new forms will be available in your area.

Also, really to provide you with some resource and support, as of today, a new page has been launched on eyes.nhs.scot. So, if you now go into the general Ophthalmic Services part of eyes.nhs.scot, there is now a section called 'Referrals to the Hospital Eye Service', and if you go into there, this is the screen that you'll see. There is information about every single one of those referrals, including videos for you, which show you exactly what the new form looks like, how to fill it out, and any additional features, and hopefully will just be really useful. There's also within the cataract section, the aide memoir that Janet's been talking about, and also information for you about intermediate, not intermediate, immediate sequential bilateral cataract surgery, which now does appear on the referral form. So hopefully really, really useful information there and it's probably worth giving that a look before the forms are launched in your particular board.

So, without further ado, I'm going to pass over to Stuart McConnachie. So, Stuart McConnachie is Optometrist Advisor, NHS TAYSIDE, has been very involved and very committed over the last two years, and I'm very grateful to him for the work that he's put in in helping to shape these different updated referrals. And Stuart's going to give you the optometrist perspective in his mind about these updated referrals. So if I pass over to you, Stuart, if I may.



Stuart McConnachie 15:19

Of course. Thanks, Helen. It's been an amazing couple of years to try and get all this together. And for me, there's been two takeaways over that two years. Like, it's just how long it takes to get things done within the NHS system. But also, you know, this didn't happen on a whim. It's been really well led by Helen. It's been well resourced and well, like represented as in, there's been lots of professions represented, lots of people with a kind of stake in this have been there.

To remind myself of what happened, I actually watched back one of the recordings of the early meetings, and for all the meetings, for all the forms, it took something like 18 meetings. It turns out your calendar can tell you these things. And you know that way when you hear your own voice, it's a bit weird. Well, I listened back to it at 1 1/2 times speed, and that did not make it better!

But, I mean, there's just loads of people there. Helen's touched on that already. And I think we're all aware, you know, like we do have some frustrations with the SCI forms. The thing that always really frustrating me was the Paed form and the cyclo refraction part of it. And just it was just so ambiguous, I don't think anybody at either end of that form really understood exactly what was being filled in or what was being received at the hospital. So hopefully we've made these things better. And what we did, we looked around the country and we looked at what was being used and we looked at what other platforms were doing well as well, so not just what was happening in SCI.

And I think it's worth saying that it wasn't just a bunch of talking heads in a room. Like there was in between the meetings, there was questionnaires and emails and consensus was formed without this kind of pressure to conform. I'm sure there's like proper names for the kind of this technique that Helen's using to try and form the consensus, but she will keep us right on that. But it really was a great environment. We were able to thrash things out. It didn't let like that one domineering voice lead everybody down one particular path, you know, everybody got the chance to see their piece. And there's also was this awareness that when you've got loads of people with opinions of what should be included in the form as a risk that you just keep adding and adding things and you end up with someone that's a monster that's 13

pages long. So I think the thing with cataract surgery in particular is that most people are relatively straightforward candidates and part of the aim of the referral is to let the hospital pick out the ones that aren't necessarily straightforward, the outliers. And I heard a line in the meeting, somebody said that, you know, if you're trying to find the needle in the haystack, you don't want to increase the amount of hay. So we were really conscious to, yes, we want certain data, but let's keep that as controlled as possible and minimize it.

And then the other thing that I think should be really good is the fact they're going to keep them all the same across the country. Like it must be so frustrating to move from one board to another or even be in one board, like I referred to two boards and the forms are different. And that just slows you down if you're familiar with the forms, it's much easier to get on and get things done quickly and accurately, I would suggest as well and I'm sure they receive an end. That's awkward if you change boards and doctors do move as well, don't they? So yes, we had this, I would say, really extreme focus on making it as easy to use as possible, but while still gathering what's useful for the hospital. And we were aware when it came to cataracts that it needs to support like traditional two-stop surgery, one stop, high volume pathways and this immediate sequential bilateral cataract surgery. And even if some boards don't have some of these things in place, you know, they may well come. So we had to feel we had to get all that in place. And to be honest, the difference between our two stop form and one that includes these other pathways it doesn't add that many data fields. It's only really a handful. So some of you might feel that you're putting in a bit more information, but I think others might find it's less. And we're actually, I actually think that even if there's a bit more information, we were really pushing for less clicks, less keystrokes. So with a bit of luck, you'll find that even though the form looks a bit longer, it's actually easier and quicker to fill in in a long clinic. Like I can't be the only one who gets that kind of heart sink moment just now, sometimes when I know I have to do a referral because of how clunky SCI is. And I think Helen touched on this as well, like there's definitely limits to what the SCI platform can do. I'd like to think if you think we've missed something, it's probably because it's not possible in SCI. Like I've had a couple of kind of soapboxes throughout this. One of them I've stood on quite a lot is this, is the CHI lookup. I get so annoyed typing in patients details and not finding them. And it turns out it's because 'Jack Smith' is actually known under CHI as 'John', or I've got his date of birth wrong by one year or

