

SMDRS

Grader advice

Access to patient records in Vector.

Patient records can be accessed via the PIN number or by using the patient name, DoB and postcode. It is NOT necessary to phone the admin centre for the PIN number if the patient has not brought it unless you are having trouble finding the record.

Requests to add new patients to Vector will not be processed until the GP surgery has confirmed demographics, NHS No. and diabetic status. So allow time for this when booking patients. It means that you won't be able to screen a walk-in who is also a new patient.

Why is this done? 2 principle reasons:

We tried adding patients with temporary IDs but this was creating an awful lot of work each time the register was updated with new patients from the GPs. It meant they all had to be looked at manually and reconciled with a new patient on the system that now had a real NHS No. It only takes a small error in a postcode or spelling of a surname to end up with the same patient on twice.

Second, and more important, picture the following scenario: a practice requests the addition of a new patient, which is done with a temporary ID. Unfortunately, neither the practice nor the admin centre spot that the patient's GP (and therefore the patient) are not in our area. Both should have done as it is fairly obvious! The patient turns out to be R3 and an urgent referral. Not the right area, so appointment doesn't get processed by hospital and the GP receives a letter, but just presumes it was a standard result and doesn't pick up on R3. So the patient languishes for some time before the problem is spotted and dealt with. This incident has happened and it leaves both the practice and the admin centre vulnerable, so the systems have been changed (as described above) to ensure it cannot happen.

Consent

Note that the preferred form of consent is **operational and research**. This allows the images to be used for teaching purposes. This is the information that patients will have been given in writing and they are asked to tell you if this is not acceptable. If they do not consent at all then they cannot be screened.

Newsletters and leaflets

The "Facts" leaflet has been updated and is on the website. The newsletter and practice list is with the printers and will be available on the website shortly. You will be sent a small supply of each on request.

EyeCap Software (Canon Cameras)

For certain more recent models of camera back – definitely the 30D, but possibly the 20D in some cases, Eyecap uses a small utility to speed up the transfer the images from the camera to the PC. If, during the day, you notice a small programme running in the Task Bar called “CanCap”, then this applies to you.

Vector has a similar utility called EOS Capture and it cannot connect to the camera whilst CanCap is running. The easiest answer to this is to close EyeCap whilst capturing with Vector, and then to open and log back into Eyecap after finishing with Vector.

There is a quicker but more complicated fix. If you feel reasonably IT-literate, then contact me and I will describe the alternative which involves re-starting CanCap in a specific manner.

The problem does not apply the other way around as Vector closes its utility as you leave the capture screen.

Graders

If there is a non-DR reason for poor acuity (e.g. amblyopia) you **must** make a note of this in the text field of the “other lesions” pop-up on the grading screen. This will ensure that the 2nd grader does not disagree with your grade on account of the poor acuity.

Similarly, if there is an obvious other, but benign, lesion that you know is of long-standing, please make a note to that effect (e.g. a naevus).

If you are not providing a sight test to the patient and you believe that a sight test is required (e.g. modest optic disc cupping and the patient cannot remember when they last had a test), then tick the box to advise a test and add a note of the reason for the GP letter in patient notes or the other lesions text field. Both the GP and the patient will be informed of the need for a sight test. If the patient knows who their sight testing optometrist is, then completing the details to inform them will ensure they are sent a copy of the GP letter.

Remember that if you do a sight test for the patient along with screening, then ticking the box “GOS ST today” will inform the GP of this fact, which takes care of your regulatory obligation.

If you find, having captured the images, that it won't let you enter the grading result, this is a bug. Just click the back button to go back one screen, then forward again and all will be well. This only occurs if you use the full screen option for Vector. Stick to using the medium screen (thumbnails on and off) and you won't get this problem

Recall

Practices may wish to consider the timing of their own recall letters to patients with diabetes. It is preferable that the patient receives the letter from DRSS first so that there is no possibility of them attending early.

Most reminders are sent at the 11 month mark. For these patients, the screening will only be paid after 11 months. For a small number of patients the recall letter goes out after 10 months and these patients will be paid after 10 months. However, the system will flag them as early and they are checked manually. The odd one may slip through and then you will need to query it.

In special situations - such as an elderly patient who has trouble getting to the practice, but who visits slightly early for some other problem, you can ask the office to OK the early screening.

Transfer of Images

Vector transfers images to Salford when you exit the programme. Given the upstream speed of an 8MB broadband connection, you can expect it to take up to a couple of minutes or so per image. So if you have screened a few patients it may take a while. Bear this in mind when closing down – **you must ensure the images are sent**. Until the images have been sent, the patient cannot be second graded.

