Department of Health - An Information Revolution – a consultation on proposals

Overview

Together the Optical Confederation represents the 12,000 optometrists, the 6,000 dispensing opticians and 7,000 optical businesses in the UK who provide high quality and accessible eye care services to the whole population. The Confederation is a coalition of the five optical bodies: the Association of British Dispensing Opticians (ABDO); The Association of Contact Lens Manufacturers (ACLM); the Association of Optometrists (AOP); the Federation of Manufacturing Opticians (FMO) and the Federation of Ophthalmic and Dispensing Opticians (FODO).

We are pleased to have the opportunity to comment on this consultation. We do so from the perspectives of our eye care patients and as providers of community eye care services.

The Optical Confederation has welcomed the Government's *Liberating the NHS* reforms. Operating in a genuinely open and competitive market, the optical sector already provides high levels of quality, access and choice to all patients in every part of the UK at excellent value to both patients and the NHS.

The Optical Confederation supports the Information Revolution response from Pharmacy Voice and we have highlighted some specific common concerns in our response below.

Information Revolution

1. Turning to this consultation in particular, the optical sector welcomes the information revolution promised in the Foreword (p3).

2. We welcome the Government's proposals

   - to ensure that "GPs and other health care professionals are being encouraged to enable patients and service users to communicate with them and to access services on line" – in community optical practices patients are increasingly able to book optical appointments either on line or via a simple telephone access point (p6)

   - "patients and service users (should be) able to keep a copy of their care record themselves" and if they wish, "share that copy as they see fit with others" (p6) and "that confidentiality and privacy in relation to personal information remain critical priorities for those who hold patient and service user records" (p6)

- that "types of information need to be available to enable patients, service users and their carers to make fully informed choices". In our sector patients already have a very wide range of optical practices to choose from – all of whom compete vigorously to meet their patients' need and to attract them to their practice.

3. We do, however, have a concern about "the publication of data, both locally and nationally, as being crucial to public accountability" (p8). Our recent experience is that unintelligent application of these principles has led to some PCTs proposing to publish commercially sensitive data about income for individual optical practices.

4. Given that all optical practices already operate in a highly competitive commercial market, practice level data should not be published in the name of 'the public interest'. On the contrary, publication would be against the public interest in that it would interfere with the functioning market in optics and may affect the important drivers of quality, access and choice on which the market depends. We would support the comments from Pharmacy Voice that this would be unfair.

5. It is important therefore that the Department establishes clear parameters for how such information should be released, as has also been argued by our colleagues in Pharmacy Voice. Aggregate regional (or GP consortium-wide) information is of course, no problem and an important tool in enabling the public to see how much resource is spent in various areas of health care. What we are opposed to is the publication of detailed information at practice level which would be commercially sensitive and, if published, would distort the effective operation of the market.

6. Other than that caveat, the Government is largely pushing at an open door in respect of the 'information revolution' for community optical practices. The optical system has recently been described as a model or 'exemplar' of how the Government's *Liberating the NHS* reforms should operate[1]. It is clear that, with the simple and pragmatic "information" steps detailed below, the community optical sector could provide far more ophthalmic care outside hospitals in accessible community locations and at lower cost i.e. delivering fully on the NHS White Paper and QIPP reforms.

Simple IT Links

7. An important requirement from our perspective is the need for simple, proportionate and cost-effective IT linkages between community optical practices and other parts of the NHS. Ideally we simply need secure email transfer or NHS Mail. We have had difficulty in the past with a 'one size fits all' approach to IT and information governance from Connecting for Health which has been a hurdle to improving our connectivity with the NHS.

8. Full N3 connection and the onerous information governance requirements developed for other services by NHS Connecting for Health are unlikely to be necessary for referrals or

[1] Liberating the NHS: Eye Care, Making a Reality of Equity and Excellence, Bosanquet, N. December 2010

interchanges between community optical practices and the rest of the NHS. We feel that it should be possible to utilise less expensive secure connections, which are acceptable to the banking industry or other parts of government, for secure email and data exchange.

9. Optical practices in the UK are already committed to appropriate information governance through the compliance package *Quality in Optometry*[2].

Centralised Claims and Payments (as for dentists and pharmacy)

10. Much valuable trend and probity information has been lost by the previous administration's decision to devolve optical claims and payments – for what is essentially a single national sight testing service – to each PCT.