his postcode or something like, so we've been copy and paste the CHI in and do a look up. I feel that's a bit of a game changer for me, and that should be on the new form.

The thing that we weren't able to fix is the multiple attachments, which isn't such an issue for cataract, but thinking glaucoma forms that can be an issue, but that's just, SCI just can't do it. So sorry that we weren't able to fix that. And other things we've done, you know, is maybe pre-filled default values and use tick boxes that say like 'set all to yes', 'set all to no' and really thought about the order of the layout so that it flows. And we've tried to minimise the mandatory data, although there is of course some mandatory data, and also tried to use like any kind of clever functionality that SCI does have. So in the cataract one, for example, they're all preset to routine when you first create it. But if you want to change that to urgent, then it's only at that point that the priority reason box becomes mandatory. And I think that's reasonable if you want to put something in as urgent to have to explain why you want that as urgent. And then things like the 'set all to no' or 'set all to yes', like there may be 5 five boxes. A lot of the time they are all 'no' or 'yes', and maybe you want to change one of them. Again, that should just make things a bit quicker.

And maybe we're saying as well that there's some things that were mandated that were just out with our control, like patient demographics. I could do without that. To be honest, I'm not sure it's filled in. Like the ethnicity box, I'm not sure it's filled in accurately. I certainly don't ask my patients that. So then I come to fill in the form and I'm either guessing or I put not knowing. I don't think either of those responses is very satisfactory, but it's where we are.

And we've also tried to, like, really just to trust to do this right. So, like, at the moment, we're really constricted on the how you put prescriptions in. You have to do plus or minus, and then another box, the sphere, plus or minus another box, you know, just all as a faff. So now we've got a free text box for putting prescriptions in. I'm sure that we are capable of writing a prescription. And we also have a free text box for putting in the VA. And again, you know, it's something I always find annoying. You know, my test chart doesn't fit nicely. 6/15 would be the classic line – you then you have to write that additionally. It's all just extra work, isn't it? So now you can just put it in free text, make it easy, and you can even, if you want, be a bit

fancy, and you can write in LogMar or EDTRS if you want. I'll probably stick to VA for now. I've not quite got the rest of that in my head. So I'm really optimistic this is a change for the better.

Like any change, I'm sure there'll be a adjustment period, but I think six months down the line we'll all be glad for this.

HC Helen Court (NHS GOLDEN JUBILEE) 23:18

Thanks, Stuart. That's really helpful and good to just delve into a few of those changes. Well, let me now pass on, if I may, to our next speaker, and that is Janis. So Janis is going to give us a perspective from the hospital and hospital vetting. Janis is a highly skilled hospital optometrist, advanced clinical practitioner, and does a lot a lot of vetting within the hospital in NHS Lanarkshire and also with a specialism in glaucoma. So Janis was very involved, especially in the general referral form. So I'm going to pass over to Janice and just thank her in advance for speaking this evening as well.

JO Janis Orr (NHS Lanarkshire) 24:01

Thank you very much, Helen. I'm going to try and share my screen now.

Has that worked? Can you see my screen?

Yep, perfect.

Okay.

There we are. Okay, so I'm going to try and give some insight as to what vettings like from the hospital eye service side of things.

JO Janis Orr (NHS Lanarkshire) 24:30

The SCI Gateway updates were done, as has been described already, collaboratively between consultant ophthalmologists and community and hospital optometrists. I had no involvement at all in the glaucoma one, so I'm impartial, but I fully agree with the changes.

