



THE COLLEGE
OF OPTOMETRISTS



Better data, better care
Ophthalmic public health data report 2013

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Acknowledgements

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About the College of Optometrists

The College of Optometrists is the professional, scientific and examining body for optometry in the UK, working for the public benefit.

Supporting its 13,000 members in all aspects of professional development, the College provides pre-registration training and assessment, continuing professional development opportunities, and advice and guidance on professional conduct and standards, enabling our members to serve their patients well and contribute to the wellbeing of local communities.

About this report

The aim of this report is to stimulate debate and to highlight actions that we believe are needed to improve public eye health.

This report has been compiled through a process of research and engagement within the ophthalmic public health sector. A review of the available literature on ophthalmic public health data was presented to a workshop of optometrists, ophthalmologists, and other representatives from the sector. Both the findings of the literature review and the discussions from the workshop have informed this report. While the views in this report are entirely those of the College of Optometrists, we would like to thank those organisations involved for their input.

The report is intended to be read by a wide range of interested parties, including politicians, civil servants, local authorities, trade, regulatory and consumer bodies, as well as the media.

For more information on the background to this report, please contact the Public Affairs team at the College of Optometrists on: **(0)20 7766 4301**

Executive summary

It is impossible to deliver patient centred care without data and information on health and social care. Ophthalmic public health data, as collected by optometrists, ophthalmologists and other clinicians have a key role in improving care and ensuring that care is appropriate for the population and is good value.

The availability of useful data on significant sight loss and blindness enabled an eye health indicator to be included in the Public Health Outcomes Framework for England in 2012, which sets out desired outcomes for public health. The eye sector should support this indicator and the data set it is based on to ensure that eye health continues to be recognised within the greater public health sphere. Similar measures to recognise eye health within public health should also be supported in Wales, Scotland and Northern Ireland.

While the eye health indicator is a success, other data sets within the sector are subject to variation in quality. For instance, the data for NHS sight tests could be improved by moving to an electronic system and reviewing the data collected. Optometrists and other clinicians should also be made aware of how they can use data and the factors that contribute to its quality. Data and information on services can enable clinicians to assess their local communities' care needs, and commissioners to identify and provide better quality services at greater value to the public purse.

Introduction

Optometry has much to offer patients within the modern health service. Eyesight is consistently identified as the sense we most fear losing, and optometrists are trained graduate clinicians whose role is to help the public look after their eyes.

Optometrists not only examine the eyes to detect defects in vision, but also to detect signs of injury, ocular diseases or abnormality and problems with general health, such as diabetes. Optometrists are normally conveniently located within a community, have readily available appointments, and are likely to have weekend and evening opening hours.

In short, they are an accessible resource for the public. Together with ophthalmologists and other eye health professionals, optometrists help protect the public's eye health. Optometrists can also ensure that no one has to live with poor vision that can easily be corrected with a pair of glasses.





Context

Those who are familiar with the profession will be aware of its many benefits. But what about those who are not? How can we as a profession ensure that the public understands why optometry is important for them?

Further, how can we ensure that those who commission health services understand that optometrists are able and willing to provide services above and beyond the conventional sight test?

Data and evidence should be the drivers behind decisions about health and social care. The National Institute for Health and Clinical Excellence (NICE) has created NHS Evidence as a service to provide data and to help people from across the NHS, public health and social care sectors to make better decisions as a result.

At local level, health and wellbeing boards are being created to oversee local commissioning.

The role of health and wellbeing boards is to coordinate public health in their local areas, and they will use their joint strategic needs assessment (JSNA) to shape their decisions. Essentially a repository of local health and social care data, the JSNA should contain the data and information needed to make good commissioning decisions. If eye health is to be included in a local authority's greater plan for health and social care, good quality ophthalmic public health data must be included in the JSNA. Although many may already be familiar with JSNAs as they have been around since 2007, they now have increased prominence and importance in local commissioning decisions.

"The quality of health and social care data is fundamental to delivering high quality, patient led care. The primary purpose of data in health and social care is to support the delivery of a good quality service to patients and service users. But poor quality of data undermines confidence in information used to plan and commission services, assess quality, facilitate patient choice, support audit and research and ensure effective use of resources. Data needs to be 'fit for purpose' for its intended use. The responsibility for the quality of data rests with individual organisations that generate and provide it; the hospital, the care provider or the GP practice."