11. This has resulted in a multiplicity of data management and collection systems within the NHS, which has added to cost and complexity both for the NHS and providers – costs ultimately borne by front-line care. Moreover the significant advantages that this rich data pool would have provided have been lost.

12. Twice under the previous administration, the national optical representative bodies had requested the development of a national electronic claims and payment system analogous to those for community dentists and community pharmacists. Despite at one point Ministerial agreement (Jane Kennedy) and a further consultation (Ann Keen), for some mysterious reason which was never explained to us, this was never progressed.

13. We are now repeating this request of the new Government and are more hopeful of success this time. Optical claims and payments could even be bundled with dental claims and payments due to the similar nature of both contracts and possibly contracted-out by the Business Services Authority (BSA).

14. The development costs to centralise optical claims and payments should by and large already have been incurred because the system for dentists should be easily transferrable to community optical practices. The inclusion of optics within a package that could be tendered for would make it more attractive to potential outsource providers, more efficient for the NHS and less costly for optical practices – the very model of a 'win, win, win' situation.

National Quality Standards (Pathways)

15. The approval of national pathways for community ophthalmic services e.g. glaucoma referral refinement, stable glaucoma management, cataract, minor emergencies in the community etc is long overdue.

[2] http://www.qualityinoptometry.co.uk/

16. The first attempt at this was in 2004[3] and there have been many since; more recently the excellent Local Optical Committee Support Unit (LOCSU) pathways (described by NICE is respect of glaucoma referral refinement as 'flawless').

17. As *Liberating the NHS* proposes, national quality standards (pathways) approved by NICE will, ultimately, simplify matters for patients, providers, GP commissioners and the public. Although these would need to change over time as technologies and evidence changed, nevertheless, having single national pathways would make information simpler and more available for patients, practitioners and the public alike.

18. National pathways would not of course preclude local customisation to align with local systems and requirements, e.g. geographic spread of patients. They would, however, significantly reduce complexity, cost and risk for patients, the NHS and professionals.

19. We recognise that approval of national optical pathways (quality standards), other than for glaucoma, may not be a priority for NICE in the short term. However there are now sufficient tried and tested models (e.g. those developed and published by LOCSU) which could be recommended to GP consortia by the Department of Health/ NHS Commissioning Board for national implementation, saving costs to the NHS and enabling the Government's reforms to be implemented fully in the eye care sector.

20. These could be approved/commended by the Royal College of Ophthalmologists and College of Optometrists in the first instance and then subsequently approved by NICE when resources permit.

Information to Practitioners

21. As far as information support for practitioners is concerned, we already have excellent professional guidelines developed by the College of Optometrists for optometrists and the Association of British Dispensing Opticians (ABDO) for contact lens and dispensing opticians, and which are approved by the optical regulator the General Optical Council.

22. These are regularly updated, including with stakeholder and lay input, to ensure an up-to-date peer view and are available to all practitioners, accessibly and cheaply on line.

23. These two trusted sources provide all the information that optical practitioners in the community need and we would be concerned about the development of any additional sources of information which might be less evidence-based and well-researched, and which could lead to confusion.

Information to Patients

[3] *National Eye Care Services Steering Group First Report,* NHS Modernisation Agency, April 2004

24. In optical care, the sight testing regulations already require all patients attending for a sight test to be given
    - either a copy of their prescription
    - or a written statement that no prescription or no change in prescription is necessary
    - a copy of their specification for contact lenses which will enable the lenses to be replicated from alternative providers
    - copies of referral letters to their GP, hospital eye department or Choose and Book centre.

25. In addition all practices provide a practice leaflet (or information leaflet for mobile providers) for new or existing patients and have an agreed practice information and publications policy based on the model agreed for community eye care with the Information Commissioner.

26. These provisions, combined with practice advertising, we believe provide an appropriate and welcome amount of information at both individual and community level. Moreover, given that community eye care operates in a genuinely market driven consumer-focussed sector and NHS providers compete vigorously for patients, if patients or the public required further information, optical practices would compete to respond to their wishes without the need for further regulation. We also have close relations with patient representative groups to ensure we deliver on our patients' information requirements.