I wasn't on the panel, as I said, but I really fully agree with the changes that have been made. They're designed purely to make things easier for the patients to avoid any delays and then being seen in the hospital.

And despite appearances, they've not been designed to make life more difficult. I think the glaucoma one is definitely going to be lengthier to fill out, but I hope I'll be able to convince you as to why we've done that.

Like you, in the hospital we are really under pressure. We have such a limited amount of time and resource with insufficient capacity, ever growing waiting lists and less and less time to actually do vetting. This number seems low, but I promise Helen the number of new glaucoma referrals in the last seven days, that was 28 and general referrals, that's not including cataract.

AMD was 188. Now, this is nobody's job to do this. Nobody's employed to do referral vetting. This is all done around clinical activity. A few of us have dedicated vetting sessions, but not many. And this is all done by the consultant, specialty doctors and advanced practitioners; such as optoms, orthoptists and nurses, but fewer and fewer of us have vetting sessions purely because of pressure in the service. We use Trak Care, so your SCI Gateway referrals land on our TrakCare system and we view the referrals individually and we can direct a referral, certainly in Lanarkshire, only in one direction, which means one pathway. So you can't have multiple reasons for referral on one referral form because we can only send it one way. Now I believe from being on the general referral group myself, that's not an across the board issue, but it's certainly an issue in Lanarkshire and some other trusts. It's not a SCI Gateway thing, it can be fixed, it's a TrakCare thing, but certainly in Lanarkshire that's our issue. We can only direct each one one-way.

Now, there is a really good video on the eyes.nhs.scot website going into the glaucoma form in detail, but I'm going to skim over why the changes are really good.

So the priority is automatically set to routine, but if you change it to urgent, you have to say why. The reason for referral, which is great, is in free text, so you can highlight straight away what you think the problem is.

And the risk factors are all individual drop downs. Now to make life easier, you can 'set all to no' and change the ones that apply to yes, but you need to answer to every single one of these, which means you need to have asked. So it encourages you to do a better referral and more helpful for us. Medical history, again, these are all things that you need to give a positive or a negative answer to. You can hit

'set to no' and change the ones that apply to 'yes'. And for glaucoma specific information, you need to give Van Herricks and that's a drop down for the grading. Gonioscopy and AC description is not mandatory but useful if you can do it, but if not, a comment on the ACs always quite useful and free text that is. And optic disc features is absolutely mandatory. Describing the optic disc is free text, but as much information as possible is always valued. And disc images are mandatory as well. And if you haven't attached them, you have to say why you haven't.

Other signs, these are all drop downs as well, so you need to check for these and you can 'set all to no' and change the ones that apply to yes, but you need to have checked. Tonometry values, applanation tonometry, ideally that is mandatory, but repeat measurements are not. These are always quite useful and kind of borderline referrals, but certainly the tonometry must be there and there's a box for additional intraocular fresher information. So if you didn't use applanation tonometry, for example, or any other information you want to apply, that would be there. Corneal pachymetry is mandatory and the method you used, delighted that that's there because it's very, very useful. But please do not correct your IOP values for CCT. We want the measured tonometry and we consider the CCT certainly is valuable, but it's an independent risk factor. We want to know what that is, but please don't correct your IOP for that. Visual status is visual fields and I'm so pleased to see this. As somebody that vets the bulk of the glaucoma referrals in Lanarkshire, all too often we used to get, "sorry, SCI Gateway would not let me attach the file", but there would be no comment on the visual fields. You didn't know if it was full or fully constructed. There was no comment whatsoever. So you can't do that now. You have to select in a drop down, normal, abnormal, suspect or not possible and why your fields should be attached and if not, you have to see why not. And as Stuart said before, refractions freehand, which is really good and VA is mandatory, but again, it's, you know, you can take that rather than be set with the boxes.

So what I'm showing you here now is what we see on Trak. So this is a typical Trak page, except we have lots and lots and lots and lots and lots of them. So the patient data there has been redacted, but each one represents a patient referral. And my preference is I had ophthalmology and ophthalmology glaucoma that I can set to any of them coming up and the list gets bigger. I concentrate on these ones when I am vetting and I've actually selected just a couple of referrals from any normal sort of

vetting session to highlight what a good referral looks like and what a not so good one looks like. And hopefully that will justify why we've introduced some of these changes in order to allow better referral and vetting.

