Statement for Bradford LOC to distribute to community Optometrists

Dear Colleague

The CCG commissioned an audit in order to quantify Hospital Eye Clinic referrals from GPs, the majority of which have originated from community optometrists. This is not particularly from a clinical perspective but more from a practical and logistical perspective. The exercise has proved very interesting and highlighted many areas for discussion, some of which have come as no surprise and some of which were more unexpected.

It is clear that if referring optometrists have a closer understanding of the referral pathway *after* letters have been received by the GP's then this may be useful when counselling patients after a decision has been made to refer.

Ensure all relevant clinical information is included to aid triage and reduce referral rejections

The department receives over 400 referrals per month from the community. On receipt within the eye department, all referrals are triaged by a clinician to determine:

1. Which is the most appropriate clinic for the patient to be seen in and
2. Within what timescale they should be seen.

Hence in order to successfully triage it is essential that all referrals are complete. It has been found that in certain cases there is insufficient essential information in the referral to enable this. A common example is missing visual fields or no repeat measurements via referral refinement. These referrals have to be rejected and ultimately this will lead to a longer wait for these patients to receive appointments.

98% optometry referrals sent via GP are considered routine and will be seen within about 12 weeks

The time scale for routine appointments is currently around 12 weeks from the time the referral is received from the patient's GP, (although this may be reduced if triage indicates). In order to manage patient expectation, optometrists might find it useful to convey this to patients. Promising an appointment within 4 weeks leads to anxiety and frustration for the patient when this fails to materialise.

Consider if the patient could be managed in the community

An increasing number of conditions may be amenable to management by the GP. The CCGs are rolling out information for GPs regarding some ocular conditions such as dry eye, allergic conjunctivitis, and chalazia. The information contains management strategies prior to hospital referral. If patients are made aware that they may not require an immediate HES appointment, this would be useful as patients may be less demanding of their GPs to onwardly refer

Sending routine referrals direct to the eye department incurs delays

Additionally, some routine patients were referred direct to the eye department from the optometrist, either by letter or fax and while this may be initially seen as saving some time by removing the "pass through" element of the GP, this also counts as an incomplete referral as (at the very least) the NHS number is required and after toing and froing with the GP, patients may again wait longer to be allocated an appointment.

Patients with an immediately sight threatening condition should be communicated via telephone to the Acute Referral Clinic

Patients with suspected sight threatening conditions should be seen in the Acute Referral Clinic and optometrists should phone while the patient is with them so that an appointment can be made immediately. A note of your findings should be given to the patient to bring with them to the clinic.

Tel Number for Acute Referral Clinic: **01274 364238**

The ARC does not offer a walk in service and patients without an appointment are likely to be turned away.

It would also be useful if optometrists are aware of the partial sight registration criteria as some patients were disappointed when told by ophthalmologists they were ineligible for visual impairment certification. A judgement is made based on the vision in the **better** seeing eye: having one blind eye does not make a patient eligible for partial sight registration.
However this must not be confused with the LVA clinic, the department is happy to see *any* patient that may benefit with LVA's regardless of their legal visual status.

Clearly print referring optometrist's name and practice address to facilitate feedback from the HES

The pilot has also highlighted the need to feedback to optometrists regarding referrals, and if referrals are rejected the hospital will endeavor to send referrals back to the optometrist when one of the above scenarios occur. We will send a covering letter for either further information (such as visual fields) or advice to monitor the patient and avoid an unnecessary hospital appointment.
In order to receive feedback letters it is important that the referring optometrists name is clearly evident as clinical letters are unable to be addressed simply to a practice.

The department values highly the excellent relationship that has been forged with local practitioners over many years and the region is lucky to have a hospital eye department, a university eye department and an active LOC who all strive to work together for the benefits of local patients.

Summary

- Ensure referral letters contain ALL relevant clinical information
- Ensure all non-urgent referrals are sent via GPs rather than direct
- Manage expectation – time scales for HES appointments are currently around 12 weeks
- Manage expectation – some conditions can be managed in primary care rather than HES
- Manage expectation – understand criteria for Certificates of Visual Impairment
- To receive feedback letters, ensure name of referring optometrist is clearly printed.

If you have any queries about any of these points please contact Clare Green or Rachel Pilling at the Ophthalmology Dept at the BRI.

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