*NHS Information Centre*¹

The government is committed to transforming information and technology in the NHS over the next 10 years². A new approach to information and information technology (IT) is laid out in the Department of Health's document *The power of information* and praises the ability of data and information to enable safer, better care which is more cost effective and better meets a population's needs.

Further, the government's vision is to record and collect high-quality data for the purpose of improving care, to do so electronically, and to share it appropriately³. The government has also said that the NHS number should be used consistently as a patient identifier by 2015⁴. They believe that more information on clinical outcomes is needed, and a clear plan for publishing this data is set for 2015.

To accomplish this, the government believes that a step change among health professionals is needed to ensure that all health and social care professionals understand that information is core to good quality care and that they take responsibility for recording, sharing and using information to improve care⁶. All professional staff must become aware of the link between the data they record and improvements to patient care⁷. Further, their message is clear: not sharing data and information has the potential to do more harm than sharing it⁸. To this end, plans have been launched to join up health and social care data sets for the first time to aid integrated commissioning⁹.

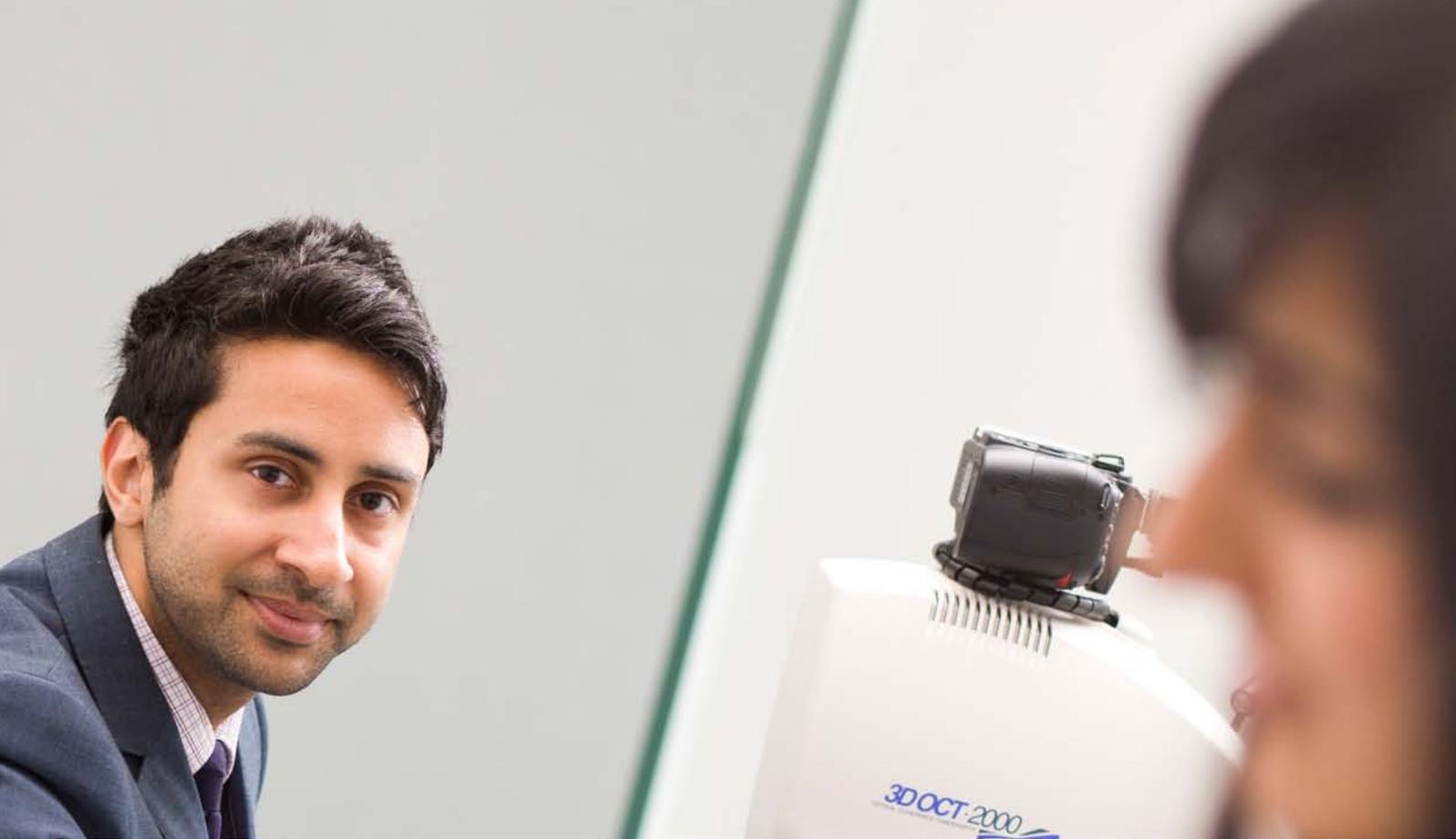
Dame Fiona Caldicott is leading an independent review for the government of the balance between protecting patient information and sharing it to improve patient care, and is expected to publish findings shortly¹⁰.