Image position

Please ensure that the disc and macula are accurately centred for “good” shots. It tends to be the Topcon cameras without the recent changes to the internal fixation target where this is most difficult. A typical off centre shot is likely to be adequate, not good, and you don’t want a reputation for being unable to produce “good” positioning!

Payments

These should be processed automatically. The practice will be sent a payment statement each month and each grader will receive an activity report. On the latter, each grader is given an ID number (between 1 and about 150). This number can be used to identify yourself on the performance graphs

2nd Grading

This is a vital part of the system. You call down your own 2nd grades so you are asked to perform 2nd grading on a regular basis in small quantities, not sporadically in large quantities. You should only do sufficient 2nd grading to take your overall number of gradings, including primary screen/grade, to 500 over the year – in other words do sufficient to take your number to around 42 per month. If you are an arbitration grader, these count towards the 500, so you may not need to do any 2nd grading. If you screen over 500 patients per year, please do not do any 2nd grading unless specifically requested. The uptake of 2nd grading will be monitored on a per practitioner basis.

Remember, you **MUST** grade at least 500 episode each year (April to March).

Referral of Cataract

There has been some confusion about referring cataract. Generally this should be done through the usual channels – so for T&G this is GOS18 and for all the rest it is via their direct referral pathways – unless there is also referable DR.

If the images are ungradeable, do SLBIO. If SLBIO results in a grade, then enter it and the outcome that flows from it. Obviously if this is refer for DR, then simply add a note that there is also cataract and let that referral go through DRS. If the outcome is routine annual (or 6m) review, then enter it and refer via the cataract pathway separately – by the time of the next screen, the cataract should have been dealt with and the patient will be recalled in the normal way.

If it is not possible to screen even with SLBIO but the patient does not wish to have surgery, then they need referring via DRS for a view on exclusion from screening.

Other non-DR referrals

Do not use the outcome option "non-DR referral". There is no mechanism within Vector for processing such a referral and we are waiting for the option to be removed. You need to make such referrals in the normal way via a GOS18/ARC/Fast track AMD etc. Second, the outcome needs to be that required for screening purposes. So if you are referring for glaucoma, or a BRVO or whatever, that patient will still need screening again in accord with their retinopathy grade. Note that for something like a BRVO you grade the retinopathy (if any) not the haems from the BRVO, which are not DR)

So the answer with non-DR referrals is to pick the outcome relevant to the DR grade and simply make a note under other lesions, or in private patient notes that you have referred for X,Y or Z outside Vector.

Other Lesions

If you make a note of a temporary lesion, it does actually stay there for all time unless you later remove it.

So, in the case of a recent patient, I noted cataract for the right eye, and in 2007, ticked "CRVO or BRVO" and added a comment of "small BRVO inf nasal". This all gets printed in the results letter to the GP.

I have just screened her again, the BRVO has vanished, but I didn't think about the other lesions. So the GP letter still says she has BRVO etc.

So, if you note a lesion which is temporary, and it isn't there next time, you need to take it out!

Immediate SLBIO Queue

This is a common queue, visible to all. Obviously you should only open your own patients – clearly it would be difficult to Volk a patient who was not present anyway!

When undertaking immediate SLBIO, you **MUST** choose "immediate SLBIO" in the outcome from photography then exit to the front menu and go back in to choose the patient from the immediate SLBIO queue. This marks the outcome for subsequent graders as "immediate SLBIO". If you do not (and instead enter the grades on the photo screen along with inadequate), then it will go for 2nd grading and the 2nd and arbitration grader will not know that you have carried out SLBIO and they will send your patient for further SLBIO.

Help

"HOW CAN I?" Questions on Vector

First port of call for help with the software are the administration team on 0161 212 2100.

There are also electronic manuals which can be sent to you by email on request from the admin team.

Clinical or Best Practice Queries

For queries relating to the use of the software in a more clinical sense contact the programme advisors:

Trevor Warburton	trevorwarburton@tjwarburton.co.uk	0161 480 6432
Robert Brown	robertbrown@stottsopticians.co.uk	0161 794 7703

IT Problems

For technical problems relating to the Vector or the VPN connection, you should ring the Salford IT help desk on **212 4130** and log a call. Please make sure that it isn't your broadband connection at fault before you connect (can you access the internet?).

The helpdesk will issue you with a call reference number. It is **vitaly important** that you make a note of this number and quote it during all contact with the helpdesk. The helpdesk's principal function at first contact is to make an accurate record of the issue, assess priority and assign a reference number. From this point the job will be automatically assigned to a technician who will get back to you.