So this is the not so good referral. The information is redacted that would identify the patient or the optom. I think more relevantly, we'll skip to the next page and show you what's not there. So we have no values for IOP. We have no values for CCT. We have got no clear comment on the disc. All we have is a refraction and anterior assessment normal. Nuclear cataract, fundus assessment unremarkable. So it's a cardinal sin not to have pressure. IOP and a glaucoma referral and CCT being missing as an issue. But going back to the actual body of the referral, it's all in this.

A strange symptoms box. Patient presented for a routine exam. During the exam, a visual field defect was identified. Great. What was it? Was it in one eye? Was it in both? The visual field was repeated a few days later and the defect remained present. Again, what was it? No more information.

Her intraocular pressures were within normal limits in both eyes. Was that 11? Was that 21? Where was that pressure? What was it in each eye? And the optic nerve appears paler than previous scans. That might not even be glaucoma. No comment on the disc at all. She has a family history of glaucoma with her brother being diagnosed in his 50s and she is concerned about normal tension glaucoma. No comment on, or they didn't say which gender actually, but basically no comment on the NDG risk factors, no comment on CCT, just no information at all and no differentiation between the eyes. So again, there's just not any information for us to make a really good decision. What we don't have is time to go chasing for that information. We don't have time with the volume of referrals we have to deal with. So we either delay that referral being vetted by sending someone to get that information or we just make a decision with what we've got but that could be a much more urgent glaucoma. There's information that we need that we don't have.

This is a far better, glaucoma referral is not perfect, but this is a better one. And we have attachments for OCT, we have disc images, we don't have vital fields, but it's definitely far more forgivable in this case and you'll see in the next stage why. So very clearly, they state suspect left normal tension glaucoma, change in disc appearance and inferior notch with corresponding repeatable superior visual field defect with 24-2. They then describe the right eye being full, left eye having the

defect and then some comment on the disc which is repeated again below, and the comment and the retinal nerve fibre layer thinning. So that gives us far more information on the two eyes. And then we have the other information that we need. We've got a DDLS score, we have IOP, the applanation tonometry and we have CCT. So that then gives us a far better idea and this is why we need to have this information available to us. And as I said, we just don't have time to chase referral, chase that information to make an appropriate referral and it can just lead to unnecessary delay to patients.

So as a rule of thumb, please do provide as much information in the referral as possible. Fill in all the mandatory fields and if not, explain why not and try and make some sort of comment because it's just to help us make a decision on the patient. It's not to make life more difficult from community optometry. And this as a Lanarkshire, maybe not all boards thing, but please do not put a multiple issue referral together. A classic is having cataract in one eye and PCO on the other. We will vet for the more pressing issue, which is the cataract, and nothing will be done about the PCO till the patient gets the cataract clinic months or longer later, and then they would join the capsulotomy list. If we had another referral, they'd be like vetted straight to capsulotomy clinic there and then and then they hopefully have had that by then. So it's just an example of unnecessary delay that can be avoided. And we're all out for the same thing. We want our patients to be seen sooner and at appropriate timing and we have to make efficient decisions if, when and why patients are seen. So Good referrals make all the difference from our end. Thanks very much.

HC Helen Court (NHS GOLDEN JUBILEE) 36:38

Thanks so much, Janis. That was fantastic and incredibly helpful. So without much pause, I'm going to pass straight on now to Douglas Orr. So Douglas is Optometric Advisor in Ayrshire and Arran and again has been incredibly involved through the last two years in all of the different groups for all the different referrals. But specifically, Douglas is just going to share a bit from his perspective around the wet AMD form and the general form. So I'll pass over to you, Douglas, if I may.