Clearly, good quality data are needed for optometrists to make a convincing argument to commissioners about the services they can provide. Data are needed for commissioners to realise that optometrists are able to provide high quality, good value care and commission accordingly. But this begs the question: Does optometry have the data that commissioners need?

Commissioners will want to see evidence of:

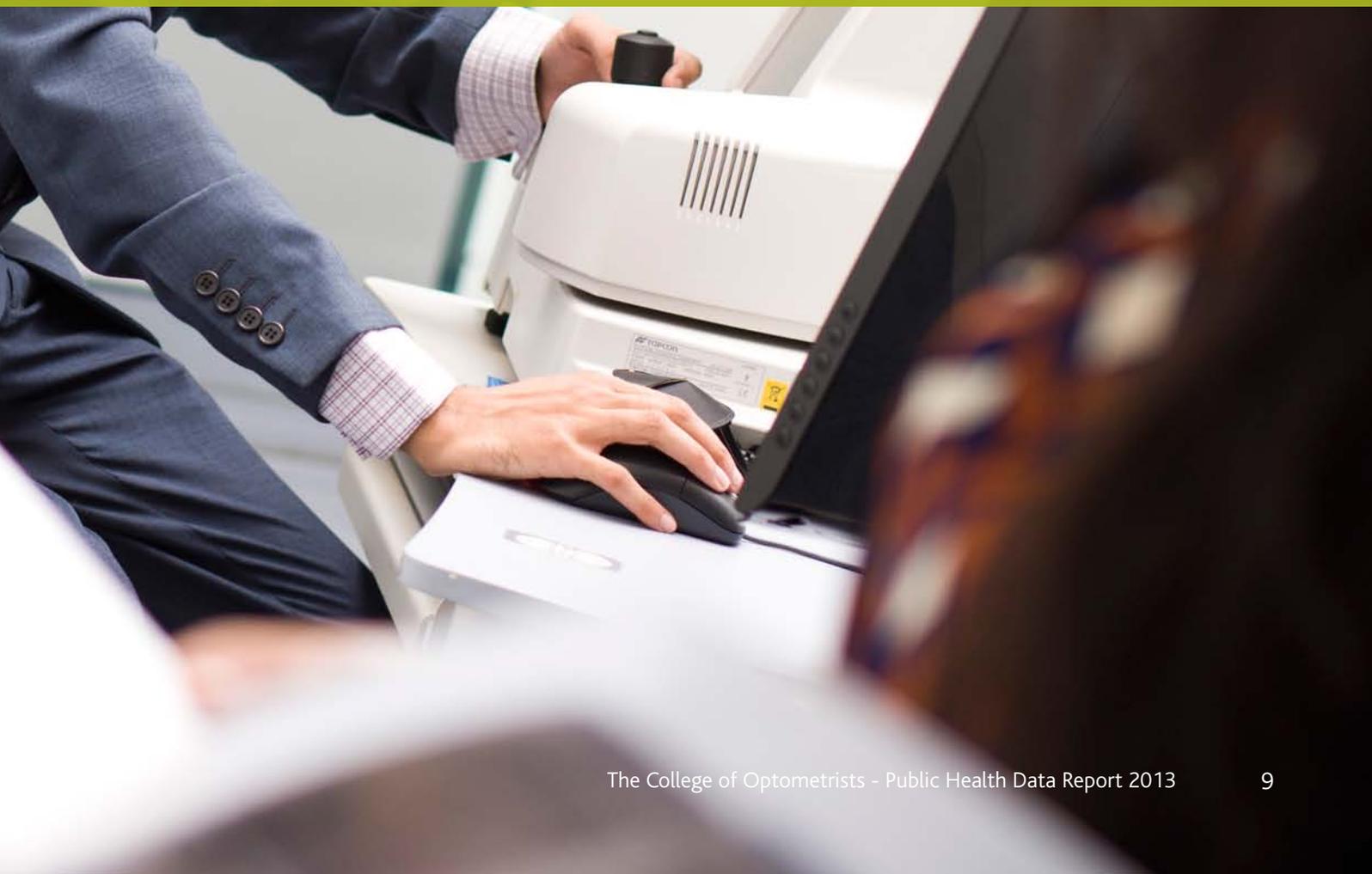
- cost effectiveness
- any variations of care
- patient satisfaction
- effectiveness of alternative models of care
- how care is delivered in the community
- the mechanics of collecting data.

