October 2018 General Ophthalmic Services (GOS) changes –

Frequently Asked Questions

Purpose

This document aims to help optometrists and other optometry practice staff understand the changes introduced to GOS in Scotland from 1 October 2018, as set out by the Scottish Government in PCA(O)(2018)01 and PCA(O)(2018)02.

This document is evolving and subject to ongoing amendments.

Content

Background

The Community Eyecare Services Review (CESR) published in April 2017 made various recommendations to improve community eyecare services in Scotland. The CESR was prompted following various suggestions from Optometry Scotland, the profession and other groups after the current GOS arrangements were introduced in 2006.

Key recommendations of the CESR included the following:

- Establish a revised framework for GOS which has a focus on delivering person centered care and removing the 'tick box' approach to carrying out tests and procedures for GOS eye examinations by enabling greater flexibility for professional judgement;
- Develop 'first port of call' principles for community optometry services;
- Raise public awareness of eye problems as a public health initiative;
- Improve access to care;
- Improve interdisciplinary / interagency working;
- Incorporate SIGN 144 – Glaucoma referral and safe discharge within GOS;
- Investigate more optometry involvement in diabetic care;

- Review domiciliary services;
- Review low vision care – to community develop community based networks;
- Improve care for patients with complex needs;
- Improve the primary / secondary care interface;
- Improve IT links / referrals / chronic disease management;
- Facilitate essential data sharing – e.g. the emergency care summary information;
- Establish Clinical Governance / Quality - Monitoring / Audit / Quality Markers;
- Review the mandatory education and training requirements for optometrists and dispensing opticians - consider a new accreditation process;
- Develop enhanced services provision across Scotland, including roll out of Board-specific schemes such as those in Lanarkshire (the Lanarkshire Eye Health Network Service) and Grampian (Eye Health Network);
- Introduce universal, nationwide practice equipment requirements to a common minimum standard;
- Facilitate national listing arrangements for optometrists and dispensing opticians.

Various elements from the list above fit within GOS and will be phased in over time. Some, such as SIGN 144, formalising 'first port of call' responsibilities for emergency presentations, new support arrangements for complex needs patients, mandatory training and national equipment requirements were brought into GOS from 1 October 2018. Others will be introduced later such as the changes to domiciliary care.

Tests and procedures for GOS eye examinations

Why was it necessary to review the arrangements for determining clinically appropriate tests and procedures for GOS eye examinations?
It had been evident for some time that the approach to determining the tests and procedures for GOS eye examinations had been reduced to a 'tick box' exercise for many optometrists. Clinicians will now have greater flexibility to use their clinical judgement in determining the tests and procedures of a GOS eye examination which are appropriate to the presenting signs, symptoms and needs of the patient.

How will this look in practice?
The general structure and layout of the new GOS Statement (which can be found in PCA(O)(2018)02) is simpler than before, and no longer contains the previous long, prescriptive tables outlining mandatory tests and procedures – some or many of which may not have been clinically appropriate for particular patients.

The new Statement defines a smaller set of tests and procedures which have been deemed as mandatory for all primary and supplementary eye examinations, unless

certain grounds apply – such as the patient refusing the test or procedure, or the optometrist deeming it to be clinically inappropriate.

The Statement and GOS regulations also now incorporate 'SIGN 144 – Glaucoma referral and safe discharge' within the GOS Terms of Service, and the College of Optometrists 'Guidance for Professional Practice' continues to form part of the Terms of Service. A GOS eye examination should be conducted with reference to both sets of guidance.

Do I need to annotate my record with a reason for every test or procedure that I don't carry out because, for example, I don't believe it to be clinically appropriate?
The revised Statement sets out the level of care expected to be provided for all primary and supplementary eye examinations. A key principle of the new GOS arrangements is to remove the previous 'tick box' approach to care, but all optometrists should consider the content of the Statement and the guidance contained in the College of Optometrists and SIGN 144 guidance. If an optometrist does not fully comply with what would normally be expected they should annotate the reason on the patient record.

