Centre for Sustainable Delivery

NHS SCOTLAND

Modernising Patient Pathways Programme:

Optometry Task and Finish Group (OTFG): Report and recommendations

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Contents

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1.0 Summary

Scottish Government commissioned the Cataract Sub-Specialty Delivery Group (CSSDG) to help enable ophthalmic services to increase efficiency and productivity across cataract only surgical sessions in core theatre lists across hospital eye services (HES) in NHS Scotland. To achieve this purpose, a number of Task and Finish Groups were developed, including the Optometry Task and Finish Group (OFTG). Through stakeholder engagement and utilizing the expertise of its members, **the remit of the OFTG was to identify current referral processes and practices from community optometry practice to secondary care, and make recommendations for further improvement.**

The OTFG met four times between May and October 2023 (via Teams) and included representation from community optometry practice, Health Board Optometry Advisers/Leads, Optometry Scotland, HES, NES, Scottish Government and CfSD (Appendix 1).

This report outlines the current challenges identified by the group, alongside opportunities and recommendations for improvement.

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2.0 Challenges, opportunities and recommendations

2.1.1 Challenge 1: No standardisation across NHS Scotland Health Boards (HB) of mandatory data included in referrals

- Variability exists between HBs in the amount and type of data, including mandatory data, included in the e-referral form template used to refer patients from community optometry practice to the hospital eye service (HES), irrespective of the referral pathway (1-stop or 2-stop pathway).
- Anecdotal evidence indicates that some referrals received by HES have insufficient data.
- **Quality and consistency of referrals will be supported across Scotland if all HBs include the same core mandatory data within their referral templates.**
- The newly developed HIS Standards for cataract surgery have identified the importance of a standardised national approach: "Standardised referral templates should be used to promote national consistency for referrals from optometry and other hospital ophthalmology clinics"[1].
- National Waiting Time Treatment Centres (NWTCs) which receive referrals from multiple territorial HB's would benefit from the standardisation of referral templates (as NWTC patients are not identified at point of referral preventing an NWTC template being adopted)

2.1.2 Opportunities

- **Previous work:** The West of Scotland (WoS) regional group has previously undertaken a project to standardise their referral templates for the region. This resulted in an agreed standardised template, however, this template has not yet been utilised in the region.
- During June 2023, members of the Optometry Task and Finish (OTFG) Group provided feedback about which data fields should be mandatory in the cataract surgery referral. The data reviewed included all data fields from existing templates utilised across all the HBs, including a template developed for WoS, and included some proposed new fields.

2.1.3 Recommendations

- Tables 1 and 2 (appendix 2) identify the data HBs should make mandatory within their cataract referral template[2].
    - **Table 1:** mandatory clinical data which should be included in all HB templates (irrespective of one- or two- stop pathway), including new data fields.
    - **Table 2:** recommended mandatory clinical data which should be included if a HB desires to adopt a one-stop (or 'straight-to-listing') approach.
- Development of template to be informed by Optometrists and include user testing.

[1] https://www.healthcareimprovementscotland.org/our_work/standards_and_guidelines/stnds/cataract_surgery_standards.aspx

[2] In most cases, mandatory fields were selected based on a majority consensus from the OTFG. Where there was no majority consensus, but feedback from a high-flow cataract surgeon identified a field should be mandatory, that field was also included in the recommendations.

2.1.2 Challenge 2: No community optometrist access to Clinical Portal in some HBs

- Clinical Portal (CP) provides access to an electronic summary of an individual's healthcare records, including HES discharge letters. It can support safe and effective patient management by ensuring that community optometrists have accurate patient information.
- To date, only a small number of HBs have provided their community optometrists with access to CP (including NHS Ayrshire and Arran, NHS GGC and NHS Fife).
- **In HBs without optometrist access to CP, there is a risk to effective patient management.**
- There is no overall ability for a community optometrist to access CP nationally (i.e. accessing CP to CP between two HBs). This compromises the ability of a clinician to access all relevant patient information in cases where a patient has moved, or where they have been treated in a different HB or at a NWTC.