27. We feel therefore that any additional information requirements – which might be needed to substitute for genuine market mechanisms elsewhere – should not apply to the community optical sector.

Information Security

28. Against this background of free availability of information, the optical sector nevertheless takes patient data and security issues extremely seriously. All practices have an information security policy based (as noted above) on the requirements of the Information Commissioner and, to date, we have not seen any of the unfortunate leaks in optical data which have so be-devilled parts of the NHS.

IT in 'Bite Sized' Chunks

29. Finally, we would emphasise again the need for simple IT links between optical practices and the rest of the NHS through simple, cost-effective secure email such as NHS Mail.

30. We applaud the new Government's proposal to tackle IT issues in the NHS in appropriate 'bite-sized' chunks and believe that community optical practice is one such chunk that can be easily fixed.

31. Sadly, when major IT programmes have been introduced in the past, optics has always been at the end of the queue which has meant that optical practice are prevented from providing the excellence of service in respect of referrals and discharge information that they provide in other areas. This is not through any reluctance on the part of the optical sector, but through issues of connectivity and poor prioritisation within the previous NHS IT systems. We are fully in agreement with the comments from Pharmacy Voice that community pharmacy, optometry and dentistry should be involved in NHS IT programmes at an early stage.

32. As a sector, we stand ready to help the Department on any of the above issues in any way we can. In the meantime, our responses to those consultation questions which apply to us are below.

Optical Confederation

Q1. What currently works well in terms of information for health and adult social care and what needs to be changed?

A1. Information flows to patients and the public about optical services operate well in the competitive, market-driven community eye care sector. What is less successful, however, has been getting the public health message across to the public about the need for regular sight testing (usually every two years for adults) to ensure pathologies are picked up early and longer term visual impairment and blindness is avoided.

Research by optical providers has shown that the public and patients simply do not respond to this kind of health advertising when promoted by the sector itself – possibly because it is perceived as self-interest. Nor do they respond to such information when published by charities such as the Royal National Institute for Blind People etc as younger people tend to see visual impairment and blindness as the problems of older age and not something they need to worry about.

We would be interested, therefore, in working closely with the Department of Health in its new public health role as well as with local authorities to get across this powerful public health message to all members of the public, particularly excluded and at risk groups, in order to reduce the burden of visual impairment and blindness on individuals, on society and on the health and social care systems as a whole.

Q2. What do you think are the most important uses of information, and who are the most important users of it?

A2. The most use of information in eye care is to inform the public of the benefits of regular sight testing in order to reduce avoidable visual impairment. We would very much appreciate support from the NHS at all levels in getting this message across. We have found in the past that the public are more receptive to this public health

message when it comes from an established NHS body, or indeed, their local authority.

There are five important users of information about eye care

- Public
- Patients
- Professionals
- Government/NHS Commissioning Board in terms of ensuring value for money – which is why we advocate a centralised claims and payments system for sight testing
- GP consortia about a) the services community optical practices offer and b) commissioning feedback about outcomes and cost.

Q3. Does the description of the information revolution capture all the important elements of the information system?

A3: Yes, in terms of content, but no, in terms of infrastructure. In our view, this whole super-structure should be hung on a spine that is predicated on

- simplicity – the lowest possible level of complexity consistent with performance
- efficiency – lowest specification consistent with performance and safety
- cost – simple, non-'gold plated' or highly technical solutions for information transfer between the different parts of the system based on existing secure internet transfer.

In our experience, overly ambitious and complex information strategies often fail because they are not based on the simple tenets above.

We would ask the Government therefore to give careful consideration to how the information revolution is to be delivered in the most cost-effective, ambitious but not unnecessarily complex way to deliver the benefits the Government envisages.

Q4. Given the current financial climate, how can the ambitions set out in this consultation – to make better use of information and technology help drive better care and better outcomes – be developed in the most effective and efficient way?

A4. Please see our answer Q3 above.

Q5. Where should the centre be focusing its limited financial resources and role to achieve the greatest positive effect?

A5. The centre should use targeted funding to encourage the flow of information (for example by funding NICE endorsement of national model enhanced eye care pathways – as recommended by the Bosanquet Report[4]) that would support local developments to meet local needs and to do so on the 'do once and share' principle, spreading the lessons across the NHS and particularly GP commissioning consortia.