What will be the role for PSD for payment verification?
The payment verification process is currently under review to determine whether if requires to be updated to fit with the new GOS arrangements. PSD will still have a role to monitor claims as they have a duty to comply with NHS Board requirements for payment verification.

Primary eye examinations – frequency changes

What changes have been made to the frequency of primary eye examinations?
The rules relating to the frequency of primary eye examinations have been altered to reflect recommendations from "SIGN 144 - Glaucoma referral and safe discharge". SIGN 144 indicates that patients under 60 years of age with a single risk factor for glaucoma do not need to be seen every year.

The primary eye examination intervals for the following groups of patients have therefore been changed from one year to two years:

- Patients with glaucoma;
- Patients aged 40 and over with a close family history of glaucoma;
- Patients with ocular hypertension.

Optometrists are advised to exercise clinical judgement as to when patients need to be recalled for review. This is of particular importance for patients living with multiple risk

factors for glaucoma, when it might be appropriate to review annually and claim the relevant supplementary eye examination fee code, e.g. supplementary code 2.3 where the patient's pupils are not required to be dilated and code 4.3 where the patient's pupils are required to be dilated.

What are the recognised glaucoma risk factors?
SIGN 144 describes a number of risk factors for glaucoma including: aged over 60, myopia (POAG), hyperopia (PACG), ethnicity (African[POAG], Eastern Asian[PACG]), family history of glaucoma, diabetes, hypertension, peripheral vascular disease, thin corneae, ocular hypertension, pigment dispersion syndrome, narrow anterior chamber, pseudoexfoliation syndrome, female gender (PACG).

If a patient is living with more than one risk factor, consideration should be given to the patient been seen more frequently than the routine two year primary eye examination interval, with the appropriate supplementary eye examination code claimed (2.3 or 4.3).

Glaucoma Case History 1
A 46-year-old female presents for an eye examination. She has a family history of glaucoma* but enjoys good general health. A subsequent eye examination reveals normal IOP R 16mmHg, L 17mmHg [GAT @ 11.07am]. Pachymetry R 571, L 569. Both anterior angles are open on gonioscopy Shaffer Right 3, Left 4. Both central visual fields intact. Slit lamp biomicroscopy revealed normal optic nerve head appearance DDLS = 3 (both eyes). *This patient has a single risk factor for glaucoma, because she has a family history of glaucoma and, in keeping with SIGN 144, should be recalled in two years for review.

Glaucoma Case History 2
A 58-year-old male presents for an eye examination. He is myopic* and his sister has glaucoma*. An examination reveals IOP R 21mmHg*, L 19mmHg [GAT @ 1.31pm]. Pachymetry R 530, L498*. Both anterior angles are open on gonioscopy Shaffer 4. Slit lamp biomicroscopy suggests that both optic nerve heads appear normal DDLS = R 3, L 4. This is confirmed as normal on the OCT. Both central visual fields are intact (SITA 24). *This patient has four risk factors for glaucoma and he should be monitored for signs

of glaucoma. In keeping with SIGN 144, it would be good practice to review him again in a year and claim a supplementary examination for doing so - either code 2.3 (undilated) or code 4.3 (if dilated).

Glaucoma Case History 3

A 63-year-old* female* attends for a routine eye examination. She does not have any family history of glaucoma. She is hyperopic (approximately +5.00DS in both eyes*). Living with Type 2 diabetes mellitus* for 10 years and has peripheral vascular disease*.

An examination reveals early nuclear and cortical cataract. Gonioscopy indicates narrow anterior angles Shaffer Right Grade 2, Left Grade 2*. Her IOP is recorded as R 22mmHg, L 23mmHg*[GAT @ 10.21am]. Pachymetry R559, L 557. Both central visual fields are intact SITA 24. Slit lamp biomicroscopy reveals suspect glaucomatous neuropathy right and normal appearance in the left eye. DDLS R = 5, L = 2.