2.2.2 Opportunities

- **Proof of concept:** approximately a third of HBs have successfully provided community optometrists with access to CP.
- In HBs which have provided access, there are community optometrists who have still not registered. There is opportunity to engage clinicians and practices to improve uptake.
- The national ophthalmology electronic patient record (EPR) is currently rolling out across HES departments in Scotland. Once established in secondary care, with appropriate funding, there is an opportunity to integrate community optometrist practice. This could allow optometrists access to the full ophthalmic patient record overcoming **some** of the challenges associated with CP when patients move from HB to HB.

2.2.3 Recommendations

- **In HBs with no community optometrists access to CP:** it is recommended that providing access is prioritised as a matter of urgency. This includes ensuring that all optometrists are provided with an NHS email account (via a Microsoft 365 licence), which is required to enable to access CP.
- **In HBs with access:** to support safe and effective patient management, it is strongly recommended that all optometrists are registered with CP and have an active account. Additionally, that optometrists have access to any available CP training provided by the HB.

2.3 Challenge 3: Provision of pre-referral patient information

- **Ensuring a patient has relevant information about their choices and the risks/benefits of surgery prior to referral helps reduce unnecessary referrals to the HES and wasted HES resources.**
- There is no standardised patient information leaflet or resource available to patients across HBs, and a sample of the current information leaflets identified variability in terms of length and content.

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- OTFG feedback suggests that confusion exists amongst some optometrists about the 'Cataract Referral Advice and Counselling' (supp code 2.9) appointment which is leading to underutilisation. The express purpose of this appointment is to provide patients with information and support shared decision-making.

2.3.1 Opportunities

- **Previous work**: NHS Tayside has developed a patient information video that supports the patient decision-making process prior to referral[3]. Initial patient feedback has been positive.
- A standardised aide memoir to support the 'Cataract Referral Advice and Counselling' (sup code 2.9) is currently utilised by some HBs (see Appendix 3).

2.3.2 Recommendations

- Develop national level standardised patient information resources, this should include:
    - A patient information video
    - A patient information leaflet.

- Provide training for optometrists to clarify the use of the 2.9 supplementary code. This could include a short case study/training resource produced by NES available to optometrists via Turas, in addition to national level reminders via Primary Care Administration (PCA) publications.

- Ensure that optometrists in all HBs have access to a standardised Aide Memoir and consider including this within the 2.9 supp appointment. This should be nationally accessible via eyes.scot and supported with training resources as appropriate.

- HBs to provide a regular update (e.g. 3/12) of current waiting times for cataract surgery. This will allow optometrists to inform the patient.

2.4 Challenge 4: Identification of the relevant optometrist education to support high quality cataract referrals

- Current cataract module on Turas (Cataract Referral Refinement) published June 2020 and would benefit from update
- Anecdotal feedback from HES suggests that areas required for further optometrist education include:
    - corneal assessment, specific to cataract referral
    - communication of risk factors to patient

2.4.1 Opportunities

- **Current work:** NES currently undertaking an audit of cataract referrals at NHS Golden Jubilee. Output from this audit may identify specific areas for targeted educational resources to support high quality referrals.

[3] NHS Tayside: Patient Journey for Cataract Surgery – A Patient Guide

2.4.2. Recommendations

- The current NES Cataract Referral Refinement module on Turas should be reviewed and updated, including training/clarification about the use of the 2.9 supp code and the cataract Aide Memoir. This could be incorporated into the GOS annual mandatory training.

- Development of training resources of clinical factors related to cataract referral, including corneal assessment

- Integrate corneal assessment into new pre-reg programme

3.0 Final comments

The recommendations within this report pertain to referral processes and practices from community optometry practice to secondary care. However, after surgery, patients return to community optometry practice for a post cataract review 4-6 weeks after surgery (traditionally undertaken in HES). It is recommended that further work focus on identifying any improvements that could be made to this part of the pathway to support safe and effective patient care.