All eyecare providers must be able to provide a record of the quality and good value of their patient care. Ophthalmic public health data should be robust and complete. So, are they? Does the sector have what it needs to participate in the newly designed health service?



There is a new currency in the NHS: information.

*Health Service Journal*⁵



The current status of data

Although significant amounts of data are currently collected through the General Ophthalmic Services (GOS) claims, these are not designed for ophthalmic public health work, and therefore do not provide the data that are needed for good decisions.

The mechanisms for collecting data and the quality of data are similar in England, Wales and Northern Ireland and the analysis below encompasses all three countries. Scotland's arrangements for data collection are different and will be addressed separately within this report.

The Public Health Indicator for Eye Health

In January 2012 the Department of Health drew attention to avoidable sight loss by including an eye health indicator in the Public Health Outcomes Framework for England. The indicator will track the rates of three major causes of sight loss including glaucoma, age related macular degeneration (AMD) and diabetic retinopathy. The indicator is based on certificates of vision impairment (CVI) data, and the eye health sector's ability to convince the government to include this indicator owes some of its success to the existence and quality of the CVI data set. No other sensory impairment indicator was included within the Framework.

A CVI is a document stating that a person has a significant sight problem affecting both eyes that is not correctable with either spectacles or contact lenses. The process is completely voluntary and is the first of a two-part process.

When a CVI is completed, one copy is sent to the certifications office at Moorfields for anonymised analyses. A second copy is sent to the patient's social service department who contacts the patient, offers them a needs assessment and formally places them on the register (completing registration). Ophthalmologists are responsible for starting the certification process, but optometrists, administrators and social care professionals are also involved and can help facilitate the process.

The CVI data set is a useful data source for the causes of uncorrectable visual impairment. However, this measure could and should be improved. There is concern about coverage of the data set and it is important to note that registration cannot occur without the offer of certification from a consultant ophthalmologist. There is considerable anecdotal evidence that CVIs are regularly not completed for a variety of reasons and that in some instances patients may not be being informed that this is an option. The result is that while the CVI data set is useful and important, there is clear scope to improve and strengthen it. It is important to ensure that CVI data are as rigorous, timely and universally applied, and thus as reliable as possible.

More should be done to educate clinicians and providers on the importance of timely, complete submissions of CVIs to social services departments, including raising awareness about criteria for certification – ie when a person with visual impairment should be certified. Patients should be certified for two reasons. First and foremost, every patient who is seen by an ophthalmologist / hospital eye service and who meets the criteria for a CVI should have this recorded so that this vital data can be used to monitor the effectiveness of interventions aimed at improving ophthalmic public health and reducing sight loss / visual impairment. Secondly, patients who are eligible should be informed of this and be given the option to be registered without the delay to enable them to access social support to which they are entitled. Such an approach would ensure effective interventions are available to patients to access and that the CVI data set is further strengthened to improve its utility as a public health measure.

IT systems and data

While CVI data is an important part of the ophthalmic public health data set, it is also part of a much larger picture. The eye care pathway involves many different settings of care which include high street practices, hospitals and GP surgeries – but communication between these can be difficult. This is contrary to the NHS's commitment to continuity of care, and also does not help accurate and timely data collection.