Fallback position

As many will have discovered, the emergency Vector icon is not currently working but is for a future version which will operate if your connection is down.

In the meantime, if you are using Vector and it stops working, then the fallback position from now on is as follows:

- Inform IT of the problem and tell admin you will have to use the paper fallback option.
- Screen and capture images into your own imaging software
- Grade and enter the results onto the paper form.
- When Vector is up and running again, enter the results in the same way as for immediate SLBIO (run through, mark as inadequate and immediate SLBIO, exit and choose SLBIO then enter the results.
- Make a note in the private patient or visit notes that Vector fell over and these grades are by the fallback option.
- Send the paper form to the admin team (keep a copy) by post or fax (0161 212 2009)

The form is available on the website at www.smdrs.org.uk and has already been sent to you by email. Please email the admin team if you have not received this form as a matter of urgency.

Missing Images on 2nd grading

As we have largely caught up on 2nd grading, there is a risk that a 2nd grade is supplied in the queue before the images have been uploaded. We don't have much trouble with failures these days so if you find one with no images, I suggest you exit and leave it in your queue for 24-48hrs and then try again. Generally you will find the images have caught up.

Patients under the care of the hospital for DR

In the longer term these patients will be suspended from screening and will not be invited. It will be one of the functions of the admin centre to periodically check to ensure that these patients remain under active care and have not been lost to follow-up.

Everywhere except Stockport

If a patient has been invited for screening and it appears to be under the active care of the hospital for DR, then you use your judgement as to whether to screen them. If they have been seen recently, then don't screen, just wizz through to the grading screen and pick discharge with a reason of under care of X. **Note that this only applies where they are under care for DR.** It does not apply if the only reason they are attending the hospital is for, e.g. glaucoma or dry eyes. These patients should be screened in the normal way.

If the patient has referable retinopathy and you are confident they are under active management, then make a note for the 2nd and arbitration grader which explains why you are recommending discharge rather than referring. If you suspect they may have been lost to follow-up, then allow the referral to go ahead in the normal manner.

There is an option to indicate if the patient is under the care of the hospital and to make a note of the last date the retina was checked. This is not, by itself, useful information to subsequent graders. It is important to add a text note to confirm they are under active care for DR. Remember, if they are under the care of an ophthalmologist for a condition other than DR then it is irrelevant when the retina was last checked at the hospital – they still need to be screened within the programme.

If you have reason to believe that the patient may have been lost to follow up, then use the outcome as if they were not under care (review or refer).

Stockport

Because of fears of patients being lost to follow up, Stepping Hill consultants have asked that all patients be screened. Again, use your judgement. If they have only just been seen, then mark them for discharge and don't bother screening. Admin will reinstate them for annual review. If they have not been seen recently, then screen them. If you find referable retinopathy and have reason to believe they are under the care of a named consultant, then I (TW) normally write to the consultant saying what I have found. I then mark for discharge and make a text note that I have written to the consultant and please reinstate for annual review. If you don't do that, then the episode will go for 2nd grading and then get referred, probably to another consultant, so writing just helps keep it tidy.

Notes

Remember that if you wish to send a message to subsequent graders, then use the private patient or visit notes. The normal patient notes are reproduced in the GP letter, as is text in the "other lesions" field.

If you use "Grading Comments" for a note when doing a grade, note that there are 2 boxes. Please ensure that you use the one headed "Visit Notes" and not the one that says "GP" unless you intend for your notes to appear in the GP letter. I am quite happy to have a message saying "*not sure whether dots in left are exudates or drusen*", but it isn't a reassuring message for the GP, so keep it in the visit notes.

Better still is to put it into PRIVATE visit notes, then there is no danger of them getting printed anywhere. Click the Menu button, then "Visit Notes".

Unfortunately it is not currently possible to access the notes from Immediate SLBIO, nor is it possible to get back in once the patient is allocated to SLBIO, so if you want to make a note, do it before heading for imm SLBIO.

Referrals and Emergencies

It is difficult to think of many reasons to mark something for emergency referral within DR. In terms of DR, retinopathy is generally urgent or routine, but not an emergency. Indeed, R3 is the only urgent referral. Please do not select urgent for any other grade.

If you have a true emergency – acute angle closure from the drops, or a tractional retinal detachment – then you should send the patient to the appropriate urgency service after phoning ahead. Despite the option of emergency referral in the outcomes, Vector is not equipped to handle them. By the time it has processed the information and a letter run has been printed, some time will have passed and for a true emergency you need to pass them on as soon as possible.