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Appendix 1: OTFG membership

Dr Helen Court (Chair)	Ophthalmic Programme Manager, National Eyecare Workstream
Dr Deepa Anijeet	Consultant ophthalmologist & Lead for cataract and cornea, NHS GGC
John Caulfield	Optometric advisory, NHS Dumfries & Galloway
Soma Chakrabarti	Ophthalmic consultant, NHS GGC
Dr John Ellis	Ophthalmic consultant, NHS Tayside
Jason Graham	Hospital eye services manager, NHS Forth Valley
James Graham/Jayne Kyle	NES Optometry
Steven Halstead	Optometric advisor, NHS Fife
Dr Paul Johnson	Ophthalmic consultant, Eyehealth Scotland, Chair
Rosanne Macqueen	National Improvement Advisor, CfSD
Cora MacLeod	Optometric advisor, NHS Highland
Ashley McCann	West of Scotland Regional Planning
Stuart McConnachie	Optometric advisor, NHS Tayside
Karen Mowat	Community Eye Care Senior Policy Manager, SG
Frank Munroe	Optometric advisor, NHS Lanarkshire
Douglas Orr	Optometric advisor, NHS A&A
Suzi Reid	Optometric advisor, NHS Forth Valley
Pam Roberston	IP optometrist, NHS Tayside
Alison Simpson	Ophthalmology Information Manager, NHS Tayside
Gill Syme	Optometry Scotland
Kevin Wallace	Optometric advisor, NHS Lothian
Charlotte Ward	Optometric advisor, NHS Grampian
Emma Whyte	Project Support Officer, CfSD
Willis Wilkie	IP Optometrist, NHS GGC
Leanne Will	IP optometrist, NHS Tayside

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Appendix 2: Recommended mandatory cataract referral clinical data set

Table 1: Recommended mandatory clinical data fields for all Health Board referrals, irrespective of one- or two-stop pathway

Note: to improve flow/ease of completion, yes/no dropdowns should default to 'no'

Category	Data fields	Suggested response option	Comments
Patient History, Symptoms, General Health	**Details of Patient Health**	Free text	
Refraction Details	**Date of eye examination**		
	Refraction (R&L)	Drop down	
	Corrected VA (R&L)	Drop down	List to include LogMar
	Add (R&L)	Drop down	
	Corrected NVA (R&L)	Drop down	
Lens	**Nuclear sclerosis cataract**	Y/N	
	Cortical cataract		
	Posterior sub-capsular cataract		
Ocular examination and comorbidity	**Ocular exam and comorbidity**	Free text	
	Poor dilation	Y/N	
	Pseudoexfoliation	Y/N	
	Corneal endothelial changes	Y/N	
	Ocular co-pathology	Y/N	
	corneal refractive surgery	Y/N	
	Amblyopia	Y/N	
	IOP (R&L) (mmHg)*	Drop down	Include: 'unable to assess'
	Date		
	Time		
	Method		
Surgery (inc lifestyle factors affected by cataract presence)	**Patient has difficulties driving**	Y/N	
	Patient has difficulties with reading	Y/N	
	Wishes to have cataract surgery	Y/N	
	Cataract leaflet given	Y/N	
	Risks/benefits/alternatives discussed	Y/N	Include a prompt listing what the risks are (refer to aide memoir – appendix 3)
	Can lie flat and still for 30 mins	Y/N	

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Specific risks discussed with Patient	**High spectacle prescription**	Y/N
	Immunosuppressant	Y/N
	Any other relevant information	Free text
Additional Information	**Significant hearing difficulties**	Y/N
	Mobility	Drop down
	Driver (Y/N)	Y/N
	Learning disabled (Y/N)	Y/N
	Able to transfer to bed	Y/N
	Employment Status	Drop down
	Able to instill post-op drops independently	Y/N
	Special Visual Needs	Free text
	Communication barriers and further clinical information (e.g. dementia)	Free text

Recommended <u>new</u> mandatory clinical data fields[4]

<u>Suggested new additions to data set</u>	**Cataract Surgery indicated in: RIGHT/ LEFT/ BOTH**	Drop down
	Patient wishes to be considered for ISBCS if appropriate	Y/N
	Post-Op Refractive Status Discussed	Y/N
	AMD	Y/N
	Dilated Exam? (R/L/Both)	Drop down
	Reason for not dilating	Free text

[4] Not currently included in the majority of Health Board cataract referral templates