The vast majority of optometrists provide both NHS and private clinical care to patients in non-NHS premises.

While there are optometrists who work in hospitals, the majority of eye care is delivered by optometrists in the community, for example in the town centre or other area of commercial trade. This can improve accessibility for patients, but means that optometrists often face difficulties if they need to communicate with other NHS clinicians.

One of the most detrimental factors to ophthalmic public health data is the NHS's reliance on paper-based systems within optometry. Optometry practices are now often incredibly advanced in terms of the electronic capture and management of their patient records. However, while optometrists have set up sophisticated practice management systems, the NHS still requires paper submission for several common transactions and communications.

Information governance requirements require optometrists to use NHS secure email for patient and confidential data. Also, optometrists are not yet able to access the NHS's choose and book system and this can create inefficiencies communicating within the NHS. Those not on NHS secure mail are unable to email letters of referral, test results, or images of the eye to hospital eye departments or GP surgeries, to access a patient's medical history, or to request payment for an NHS funded sight test. Paper based systems have been eschewed by banks, utility providers, and many parts of the NHS as outmoded and cumbersome. Yet in optometry, the NHS mostly still relies on paper submissions for referrals and GOS claims.



Eye care services and data in Scotland

The new general ophthalmic arrangements were launched in April 2006. Working on the principle of “Shifting the Balance of Care”, this allowed Scotland to redesign its primary eye care services, and over the next six years there has been a progressive consequential change in secondary eye care services. The concept of universality underpinned the new arrangements and at the same time the new expanded NHS funded eye examination became free to all. Universality has been shown to increase uptake of services amongst all groups. Almost all eye examinations performed in Scotland are NHS, and GOS forms are submitted to a central payment agency. As a result, there are minimal numbers of eye examinations not included in Scotland’s official data sets.

While we fully recognise the importance of having information governance requirements to prevent any patient identifiable data going astray, being inappropriately accessed or ending up with an unintended recipient, we are also confident that these risks can be eliminated with appropriate investment in new systems of technology and guidance for users.

From a community perspective we strongly believe that there are instances where it is clearly in the patient's interest to share data and information electronically between primary care providers and between primary and secondary care. This is particularly true for shared care schemes. There is evidence that patients find the eye care system to be confusing and disjointed, and this can create barriers to their seeking appropriate care¹¹. Any steps that we can take to improve a patient's continuity of care should therefore be seriously considered.

GOS data

Data on NHS funded sight tests (which make up 70% of the total number of sight tests¹²) come from forms that are primarily a means of processing claims for fees and so have limited use in populating an ophthalmic public health data set.

Sight testing in England, Wales and Northern Ireland is carried out under the GOS contract or privately. NHS sight tests are available for certain groups of people, including those who:

- are under 16
- are under 19 in full time education
- are over the age of 60
- have certain medical conditions or a family history of glaucoma
- are on certain state benefits.

The GOS contract is negotiated nationally and as a result of the changes in the NHS will be managed from April 2013 by the local area teams of the NHS Commissioning Board. However, the mechanism for implementing the GOS contract will continue to vary, at least initially, from one local area team to another. Only a small proportion of GOS forms are submitted electronically, the rest being manually processed paper forms. In some cases, forms submitted electronically still require that a paper copy be sent through. A paper system is not only costly and labour intensive for both sides but also introduces another variable into the quality of the data collected. This is because input into the system differs from area to area, and while some enter the all the data from individual forms, others make batched or aggregate returns, which do not have the same level of detail. The electronic submission of GOS forms from GOS contractors should be a priority for the NHS Commissioning Board enabling both significant savings for contractors and the NHS and improvements in the quality of the data collected.

GOS forms do not include information about ethnicity, which limits the empirical evidence available to help support interventions to reduce health inequalities. This lack of information about minority and disadvantaged communities also affects commissioners' ability to understand their communities' eye health needs and patients' attitudes towards their own eye health¹³. While a clinician can fill in multiple reasons for eligibility for the NHS-funded sight test, for example a person who is both over the age of 60 and has diabetes, only one of these is entered into the system. This means that the data from NHS sight tests does not accurately capture why someone is receiving a free sight test.