This patient has six risk factors for glaucoma and, in keeping with SIGN 144, should be reviewed for glaucoma in a year by claiming a primary examination fee. With the other underlying issues, the optometrist may feel there is a need to see the patient more frequently and they can claim a supplementary eye examination fee for this appointment under code 2.3 or 4.3 (if dilated).

What happens to patients who are currently on a one year recall for glaucoma, in keeping with the previous primary eye examination frequencies?

This would only apply to patients aged under 60. You can still see these patients for a glaucoma review and claim the appropriate supplementary examination fee (code 2.3 for an undilated examination and code 4.3 for a dilated examination). Thereafter you should exercise clinical judgement when you wish to see them again, dependent on the risk profile.

I recall all my patients according to the minimum intervals allowed for a primary eye examination. Can I continue to do this?

Practitioners are reminded that the decision to recall a patient rests with your professional judgement and should be made in the best interests and clinical need of the patient. It should never be a blanket, automatic decision based solely on the minimum intervals allowed. There may be circumstances where, in the practitioner's professional judgement, a longer interval between primary eye examinations is appropriate. A good tip is when you set the recall interval, note down the reason on the clinical record.

Primary eye examinations – code 7, code 9 and removal of four week early recall option

Can another practice see my patient within the normal relevant primary eye examination interval and claim using code 7?
If your patient presents at another practice where the patient is new to that practice and it does not have access to the patient's clinical records, and the examining optometrist judges that a primary eye examination is clinically appropriate based on the patient's presenting signs and symptoms, then the other practice can carry out a primary eye examination and submit a payment claim for it under code 7.

If both your practice and the other practice which the patient presented at are part of the same company or group of practices, then the other practice cannot submit a claim for a primary eye examination under code 7 as it is considered that the other practice has access to the patient's clinical records.

What happens if a patient who I have examined before turns up at my practice but has had a primary eye examination at another practice within the normal relevant primary eye examination interval? Can I carry out a primary eye examination and submit a payment claim for it under code 7?
If the patient is not new to your practice but the optometrist considers that a primary eye examination is clinically appropriate based on the presenting signs and symptoms, and you do not have access to the patient's clinical records from the primary eye examination carried out at the other practice, then a primary eye examination can be carried out and claimed under code 7. Alternatively, a supplementary eye examination could be carried out and claimed if the optometrist considers that it is clinically appropriate to do so.

Why has a code 9 for sight impaired and severely sight impaired patients been introduced?

If a patient is sight impaired (partially sighted) or severely sight impaired (blind) they can now be recalled for an annual primary eye examination, using code 9 on the GOS(S)1 form. Annex B to the new Statement provides further information which practitioners should use when determining whether a patient is sight impaired or severely sight impaired. This guidance mirrors the criteria used by ophthalmologists when determining whether a patient is eligible to be registered as sight impaired or severely sight impaired under the Certificate of Visual Impairment (CVI) form process.

Why has the "early 4 week" primary eye examination option been removed?
This option was originally introduced to provide practitioners with flexibility for unscheduled patient presentations within four weeks of the patient's next primary eye examination entitlement. However, there was evidence that some practices were routinely recalling patients early for routine examinations so this option has now been removed.

Supplementary eye examinations – fee and code changes

What changes have been made to supplementary eye examinations?
A new 'enhanced' supplementary eye examination fee, and range of codes pre-fixed with a '4.', have been introduced from 1 October 2018. The enhanced supplementary examination fee is £38, higher than the alternative standard supplementary eye examination fee of £24.50. The higher fee reflects the underlying principle with the development of GOS that fees will better reflect the time and expertise that are involved in caring for your patient.

In addition, two new standard supplementary eye examination codes have been introduced – code 2.9 for providing advice and counselling to a patient before a referral for cataract surgery, and code 3.0 where an additional appointment is required to complete a primary eye examination for a patient who has complex needs.