Table 2. Additional mandatory data to support 1-stop listing

Cornea	**Cornea healthy**	Y/N	CCT or comment on endothelial quality
	Cornea additional details	Free text	
Disc	**Disc healthy**	Y/N	
Ocular history	**Glaucoma**	Y/N	
	Strabismus	Y/N	
	Contact lens (none/soft/RGP/other)	Drop down	
	Additional ocular history	Free text	
Patient Lifestyle	**Patient has difficulties with work (Y/N)**	Y/N	
	Patient has difficulties with hobbies (Y/N)	Y/N	
	Patient has difficulties with glare (Y/N)	Y/N	
Outcome	**Patient wishes to be considered for cataract surgery (1 stop)**	Y/N	
	Patient wishes HES assessment and consideration of cataract surgery (2 stop)	Y/N	
Consent	**Patient able to give consent (Y/N)**	Y/N	

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Appendix 3: Code 2.9 Aide Memoire - 'Cataract referral advice and counselling'

	RISK FACTORS
Demographics	Over 85 years
Observation	Unfit, Tremor, Deaf, Dementia
	Unable to lie flat / still 30 mins
POH	Refraction (high myope, hyperope)
	Amblyopia, Squint, Monocular
	Retinal Detachment
	Glaucoma
	Refractive Surgery
PMH	Diabetes
Drugs / Drops	Alpha-blocker eg Tamsulosin, Doxazosin
	Anticoagulant eg Warfarin, Rivaroxaban
Slit Lamp	Deep set eyes
	Blepharitis
	Dry Eye (biometry, and post-op irritation)
	Cornea guttata
	Shallow AC
	Poor dilation
	Posterior synechiae
	Pseudoexfoliation (PXF)
	Blepharospasm, flinching, twitching

Category I:
- Fit
- Mobile
- No ocular comorbidity
- Can lie flat

Category II:

1 risk factor
- Age
- Alpha blocker
- Anxiety
- Deep set eyes
- High hypermetropia/myopia
- Fuchs Endothelial Corneal Dystrophy
- Shallow A/C
- Poor pupil dilation
- PXF
- Previous surgery
- Unable to lie flat
- Deaf
- Dementia

Category III:
- Uniocular
- 2 or more risk factors

YES	NO	N/A	IMPACT OF CATARACT
			Is the cataract main cause of visual deficit?
			Is it affecting quality of life?
			Is vision affecting occupation?
			Is there difficulty, even with spectacles, recognising faces ?
			Is there difficulty, even with spectacles, watching TV?
			Is there difficulty, even with spectacles, reading ?
			Is there difficulty, even with spectacles, cooking ?
			Px advised below 6/12 (binocularly) and/or has given up driving due to vision?

YES	NO	N/A	EXPLAINED TO THE PATIENT OPTICAL OUTCOMES
			Multifocal will not be offered for patients having NHS cataract surgery (NG77)
			Astigmatism might not be neutralised
			Large Rx will lead to anisometropia (if not ISBCS)
			Some may want slight myopia but they may need specs for distance vision
			Monovision may be offered to those that already have anisometropia
			Contact lens wearers should be advised to remove their lenses before the appointment date (2 week for soft and 4 weeks for RGP)

YES	NO	EXPLAINED TO THE PATIENT THE OPERATION INVOLVES
		Usually local anaesthetic
		Can they lie flat for 20-30 mins - postural or breathing issues?
		Do they have head tremor?
		Px has claustrophobia or feels need for sedation may need general anaesthetic
		Need to stop contact lens wear prior to hospital appointment (4 weeks for RGP and 2 week for soft lenses)

YES	NO	EXPLAINED TO THE PATIENT RISKS OF THE OPERATION
		1 in 50 will have some complication which may result in a disappointing outcome
		1 in 100 will have a more serious complication resulting in a poor outcome (poor vision in operated eye meaning you rely on other eye)
		1 in 1000 will have a very serious complication (blind eye)
		1 in 10,000 will have a devastating complication (loss of an eye)

YES	NO	EXPLAINED TO THE PATIENT RISKS OF NOT BEING REFERRED FOR SURGERY
		Lose quality of life
		Risk of falls
		Need to monitor vision to ensure meeting DVLA standards

YES	NO	Patient has dementia or learning difficulties that may limit patient's ability to give consent
YES	NO	Patient deaf / interpreter needed
Notes		

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