Finally, GOS forms do not include a patient's NHS number. Although this is not currently a significant issue, given the government commitment to using the NHS as a unique identifier, it might prove problematic in the near future. In theory, using the NHS number to link each patient's records would allow for the integration of care. The optical sector should work closely with the government to ensure that any requirements for the use of NHS numbers are workable within the sector and achieve identified patient benefits.

IT effect on referrals

Optometrists currently refer approximately one million patients a year to their GP or hospital eye service¹⁵, but this is primarily done using an inefficient paper based system. As well as being subject to delays using the postal service, paper referrals do not allow good quality images from retinal cameras or ocular coherence tomography (OCT) images to be sent with the referral. This hampers the receiving clinician's ability to prioritise the patient, directly impacting upon patient care.

The paper-based system can constrain the quality and detail of those referrals. Equally as important from a public health point of view, it also means that there is little data on why referrals are commonly made, what the accuracy of those referrals is, and the ultimate outcome for the patient.

There is also no agreed referral form, which means the content and organisation of referral forms is different from one area to another. The sector is encouraging the Department of Health to develop and introduce an agreed GOS18 referral form template and must work with the Department, and in future the NHS Commissioning Board, to introduce electronic submission systems.

Outpatient data are available from NHS Information Centre's (NHS IC's) hospital episode statistics system, but information on primary diagnosis is limited and clinic level data is not available. The NHS IC's hospital episode statistics system does include referrals from optometrists, but most optometrists' referrals are grouped with GP referrals as they are often sent to the GP first. Without scope to audit referrals efficiently, it is difficult to identify patterns and trends and to target information and education for the profession.

"Patients... want organisations not to argue between themselves or send conflicting messages. They expect professionals to work together as a 'team around the patient', and they want services to work together likewise: that is, to come together at the point they are needed, and to meet people's needs in the round."

*Integrated care for patients and populations*¹⁴



An improved electronic system for referrals would reduce the cost burden of eye care to the NHS, helping to eliminate unnecessary referral appointments as well as duplicated tests. The technology is available to enable this, but the will from the government to integrate patient pathways in eye care fully is needed to implement this effectively.

Private eye examinations

In addition to NHS funded sight tests, there are privately funded eye examinations in England, Wales and Northern Ireland. The NHS IC used to provide an estimate of private sight tests, but because of concerns about data being outdated and the results being misleading, this is no longer done. As a result, there is no government body which publishes available data on the overall number of sight tests each year. This includes, for example, the number of sight tests taken up by regular VDU users, funded through their employers. The only publicly available estimated data on the overall number of sight tests each year is the publication *Optics at a Glance*, published by the Optical Confederation.

Optometrists and data

Although government at both a national and local level can do much to improve ophthalmic public health data, the optometric sector itself can do much to develop better data. The optometric bodies have a fundamental role in addressing this.

As many clinical professions have already done, the optometric bodies must convince their members that data and data collection are important. They must show their members how good data will create opportunities for the profession to provide enhanced services. If optometrists can prove their ability to provide quality patient care that is good value, they will be well placed to ensure that the services they provide are taken up by their local commissioners. Optometrists providing services beyond the correction of refractive error and the checking of eye health is essential for the future of the profession. The more patients go to their optometrists for the identification and management of eye disease, the more they will see optometrists as clinicians – clinicians who should be their first port of call for any eye related issue.

Conclusion

The quality of ophthalmic public health data is mixed. The public health indicator on eyes and the CVI data on which it is based is a positive measure and should be supported. Where possible, however, the sector should continue to seek improvements to the CVI process to ensure the long term success of the public health indicator on eyes.

Beyond the CVI process and the indicator, there is much work to be done. There are many challenges to improving ophthalmic public health data, including developing IT systems to improve data collection

and working with optometrists and other clinicians to ensure they are doing their part to improve the quality of data.

The College of Optometrists will continue to work with others in the eye care sector to support the public health indicator, to improve IT systems and review the data collected, and to further educate our members about how they can contribute to improved ophthalmic public health data. Robust data will help ensure that eye care is patient centred and meets the public's need, is of good quality, and provides value for money.

Recommendations

Support the public health indicator on eye health

- Work to improve the quality of data obtained from the CVI process to ensure that the eye health indicator remains in the public health outcomes framework beyond 2016.