When should I carry out an enhanced supplementary eye examination?
The principle behind the new enhanced supplementary examination is to provide the optometrist with more time to deal with complex clinical scenarios that require the patient to be dilated.

Typical examples could include patients who present with:

- Suspect vitreo retinal disease;
- Suspect maculopathy;
- Optic neuropathy – requiring a detailed indirect stereo view;
- Anterior uveitis;
- Trauma;
- Foreign body;
- Keratitis;
- When there is a restricted internal view due to lens opacities;
- When there is a restricted internal view due to a small pupil.

Can you claim a supplementary eye examination on the same day as a primary eye examination?

The new Statement specifies the supplementary eye examination codes that cannot be claimed on the same day as a primary eye examination for the same patient. The codes are 2.1, 2.7, 4.1, 4.6, and 4.7. It is accepted that, in exceptional circumstances, other supplementary codes could be claimed on the same day as the primary examination. Codes 2.5, 2.8, 4.5 and 4.8 can be claimed on the same day as a primary eye examination only if the patient presents for the supplementary eye examination as an emergency.

Clinical Scenario – Emergency Supplementary
A patient presents in the morning for a routine eye examination. Later that day they suffer a traumatic injury to the eye. A new supplementary examination can be carried out and the appropriate fee claimed.

How will the new supplementary eye examination code 2.9 work?

The new supplementary code 2.9 has been introduced to support optometrists when referring patients for cataract surgery following the primary or supplementary eye examination in which the cataract has been detected. The optometrist will provide advice and counselling to the patient to ensure that they are well informed of the risks and benefits of surgery and the expected prognosis.

The code 2.9 supplementary eye examination appointment can be carried out on either the same day as the primary or supplementary eye examination in which the cataract is detected, or on a separate day. If it is carried out on the same day, it must be as a separate additional appointment i.e. if the referral advice/counselling is provided within the originally scheduled appointment time then no additional payment claim can be submitted for a code 2.9 supplementary eye examination.

A payment claim can be submitted even if the patient does not proceed with surgery. The aim is to ensure that only patients who require and wish for a referral for cataract surgery are actually referred.

What do I need to do to meet the requirements of supplementary eye examination code 2.9?

As stated above, the main reason behind the new 2.9 supplementary code is to reduce unnecessary referrals for cataract surgery. Most Board areas have a protocol already in place and complying with the local protocol would allow an optometrist to claim the fee. This will normally mean a basic discussion with the patient to ensure that they wish to proceed with surgery, including the risks and benefits and perhaps going over the

consent process. Some additional requirements might include commencing blepharitis treatment if this is appropriate.

Can you explain the principles behind the new supplementary examination code 3.0 for patients with complex needs?
The introduction of supplementary examination code 3.0 comes from a recommendation in the CESR that optometrists should be given greater support when managing patients with complex needs. The main reason is to provide additional chair time so that the optometrist can get the patient back in, usually on a different day, to complete the primary eye examination. The code only applies to examinations carried out in practice premises – it cannot be claimed for domiciliary examinations.

What constitutes a complex needs patient?
There is no settled and agreed legal definition of complex needs. However, for the purposes of the code 3.0 supplementary eye examination a patient with complex needs is someone with a moderate to profound physical or mental condition which requires the primary eye examination to be conducted significantly more slowly than that of a typical patient, and as a result it is not possible to complete the primary eye examination within the originally scheduled appointment time. A patient must not be treated as a patient with complex needs solely due to their age. An e-learning programme “Simple Steps for better testing of individuals with Complex Needs” is available from NHS Education for Scotland if you would like additional training.

Can I claim a supplementary code 3.0 on the same day as the primary examination?
As stated before, the expectation is that most additional appointments will take place on a different day. However, there will be situations where it is in the patient’s best interest to complete the eye examination on the same day, e.g. in remote and rural locations. In these circumstances, a payment claim can be submitted for the initial appointment (the primary eye examination) and the additional appointment (the code 3.0 supplementary eye examination) which are both carried out on the same day.