In the case of the optical sector, a crucial building block will be a centralised IT claims and payments system as described in our introduction above. This should be fundable at almost zero cost to the public purse by bundling with the reformed BSA contracts for dentistry and pharmacy claims and payments. This would appropriately transfer risk to the private sector, whilst at the same time bringing significant benefits in reduced NHS costs, probity management and reduced burdens on the optical front-line.

Q6. As a patient or service user, would you be interested in having easy access to and control over your care records? What benefits do you think this would bring?

A6. Although not responding as a patient or service user in this instance, as described above, in community optical practice patients are already

- issued with a prescription at the end of a sight test, stating what their visual correction needs are
- or a statement that no prescription or no change in prescription is required
- given a copy of their contact lens specification once contact lens fitting is completed
- have the right to access the records optical practices hold about them and to request copies
- given copies of any referral letters to their GP, Choose and Book or hospital eye department.

We believe this provides all the information about, and access, to community eye care records that patients could wish for. We therefore fully support the Government's ambition not to apply a 'one size fits all' approach and to recognise that access to records may well need to be different for different cohorts of people in different circumstances.

[4] Liberating the NHS: Eye Care, Making a Reality of Equity and Excellence, Bosanquet, N. December 2010

Q8. Please indicate any particular issues, including any risks and safeguards, which may need to be taken into account in sharing records in the ways identified in this consultation document.

A8. As happened under the previous administration, there is great risk in attempting to apply common controls and policies derived from professional standards from the Medical Royal Colleges to community optical practices where risk is very much lower. This could result in the application of a disproportionate, inappropriate and unfunded information governance framework on community optical practice.

The Optical Confederation and the College of Optometrists have already developed requirements for information governance which fully meet the requirements of the national sight testing contract and any locally commissioned enhanced services. To go beyond this would impose an unnecessary burden on optical practices which may discourage them from taking on additional community eye care services under the liberated NHS. This would be a major missed opportunity and severely undermine the success of the Government's *Liberating the NHS* programme.

The Optical Confederation and the College would be very keen to work with the NHS Commissioning Board (or NHS Connecting for Health, although our experiences to date have not been encouraging, under the aegis of the NHS Commissioning Board) to ensure that the information governance requirements on optical practices are secure, 'fit for purpose' and do not unnecessarily replicate the information requirements developed for higher risk parts of the NHS.

We would particularly ask that these views are given serious consideration when the responses to consultation are reviewed.

Q9. What kinds of information and help would ensure that patients and service users are adequately supported when stressed and anxious?

A9. Visually impaired users constantly report a lack of emotional and other support available to them when patients are diagnosed in hospital as visually impaired or registered as blind (including sign-posting to other services).

Much wider use of Eye Clinic Liaison Officers (ECLOs) in hospital ophthalmology departments and Independent Living Coordinators (ILCOs) supporting patients in the community would go a long way to supporting patients through these difficult transitions and ensuring (a) that they have the support and orientation needed to continue their lives with as little disruption as possible (including staying in work) and (b) that they are appropriately directed to optical support in the community so that they can get the aids and adaptations they need and are entitled to.

In the past, too many people have just been given a white stick and a magnifier and left to get on with it. This is not the way a civilised society deals appropriately with people in a state of bereavement for their vision and considerable personal disorientation, depression and upset.

Q11. What additional information would be helpful for specific groups?

A11. Information from NHS bodies and local authorities about the need for regular sight testing would be helpful for the public, and beneficial in particular if this were targeted at children in schools.

As argued in our response on 'Greater Choice and Control' residential and long term care homes should be encouraged to keep an 'eye care record' in all care plans (particularly for service users with learning difficulty or dementia). These should set out clearly the date of the patient's most recent sight test, what the results were and what, if any, referral action was taken as a result. It should also set out what their prescribed visual correction, is so that care staff can ensure that patients are wearing their spectacles appropriately and for appropriate activities.

There are a number of at risk groups who, we know, are a) unaware of the risk to themselves or / and b) unaware of the services available to them.

We would strongly recommend that the following groups should be made aware of their heightened risk of developing an eye condition which could lead to visual impairment: people with a family history of glaucoma; people with diabetes; and persons over the age of 60. These groups should also be made aware that early detection of an eye condition is essential in order to prevent or ameliorate permanent sight loss.