DO Douglas Orr (ORR AND SIMPSON EYE CARE LTD) 37:11

Thanks Helen. Hopefully everyone can see that screen. So, we're going to cover both the AMD and the general templates and I will also give a wee brief view of one of the

cataract pages. And all I have there on the right hand side is the entire clinical content of the Wet AMD template. So we would generally really stress the fact that we would be asking this is only for exudative and suspect exudative AMD. No matter how urgent any other macular pathology is, it should be going through on the general template. Because of that, when we choose this template, then you will find it has automatically defaulted to urgent and we do not need to justify why that is an urgent referral. We've got the opportunity after we've commented on the symptoms, the duration of loss and the clinical findings to then move on and for the first time in a lot of these way and the templates comment on other factors that both might be relevant to the vetting but also might be relevant to the first person seeing that patient in clinic around that person's suitability to have IVT. The other thing that we will ask is that you attach all relevant imaging. Now that is simply a yes/no drop down, but we would actually explain if there was no imaging available, why that was, because they make a massive difference to the vetting and to the process once it's received in the hospital.

Now, we've talked a lot about how we tried to make visual acuity easy to fill in. This is the one template where visual acuity is a dropdown. There are far more options than the previous dropdowns, but there's a good reason for that. We want to have nice, structured, consistent data at the point of referral so that a judgment can be made further down the line as to what visual loss that patient might have experienced both while waiting for treatment and while undergoing treatment. And as we move towards using Open Eyes nationally for secondary care services, this allows us to analyse that data much more effectively. So while on all the other templates, it's free text and the Wet AMD template, visual acuity is a drop down.

If we move on to the general template, we find again that the date of referral is pre-filled. The priority will default to routine. And as Stuart mentioned earlier, if we then choose that to be urgent, the urgent priority reason box becomes mandatory. We then also have a box for the patient symptomatic and that's often a request from our vitreal retinal colleagues, particularly around vitreal macular traction and also diagnosis and now a box for current treatment. So if you have commenced somebody on some treatment or they're already on existing treatment, particularly in the context of IP and GOS specialist supplementary, we have the option now to detail out to the host what we have started in community separately from the main

history. I think we'll probably find that quite useful as time goes on. Again, there's lots of consistency in terms of IOP across the different templates. And again, we're asking you to very quickly identify whether we've attached visual fields and images, and you've got an opportunity there to comment on visual field information such as fixation and bits and pieces about how good a witness that patient was. We're back to having the free text for both refraction and VA to try and make things as flexible and as quick to fill out as possible.

In terms of being efficient, if ever, here's a wee sample of the cataract one. So, as I said earlier, it's been mentioned, we're trying to support a one-stop pathway, a two-stop pathway, and immediate sequential biological cataract surgery. So, in order to do that, although this might look as if there's far more fields than somewhere you're used to, although it be quite familiar for some of the Optoms, we've got the options to 'set all to no' to complete things in a much more time efficient manner. So where possible we've tried to do that throughout and hopefully that will make life a bit easier for everybody.

Have a look at the videos. They're very useful, they're good. I've been through them again today and you will find them very helpful in getting used to these new templates.

And that is me. Thank you very much.

HC **Helen Court (NHS GOLDEN JUBILEE)** 41:13

That's great. Thank you so much, Douglas. That was absolutely fantastic. I am now going to pass over to Elaine. I'm just going to reshare my screen as well, if I may. Great. So Elaine is head orthoptist in NHS Greater Glasgow and Clyde. Elaine. and I would like to say really all the Head Orthoptists from across the boards, and quite a few paediatric ophthalmologists, have been heavily involved and spent a lot of time updating the paediatric referral form. So it's going to be great to hear from Elaine now and her thoughts. So Elaine, are you there?

ME **McCossan, Elaine** 41:56

Thank you very much, Helen.

HC **Helen Court (NHS GOLDEN JUBILEE)** 41:58

That's fantastic. And I'll move the slides for you, Elaine. So just let me know when to share and to move on.

ME **McCrossan, Elaine** 42:03

Okay, thank you. So thanks so much for the opportunity to speak today. I'm really aware that this has been a long day, so I will try to keep this as brief as possible. I'm a passionate advocate of shared care and believe that all eye care professionals have a really important role within this and within paediatric ophthalmology.

I rely more heavily on the optometry team than the ophthalmologists. But to make the right decisions of getting the patients in to their appointments, we really rely so heavily on good referrals from community optometry to help prioritise the workload and to start the appropriate treatment.