Chronic eye disease management

How will optometrists manage chronic eye disease within GOS?
This will vary depending on the type of condition and how frequently the person needs to be seen. A common presentation would be blepharitis / dry eye and this type of patient normally requires ongoing lifelong care and management of their condition. Other scenarios could include patients discharged from a glaucoma clinic or patients requiring maculopathy monitoring.

Case Scenario – Blepharitis
A patient presents with severe blepharitis and tear deficiency. You carry out a relevant examination (either a primary eye examination if the patient is entitled to one and the optometrist considers it clinically appropriate or, if the patient is not entitled to a primary eye examination, a 2.5 code supplementary eye examination), advise on treatment and decide to review in one month to see how the eyes are responding. Subsequent review appointments would be carried out under a 2.5 code supplementary eye examination.

Case Scenario – Glaucoma discharge (over 60 years old)
A patient attends your practice following discharge from the local glaucoma clinic. She is 63 years of age, has had surgery and requires ongoing annual review in the community. In this situation you can recall the patient annually and claim a primary examination for each visit.

Case Scenario – Glaucoma Discharge (under 60 years old)
A 45 year old man presents with recent peripheral iridotomies after having been discharged into the community. His IOP has been regulated with the treatment but the discharge letter states that he has to be assessed on an annual basis to check IOP, ONH examination, digital imaging and visual fields. The eye examination can be carried out as a primary eye examination, if the patient is entitled to one and the optometrist considers it clinically appropriate, or as a 2.3/4.3 code supplementary eye examination depending on whether or not the patient's pupils need to be dilated. When the patient returns in a year for review this is carried out as a 2.3/4.3 supplementary eye examination, again depending on whether or not the patient's pupils need to be dilated. The following year the patient would be entitled to another primary eye examination in keeping with the two year primary eye examination interval for this patient.

The same basic principles would apply to all chronic disease being monitored in the community such as maculopathy, uveitis, dysthyroid disease etc.

"First port of call" and emergency eye examinations

How much of an additional burden will the "first port of call" / emergency eye examination requirements place on me?

The new GOS arrangements merely incorporate into legislation the existing professional duty for all optometrists to provide appropriate care and treatment for patients presenting with emergency eye issues. All listed GOS providers are now required to

appropriately manage emergency eye presentations as part of the package of eyecare delivered under GOS.

It is expected that the initial presentation will be 'triaged' by the practice staff / optometrist in the first instance to determine the urgency. The decision of whether the patient's condition is an emergency will be determined by the optometrist, not the patient or anyone referring them to the practice.

It is not a regulatory requirement, but it is suggested that practice leads monitor the number of emergency appointments over time and try to keep some appointments free each day to meet this demand and that all practices introduce a basic training programme so that all staff are aware of the triage system.

If it is determined to be an emergency, the practice will be responsible for seeing the patient within a reasonable time period or, if they cannot see them (perhaps because no optometrist is present), making alternative arrangements for the patient to be examined, either with another optometrist or with the local hospital or GP.

If you would like further training on managing these patients then you can contact NHS Education for Scotland: www.nes.scot.nhs.uk/education-and-training/by-discipline/optometry.aspx

What will constitute as an emergency?
The new GOS regulations do not define what constitutes as an emergency appointment - this has been left to the optometrist to determine. An emergency can be construed as a recent, unexplained situation which might be sight or life threatening and requires urgent care and investigation. The College of Optometrist's guidance has similarly not defined the term 'emergency' but has indicated that this may include: red eye, recent visual loss, recent onset of ocular pain, symptoms suggesting a retinal tear/detachment, giant cell (temporal) arteritis.