Sight tests are free on the NHS for several categories of patients, however, many are unaware of this. In addition many patients who would qualify for a General Ophthalmic Services (GOS) voucher towards the cost of spectacles or contact lenses are also unaware of this.

Categories of patients who could, but very often do not, access NHS sight tests include: older people; those unable to leave their own home, or residential home, unaccompanied; children; and people with learning disabilities.

It is unfortunate that most health and social care professionals, carers and patients do not know that the NHS domiciliary eye care service exists. Domiciliary eye care services provide NHS sight testing at home for those unable to leave their own home unaccompanied. We understand that NHS Choices is currently working on including information on the domiciliary eye care service and also working to list domiciliary eye care providers by geographical area, in the same way as high street optician services are listed. We do hope that this work will be completed as soon as possible, as we know that many eligible and vulnerable patients are being denied this essential service due to widespread lack of awareness of the availability of the service. We would recommend that, in addition to information on NHS Choices, all health and social care professionals should be informed of the domiciliary eye care service.

It should be noted that correction of visual acuity (supply of correct spectacles), detection and (where possible) treatment of eye conditions, e.g. glaucoma and

cataract, can make a huge impact on the quality of life and ability to live independently of this group of patients.

Q17. For which particular group of service users or care organisations is the use of information across organisational boundaries particularly important?

A17. A particular weakness of the current paper-based referral system used in community and hospital eye care is that community optometrists rarely get feedback on the referrals they make via GPs or to the hospital eye service.

A key priority for the development of optical services in hospital, in the community and across social care (e.g. for low vision) should be proper discipline in ensuring that the prime referrer in the community has feedback about a particular patient's progress and needs, and feedback on the quality of their own referral.

In this way patient care, clinical performance and outcomes will all be improved over time.

Q18. What are your views on the approach being taken and the criteria being used to review central data collections?

A18. We support the Government's proposals for a thorough-going review of information collected. We warn, however, that there will no doubt be much special pleading for various data items and the Government should be robust in its approach to retaining only genuinely essential data collection and data sets – all of which are a cost on front-line care. These data items/sets should be retained or introduced only when they genuinely improve care, quality of service, information for public health purposes or stewardship of public money.

We would further point out that, even in the case of statutory obligations, it is not always necessary to collect data. In some cases it may not be necessary at all because the statutory obligations are so obvious; in others a sampling approach may be more cost-efficient for the NHS and for providers.

We will be submitting separately - via the Optical Fees Review Committee - proposals for how some of the unnecessary data collections generated under the new sight testing contracts in 2008 can be reduced.

Q24. How can health and care organisations develop an information culture and capability so that staff at all levels and of all disciplines recognise their personal responsibility for data?

A24. In the optical sector, the Optical Confederation, the College of Optometrists, as well as optical providers, place particular emphasis on the quality of professional record-keeping and data security.

Together we have funded the development of a record audit tool as part of the *Quality in Optometry* programme which makes it easy for practitioners and practices to audit their own information recording systems and performance.

In addition, some providers have developed IT based record-keeping systems which will not allow a practitioner to move from one field to another without completing the first field, which ensures relevant data are recorded in a timely manner.

Within the Optical Confederation, we are working with optical software suppliers to ensure similar fail-safe systems are developed for all optical IT support systems in the UK.

Q25. As a clinician or care professional, how easy is it for you to find the evidence that you need to offer the best possible care and advice? What could be done better?

A25. Optometrists, contact lens and dispensing opticians working in the community have access to excellent on-line care guidelines (including drug-prescribing guidelines) provided by the College of Optometrists, the British Contact Lens Association and the Association of British Dispensing Opticians. These guidelines are evidence-based and contain sources for the advice which can easily be followed up.

For research purposes, etc, optometrists and opticians can always access a range of sources provided by the national representative bodies which underpins much of the sector-wide guidance.

Taken together, we believe these sources more than adequately provide the evidence and research basis necessary for the development of community optical practice.

When an optometrist refers a patient for further assessment to another primary care provider or secondary care, they often do not receive feedback or information regarding the outcome of the referral. This information is often only relayed back by the patient who may or may not fully understand the details of the outcome. We would recommend that feedback of this sort to the original referring healthcare professional be encouraged and provided in a systematic manner.