BUT – remember that there are almost no true DR emergencies. The reality is that an R3 marked “urgent” will probably get seen in the right clinic by the right person faster than an R3 marked “emergency” which will get sent to the first general clinic, be seen by a junior and then re-scheduled for a more appropriate person to see them.

This section on referrals has been written in conjunction with Lorna Young and Bob Young.

Image Quality

Dark Images

There are some photos being taken where it is apparent that the flash setting of the camera needs to be increased. If your images are routinely darker than some others that you see when 2nd grading, then please wind your flash up a bit. It makes grading much easier. It is also normal to find that darkly pigmented fundi need the flash increasing slightly compared with photographing fundi in caucasians.

Positioning

Those with Topcon cameras that have not been modified to allow the internal target to be correctly positioned to capture the required fields of view will need to use some kind of external target for some of the pictures. At the moment, some Topcon users are producing a very low number of "good" images and a high number of "adequate", and this is down to field position.

We will all have seen those images which are perfectly clear, but badly positioned and thus inadequate. In these cases where you feel that the original screener should be asked to recall the patient and photograph them again, you should select re-book and, for the benefit of admin, should also make a text note in private visit notes to the effect that the original screener should be contacted and asked to recall the patient due to inadequate positioning of the photos.

In these cases, the original screener will not be paid for the original screen, but will be paid for the repeat. The 2nd and arbs will be paid as normal.

Obviously, if the images for one eye are out of line due to HM vision, then you may wish to consider whether you can see sufficient to let it go. I am always slightly loathe to inconvenience an 85 year old with HM vision if I can really see enough!

Clarity

A number of images are being rated by 2nd graders as inadequate. Often this is correct, but not always. Images from the NW100 camera get rated inadequate very frequently. It must be remembered that images from the NW100 are the lowest resolution images you will see and so they do look a bit grainy compared with images you may be used to from your own higher res cameras, and they cannot be enlarged to the same degree. Nevertheless, they do meet the minimum required specification. When viewed at 100% size (as recommended), the diameter of the image will just about match the vertical height of your monitor. Ensure you use red free and fiddle with the brightness/contrast using Ctrl and mouse to bring out the vessels. If you can see vessels near the macula, then the image is good enough and you should grade what you can see.

Discussion Group

There is an email discussion group for SMDRS screeners. So far about one third of screeners are members, but they have found that it is a useful place for asking questions about Vector, or about grading or screening generally. It is a private group and there are no members other than screener/ graders.

If you want to subscribe, either email Trevor directly, or go to:

<http://groups.google.com/group/smdrscreenersgroup>

and send me a message through there.

Grading advice

Remember that many screening episodes will be assessed by a 2nd and possibly an arbitration grader. It is possible that they may not agree with your opinion, so you should always add the caveat to any discussions that the images are subject to 2nd opinion and QA and that the patient will get the final result in writing. Remember that this may affect the re-screening interval as well.

In particular, remember that any DR flagged for referral will go to the image triage queue and will be assessed by an ophthalmologist. In some instances the decision may be that referral is not required, simply continued monitoring. In your discussions with the patient you should ensure that they understand the process. It is unwise (and unhelpful) to leave the patient thinking that they will definitely receive an appointment for the eye clinic.

It is best to say that there are some signs that require a further opinion. You will send the images for review by an eye specialist and the patient will receive the final result in writing and if they require referral they will be sent an appointment.

Roth Spots

There was a discussion at a CE evening of the "Roth Spot" haems - diamond shaped haems with a white centre. We were speculating whether these were exudates or not. Lorna has been looking into this, and the following came from a research fellow in her department:

These haemorrhages may be round, oval, or flame-shaped, with a white spot in their centre. They arise as a result of retinal capillary rupture with extrusion of whole blood: May be regarded as a gradual exudative event in diabetes, [but not "an exudate"]

There is subsequent platelet adhesion to damaged endothelium and the clotting reactions result in the formation of a platelet-fibrin thrombus.

Morphologically, this fibrin thrombus appears as a pale white lesion in the centre of the haemorrhage.

Underlying microaneurysms have been reported within diabetic Roth spots

There are variety of classical conditions associated with Roth Spots:

Subacute bacterial endocarditis

Leukaemias

Anaemia

Hypertensive retinopathy

Pre-eclampsia

Diabetic retinopathy.

So, basically the white in the centre is fibrin and these should not be regarded as exudates - just class them as a haem.

City & Guilds

Instructions for submitting modules to the assessor (Ivan Wood) and then to City and Guilds are on the website at www.smdrs.org.uk

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