Well, we have long waiting times. At this point, I think it's important to see that I received very few referrals that I feel are unnecessary from Community Optoms. However, I do frequently receive fairly frequent referrals that have a lack of information that I would find important.

Not to shame anyone, I intend to share an example of a really good referral and one that's got less information and maybe discuss why it would be helpful to have to have more important information. You might also be a little bit surprised by what I feel is not important depending on the age of the child.

Before we get to that, I think it's really important to say that I think we're all working under incredible pressures just now. Our pressures in the hospital eye service are definitely different from primary health care. Yours are, I think, probably time pressure and the existing business model that you work under, which I think probably works extremely well for adults, but possibly less well for paediatric patients. Well, ours, we seem to be a little bit more time rich, that we can take our time a wee bit more in hospital eye care services because we have that degree of flexibility, but we do have an absolutely overloaded system that causes longer waiting times.

Currently our waiting time in RHC for a shared care orthoptic appointment is about four months and Gartnavel was a little bit longer at 23 weeks. And that's why I think

we really appreciate that we get such good referrals from community optometry to start treatment because it could potentially be job done by the time the patients actually get into our services.

So this referral that I want to share is a really good example of a great referral to us. It's got all the information that we would want. It's A four-year-old child and the cycloplegic refraction is there, visual acuity is there. And then on the next slide, there's some really nice narrative.

They've got about the funds examination and the prescribed from the cycloplegic refraction and there's family history and why they've made the referral to us. And it's just a beautiful example of a lovely referral for us.

If we go on to the next slide, we'll then see maybe a referral that I see perhaps too often sometimes. And there's nothing, it's a completely blank, it's a completely blank box for that cycloplegic refraction. It's a two-year-old child, so we all know that it's difficult to assess children. There's nothing for visual acuity and that actually is what doesn't bother me? At 2 years of age, I would in the hospitalised services, I will be using a preferential looking test, Keeler cards etc. I don't necessarily expect that you all have that in your practices and if you do, you probably use it so infrequently, it's not necessarily going to be the most accurate. So actually, it just doesn't bother me if there's no visual acuity. But actually, the glasses is really the refraction is the really, really important information that will help me make so many decisions based upon this, because it will probably let me know whether the child is amblyopic, whether they're struggling both eyes.

And if you go on to the next slide, you'll then see, and I've just redacted just the personal details from that, but you'll see that the child has a nasal deviation. I'm not really sure, although it does say it's an esophoria, not really sure with what's been said, whether it is actually an esophoria or an esotropia.

So therefore, highly suspect that the child is going to be hyperopic. There's a family history of refractive error, so a refraction would have been so good in this case. Also would have started treatment ahead of getting into the hospital eye service.

The last thing I probably want to say is about urgent referrals. And the first referral that I used, although it was a really good referral, it was actually referred in urgently and yet there was absolutely no reason for that child to have an urgent referral.

Then the paediatric ophthalmology, although you only have the ability to refer in urgent or routine, we actually still use the soon within RHC, in which case, so urgent would be within two weeks, soon we would use within six weeks and routine would just be going to on the waiting list just as normal. So if we feel that we want to upgrade a routine, we will put it in as a soon, if not an urgent, but we will downgrade urgent referrals. And we have started from time to time phoning some community optometrist to ask what their clinical reasoning was for making this an urgent. So I am hoping that the new referral form will just make that just a wee bit clearer for us. That's really all I have to say. I'm happy to take any emails or phone calls at any point from anyone with a paediatric referral.

If it just lets you decide whether it needs to be urgent or routine, then I'm happy with that.

HC **Helen Court (NHS GOLDEN JUBILEE)** 49:06

That's great. Thanks, Elaine. That's really, really helpful. That's super. Well, we have whizzed through and given you an awful lot of information in quite a short amount of time, but we do now have 10 minutes for Q&A. So there's been a few questions already, and I'll just go through those questions.

ME **McCossan, Elaine** 49:07

Thank you.