Improve IT systems and review the data collected

- Move to electronic systems for GOS payment claims.
- Include information about ethnicity on and record all data from GOS forms to better understand the eye health needs of the local population.
- Move to electronic systems to enable community optometrists to communicate with hospitals and GP surgeries and include back-up information with referrals.

- Encourage the completion of the Department of Health project to produce a standardised data set for referrals (GOS18).
- Design a system which will allow referrals from optometrists to be clinically audited.
- Work with the government to include the NHS number in a way that is feasible to operate in community practice.
- Reintroduce a system to provide a more accurate estimate of private sight tests.

Work with optometrists to highlight importance of data collection

- Help optometrists understand how the collection of full and accurate data will protect the future of the profession and raise its profile with key decision makers, other health professions and the public.



The Eyecare Integration Project in Scotland

Following a successful e-referral pilot in Fife, Optometry Scotland led the business case for an electronic link between practices and the NHS from November 2008 to October 2010 when funding was made available.

Since then the Eyecare Integration Steering Group has been working to implement the project. This IT link will enable optometrists to refer patients direct to ophthalmology departments, a general practitioner or other health professionals.

Through this £6.6m project the Scottish government is building on the 2006 GOS changes and the two equipment grants, which placed digital retinal cameras and improved standardised equipment for eye examinations into every practice.

Considerable work is being undertaken at present, with agreements for five disease targeted referral templates, agreed protocols for photographic and other scan attachments, auditing practice hardware and software, and testing the protocols for linking practices. There is a target of electronic referrals reaching 50% by 2013 and 95% by 2014 of all referrals.

This electronic link will also provide access to practitioner services. It is hoped that in tandem with referrals, an electronic payment system will facilitate the submission and reconciliation of payments to this central payments agency.

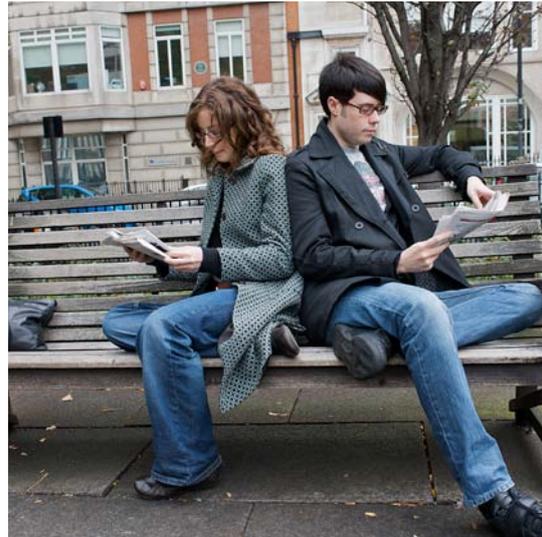
Changes will be needed within optical practice management systems and the networking within practices of the various pieces of equipment. Financial help will be required to facilitate uptake of the electronic link. Health boards are already receiving some money to help facilitate the process, but the new system needs to be easier than now to encourage practices to adopt it.

The benefits to the patient journey and outcomes, service provision within hospital eye departments, and practitioner services costs will quickly follow.



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Philippa Simkiss, RNIB
Hal Rollason, Optometry Scotland



¹ NHS Information Centre (2012) The quality of nationally submitted health and social care data in England - First Annual Report 2012, Experimental Statistics.

² Department of Health (2012) The power of information: Putting all of us in control of the health and care information we need.

³ Ibid.

⁴ Ibid.

⁵ "Full Measures, Roundtable: Commissioning Information". Health Service Journal 28 June 2012: 20-23.

⁶ Department of Health (2012) The power of information: Putting all of us in control of the health and care information we need.

⁷ Ibid.

⁸ Ibid.

⁹ Williams, D. "Plans launched to integrate health and social care data." Health Service Journal 5 July 2012: 6.

¹⁰ <http://caldicott2.dh.gov.uk/>

¹¹ RNIB (2012) Preventing avoidable sight loss.

¹² Optics at a Glance 2011. Optical Confederation.

¹³ Britain's Eye Health in Focus (2011) College of Optometrists.

¹⁴ Goodwin, N et al. (2012) Integrated care for patients and populations: Improving outcomes by working together. The Kings Fund and the Nuffield Trust.

¹⁵ Optics at a Glance 2011. Optical Confederation.

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