Miscellaneous

Will patients notice any difference to the changes to GOS?
It is unlikely that patients will be aware of any significant change to the service provided under GOS. Other than minor alterations to the primary eye examination intervals for glaucoma patients and some glaucoma risk factors, the service that patients receive will be much the same as before.

Is there a risk to patients from the new GOS arrangements?
The new GOS arrangements will provide an overall platform for improved care for

patients. The new regulatory structure places a greater emphasis on a person centered approach for GOS which allows greater clinical freedom for optometrists.

Will there be a new awareness campaign for GOS 2018?
At present NHS 24 promotes community optometry as the first port of call for all eye problems and they provide this information on request, via social media and with published posters. Most NHS Boards have produced local posters to be put up in GP practices to inform the public to attend their optometrist with an eye problem. The GP practice collaboration are also piloting a tagline promotion on repeat prescription scripts to patients with poor general health that eye examinations are free of charge. A national, targeted awareness campaign was recommended in the CESR but this has not happened to date.

Will there be a new competency requirement for the new GOS arrangements?
No, but a mandatory training requirement has been introduced for all optometrists will be required to complete on an annual basis to remain listed for GOS. This will not be onerous, and the training will be consistent with the development of GOS in Scotland. In addition, GOC CET points will be available for this training.

Will the listing arrangements for optometrists be altered?
Subject to the necessary legislative amendments being delivered, the Scottish Government intends to introduce new listing arrangements in the future which involve national listing of GOS providers. This will facilitate cross Board movement of optometrists, allowing for greater convenience for mobile optometrists and when covering for holidays etc. There are also plans, again subject to the necessary legislative amendments being delivered, to eventually list dispensing opticians, pre-registration trainee optometrists and practice owners.

My working week involves four long days. How does the rule about a limit of 20 GOS eye examinations per working day apply to me?
The current regulations state that the maximum number of GOS eye examinations – both primary and supplementary - that can be carried out by a practitioner in any single working day is 20. The Scottish Government, NHS Boards and Optometry Scotland are currently reviewing this rule to ensure it remains fit for purpose in terms of ensuring patient safety and quality of care and reflecting modern working patterns.

In the meantime, all GOS practitioners should ensure they continue to comply with this rule. PSD monitor those practitioners who submit claims where more than 20 eye examinations appear to have been carried out in the same working day, to determine why they have gone over the prescribed limit. In most cases this is often explained by an optometrist supervising a pre-registration student.

I don't have a practice management system. Can I continue submitting paper GOS forms after April 2019?

Optometry Scotland has agreed with the Scottish Government that, from 1 April 2019, only electronic claim submissions will be accepted by PSD. This is now included in the new GOS regulations. A new web-based GOS form has been introduced for practices to use that does not require practice management software, but a computer and broadband connection is needed to function properly. Any practices still not linked up to electronic GOS **should do so as soon as possible** to ensure they can still submit GOS payment claims on or after 1 April 2019.

Is it possible to charge patients for additional procedures after a GOS examination?

There are a number of precedents for this such as managing dry eye patients when an eye bag might be beneficial to treat the associated blepharitis. The same would apply to additional procedures such as fitting punctum plugs or ongoing treatment such as a patient buying lid wipes for blepharitis. The optometrist might also wish to carry out additional 'in-house' treatments such intense lid cleaning and this again could be chargeable. However, it is not appropriate to recall patients for a supplementary or primary examination solely to carry out such procedures.

Case Scenario – Blepharitis Care
A patient presents with significant discomfort and dry eye symptoms. A subsequent eye examination reveals anterior / posterior blepharitis and tear deficiency. The optometrist advises the patient accordingly and instructs on blepharitis treatment such as lid cleaning, hot compressing, lid massage and ocular lubrication. The patient returns for review in a month's time and presents with residual symptoms. The optometrist carries out a supplementary eye examination and offers an additional private 'in-house' procedure. This is allowable because the patient has had a supplementary examination in the first instance. It is not permitted to recall a patient simply for the private 'in-house' procedure and then claim a GOS fee.