HC **Helen Court (NHS GOLDEN JUBILEE)** 49:24

But if you do have any kind of burning questions now, now is the time to put them in the chat box and we'll see what we can what we can answer. So I'll invite all the people who've spoken. If you want to unmute, that's great. And then if you've got any input, that would be super. I'm just going back to some of the earlier questions. So there was a question by someone asking if the free text boxes have a character limit. So we have worked on this. On most of the forms apart from the wet AMD, there is a, I think has been referenced, the first field is 'reason for referral' and that has purposefully a shorter character limit, but it's still something around nearly 300

characters. But it's simply because the feedback from the vetting and the hospital side is they don't want to read a massive long essay right at the beginning. They need to very quickly read what's the reason. But then there is another box below that, like a history and symptoms box that has all that you could write absolutely loads in. So that's really the only box that has that very short character limit. So just so you know about that.

Somebody asked if mandatory, does that mean the referral will not go without that box being completed? That is what that means. If it's not filled out, it won't be completed. But as much as possible, where there are mandatory or the pink boxes, this is where we've really tried to do things that are going to speed it up. So the 'set all t ono', etc. So hopefully that will make it not quite as onerous. But again, the information is mandatory only because of all the work that's been done and the consensus that this is so important that the hospital know this information to make the best decisions.

A question around the glaucoma referrals, which I think, Douglas, you've already responded to a question about disc and OCT images and mandatory. So just to clarify, and if you go and look on the videos, you'll see this, the box that says OCT images attached, that's **not** mandatory. So you don't have, because obviously, we're very cognisant that's not part of GOSS and not all practices have one. So it's just mandatory to say in that referral, are the images attached? That's very helpful to say then if they're not, why not? Because that's such a key thing for the triage at the other end.

Which cataract leaflet does it mean when it asks 'has a cataract leaflet been given?' So what I'll just first say to that is that was also a field in the original cataract form, there was a tick box that said cataract leaflet given. We have been working, it's not quite there yet, on a national cataract information leaflet, but most of the boards have some description of cataract leaflet.

If you don't, then there is obviously the College of Optometrists do quite a good one. I don't know if anybody, any of the other optometrist on there from any of the boards like Ayrshire and Aaron and Douglas, Stuart, what would you be using?

DO **Douglas Orr (ORR AND SIMPSON EYE CARE LTD)** 52:30

Yep.

Ayrshire and Arran have one that is provided to all practices in Ayrshire and Arran, so we would expect that one, and then presumably whatever your local board would provide.

 **Stuart McConnachie** 52:41

In Tayside, we've got a quite extensive cataract information leaflet. You know, it's essentially their consent form and it has like tick boxes for their drops at the end of it and things as well. And it basically, if you just Google NHS TAYSIDE cataract leaflet, which is what I do when I need it, it's like your first hit and you quickly find it.

HC **Helen Court (NHS GOLDEN JUBILEE)** 52:59

That's great. I think that's really good. There's also quite a few good videos out there as well, because obviously reading isn't necessary, especially if your vision's not great, the best media to get information on. Then somebody's just saying that they frequently get patients being sent from the hospital to the community Optometry without any real reason. And the question is, will the new system or the updated versions allow communication from the hospital back to community? So we have looked at this quite extensively, but the problem is SCI is effectively, it's like a tube where information is sent. And it appears that, and I've seen it because I've looked at a lot of them, I've looked with some of the consultants at what they've got on their side. In every board, it seems to be slightly different. So in some boards, it's set up in Trac that a letter can be sent straight back to the optometrist, but in others, it's just not set up the same way. So again, unfortunately, that's a little bit of a board related issue. So it's not really about SCI, it's about the integration and how Track Care is set up. Having said that, again, this at this point, there's limits to SCI and this is probably not the system that you're going to find is going to unfortunately support that.

Now, there's a question about Clinical Portal, and I think Colette has answered that. Colette Dunsmore, who works with Janet Pooley. So, we're very aware, and that came up very much in the Cataract Group about Clinical Portal. Douglas, do you want to come in there?

DO Douglas Orr (ORR AND SIMPSON EYE CARE LTD) 54:54

So Clinical Portal for those boards, have it even just now, there's obviously some varying levels of access as well in terms of whether it's just IP only of everybody, certainly there's benefit to everybody having it. So I know there's work going on in the background. I also just wanted to pick up Helen on one of the other questions that was asked about the Wet AMD template around, I think was it DMO or CMO?