Q26. Clinicians, practitioners, care professionals, managers and other service provider staff will be expected to record more data and evidence electronically. How can this be facilitated and encouraged? What will be the benefits for staff? And what would encourage staff to reap these benefits?

A26. As noted above, by the work that the Optical Confederation is carrying out to develop sensible prompts in electronic records systems so that practitioners have to complete each field appropriately and contemporaneously before proceeding.

Q27. What are the key priorities for the development of professional information management capacity and capability to enable the information revolution?

A27. In eye care, within the Optical Confederation and with the College of Optometrists, we will explore the possibility of developing eye health informatics programmes as part of our plans for continuing professional development.

Q28. The 'presumption of openness' in support of shared decision-making will bring opportunities – but may also generate challenges. What are the greatest opportunities and issues for you?

A28. As the Optical Confederation and as a healthcare sector, we are fully in favour of the 'presumption of openness'. However, we do have concerns that this should be implemented in a proportionate and cost-beneficial way.

In community eye care in particular, margins are extremely tight because of the highly competitive nature of the market. Collection of information that assists patients, public planning and the better operation of health and social care system are supported by us but this needs to be effected in a way that does not impose disproportionate and unaffordable costs on frontline care.

As a Confederation, we would be keen to work with the Government to develop these proposals in a proportionate, sensible and affordable way.

Q29. What benefits and issues do you think will arise as a greater range of information providers offer information? How could issues be addressed?

A29. The proliferation of information is already bound to happen in an information-rich and IT-based society. It would be pointless in our view to try to hold back this tide.

The best thing the Government could do is to give governmental endorsement to certain types of approved information e.g. such as that produced by NICE which has a kite mark of evidence base and quality which the public could trust. This would not however prevent their shopping around to compare alternative sources of information if they wished.

Q30. Would there be benefits from central accreditation or other quality assurance systems for information providers and 'intermediaries'? Would factors such as cost and bureaucracy outweigh any benefits?

A30. Please see our answer to Q29 above for the first part of this question.

The system outlined would, of course, necessitate analysis of the evidence in order to evaluate the quality of the information. This would incur costs and we would strongly recommend that proportionality is key and that, if necessary, these should be borne by government. Imposing costs of validation onto information providers could be a risky path to go down in our view. If the information (or service) provider were required to fund the cost of evaluation and endorsement, the unintentional consequence could be that the provider chooses to publish less information because of the associated costs involved in validation.

Q32. Are there any other datasets you think could be released as an early priority, without compromising the individual's confidentiality? Would there be any risks?

A32. As described above, we would very much favour a centralised IT based system of claims and payments information for sight testing and other optical services. Data sets derived from these nationally quality-assured data could then be released to the NHS Commissioning Board and to local communities (particularly local health authorities with their new public health function) to enable them to see how they compare with other areas of the country and for planning purposes.

A centralised and automated data collection system would be more reliable, less costly and produce higher quality data outcomes than requiring information to be submitted separately to the Information Centre by 10,000 different practices and 20,000 practitioners.

Q34. Are there any critical issues for the future of information in the health and adult social care sectors that this consultation has not identified?

A34. Yes, the use of the NHS logo by contractors to the NHS who provide NHS services but are not 'owned' by the NHS, such as optical practices.

For several years now the Optical Confederation has tried to engage with the NHS branding team in the Department of Health who has already approved guidelines for the use of the NHS logo by GPs, pharmacists and most recently NHS dentists. However optical practices are constantly put at the back of the queue and the adaptation of one of the existing frameworks for community optical practice – which we would happily provide the work on – is constantly delayed because of one internal review or another.

Enabling practices to advertise that they offer NHS services would be a clear and simple indicator on the high street for NHS patients about where to go for NHS sight testing and optical advice and support.

This is a long overdue development and one that has been delayed for no obvious reason that we can see. If this could be unblocked rapidly, it would significantly enhance the availability of information to patients in a very visible way and would be a very simple demonstration of the 'information revolution' on the high street.

For further information please contact:
Mark Nevin
Head of Policy and Regulation
Optical Confederation
Email: mark@fodo.com
Telephone: 020 7298 5151

January 2011