It is purely Wet AMD. Actually, Wet AMD was a consensus from all the consultants in that group. It is not to be used for any other macular pathology. So an urgent macula with CMO or something like that, we'd go through in the general template, but marked as urgent.

HC Helen Court (NHS GOLDEN JUBILEE) 55:30

That's great. Thanks, Douglas. So it's been asked as well, what's the best place to find the orthoptic referral forms? So the paediatric form is the orthoptic referral form. So if you go on to SCI Gateway and you look for the new orthoptic, in some boards they label it, the SCI team label it orthoptic, and in other boards we've realised they label it to Paediatric, but it will be the same referral form. If you want to see in more detail what's in it, then as I say, just have a look at the video. I did put the link to the new page on eyes.scot at the beginning of the chat. So if you want to go back to that, you'll be able to find that.

Hi, not sure if this is the correct platform to ask, but will SCI Gateway Access be extended to locums? I might pass that over to you, Janet, if that's at the right direction to send that question.

JP Janet Pooley 56:24

That depends on which board you're in, I'm afraid. We've still got some issues, but we're doing our level best to get that sorted out. It really should have been sorted out by now. I'm really sorry.

HC Helen Court (NHS GOLDEN JUBILEE) 56:36

That's great.

Will cycloplegic refraction perform be a mandatory box on the paediatric referral?
What I would say is, look, look at the video. Stuart, you were mentioning it has changed slightly, the sort of the cycloplegic part of and the refraction, etc. on the form. Do you want to come in and say anything about that?



Stuart McConnachie 57:01

I can't honestly remember quite how the mandatory thing works, but I think it's reasonable. I think it's reasonable to do a cyclo refraction for a, you know, a kid who's under 8 year that you're referring to the hospital. I think maybe.



Helen Court (NHS GOLDEN JUBILEE) 57:04

That's fine



Douglas Orr (ORR AND SIMPSON EYE CARE LTD) 57:13

The question is, has it been done is mandatory, and if it's not, you could explain why.



Helen Court (NHS GOLDEN JUBILEE) 57:19

Yes, there you go. Thanks, Douglas.



Stuart McConnachie 57:19

Thanks, thanks.



Helen Court (NHS GOLDEN JUBILEE) 57:25

Okay, I've had a few patients recently who have already been referred for cataract removal and said they have been told by the hospital to get the optometrist to re-refer to hurry this up. Is this possible?



Janet Pooley 57:38

I don't think we should do that. I think that'll end up duplicating a referral and then the waiting list will get longer. I think that's the patient is often given a contact number with from the hospital. So if they can contact them, the hospital themselves and ask where they are on the waiting list, probably the best thing, Helen.

Right, okay, thanks, Janet. I probably only have time, sadly, for one more question. I know looking at the questions, there's been people answering as well, other people's questions, which is great. Let me just see, just find one more. Let's just to go for this one. In NHS Lothian, if we've sent 2 referrals on the same day for two different conditions, we've had several instances where the hospital admin can cancel one of the referrals as it's been assumed it's a duplicate. We've only picked this up when we phoned the waiting list office a few months later to see what's happened. And then we're asked to rewrite the referral that was cancelled. So hopefully the hospital are now expecting multiple referrals for different conditions. So what I would say in NHS Lothian, one of the consultants who does the vetting is absolutely been all over this and has been really, really good. So he should certainly be aware, but that's really helpful and maybe something that we'll be able to take back and mention now, that's helpful question to the hospital eye service manager for NHS Lothian, just to ensure that that is filtered down, that information.

Okay, well, I promise to finish at 8 and I do want to really thank you everybody for staying on for the hour. I really hope it's been useful and these forms ultimately are going to make things better really for everybody in the pathway and especially for the patient at the end of the day.

If you've got a minute or less, I would really value you to scanning that QR code. It's just a little feedback form and it will take you 60 seconds or less to fill in. It's just very helpful because it will allow us to understand if tonight was useful and pinpoint any areas that perhaps need to be looked at further. Do remember that there's more information on eyes.nhs.scot. Do feel able to have a good look around that and yes, as I say, the PCA will be coming out relatively soon with more information. So thank you again for your time and, I hope you have a really lovely rest of the evening and all the best everyone. Thanks again and thanks especially to all the speakers and for their time this evening. Thanks again.

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