NHS e-Referral Service Vision
Optical Confederation response

Questions:

1.) What benefit can you see in having greater integration and interoperability between the NHS e-Referral Service and other clinical systems?

Although community optometric practices are not currently connected to NHS networks, we believe that greater integration and interoperability of e-referral and other clinical systems would greatly benefit patient care as all relevant information would be available to all clinicians at the time they provide that care. Despite numerous NHS reforms, there remain significant barriers to the exchange of information between primary care providers, for example, between GPs and optometrists and between primary eye care and secondary care hospital eye departments, which form the bulk of all referrals (please see also our response to question 3).

We believe that the e-Referral system must be designed so that full integration with both the referrer and provider systems is possible at the Electronic Patient Record level.

2.) How do you see the stand-alone appointment scheduler supporting all providers to use the NHS e-Referral Service?

We have no knowledge of the scheduler and are therefore unable to comment.

3.) Would the ability to send outcome/discharge information back to the referrer using the same system as was used for the referral be beneficial?

Yes, we would strongly support such a development and believe it would significantly benefit patient care. Currently community eyecare practitioners who refer a patient to secondary care eye departments rarely receive any feedback from that referral, and at best have to rely on the verbal self-reporting of the patient. As a result, the practitioner has no feedback on which to assess the quality and effectiveness of the referrals they make or to identify any refinements to their referral criteria where this is appropriate. This can result in inadvertent over or under-referral affecting both clinical effectiveness and resulting in an inefficient use of NHS resources.

In addition, optical practices providing NHS community eye care services would benefit from being able to provide feedback to clinicians (GPs or other optometrists) who have referred patients to the community service.

The e-Referral system ought to be designed with a bi-directional flow of information built in and indeed encouraged.

4.) How would an enhanced Advice and Guidance facility support local referral management priorities.

Subject to the general/template content being agreed nationally with the Local Optical Committee Support Unit (LOCSU) and the Optical Confederation, we believe an Advice and Guidance facility accessible by community eyecare practitioners as an integrated element of e-referral would greatly improve referral quality and help to ensure adherence to agreed patient pathways. Whilst we believe that for community eyecare services a single national model is the best approach and by far the simplest to implement, many community eyecare practitioners work in multiple locations that may cross NHS England Area Team and/or CCG boundaries where varying local eyecare services have been commissioned. This means that currently they may be required to adhere to a number of different local pathways with differing steps and different referral criteria. Advice and Guidance at the time of making an electronic referral would improve compliance and ensure that the pathway operated at maximum efficiency.

5.) Should the NHS e-Referral Service contain clinical templates of its own or should these always be created and held within the referrer clinical systems?

We believe either would be an appropriate location and what is best for a particular referral pathway may vary depending on its nature.

In our sector we have a nationally agreed referral form for referrals to hospital eye departments called the GOS18, which should be the basis of all referral systems due to the agreed content which is designed to work across England. This should not be deviated from for referrals to hospital without a very good clinical reason (for example, to align with a local eye care pathway for referral refinement).

The GOS 18 template could be supplemented by a set of nationally agreed referral templates based on the LOCSU eye care pathways for community services www.locsu.co.uk/enhanced-services-pathways. These templates would be implemented in line with locally commissioned services and agreed with the relevant Local Optical Committees (LOCs). The design of any e-referral system should be flexible enough to accommodate local pathways. However, we strongly maintain that a set of nationally agreed referral templates based on national patient care pathways, is paramount to the provision of high quality care in a consistent and timely manner anywhere in England.

6.) Is there a role for an electronic 'gatekeeper' to help enforce locally agreed referral priorities?

We believe there may be a need for such a role, but also believe referral pathways can be agreed in such a way, and the e-referral system designed in such a way, as to only allow referral to be made according to the correct pathway. Currently in many ophthalmic referral pathways a "gatekeeper" role exists in the pathway to both triage referrals and also to assess them for quality and completeness of information. We do believe though that this could and should be done electronically as part of the e-referral system.

7.) What rules should be put in place to ensure that Referral Assessment Services are used in a cost-effective way for the benefit of patients?

In our sector, we believe that nationally agreed clinical pathways and referral systems are the best route to cost-effective use of Referral Assessment Services. For example, optometrists accredited to provide community eye care services, who establish at a sight test that a patient needs assessment or treatment that can be provided under the community service, should not be required to refer patients to a Referral Assessment Service to await a decision on whether it is appropriate for the patient to be seen in the community service.

This might require a degree of local adaptation to align with locally commissioned services; however these should only vary when merited for clinical reasons and in close cooperation with relevant local stakeholders.

8.) Should the NHS e-Referral Service allow any clinician to act as a referrer into any speciality subject to Commissioner set controls?

Yes, we believe that the service should allow the option for clinicians to refer to any speciality they feel is appropriate to the specific needs of an individual patient. In community eyecare there are occasionally situations where referral to a neurologist might be more appropriate than a referral to an ophthalmologist and it would be beneficial to patients if this was an option as it improves access to care.

We would also favour direct eye care referrals to the hospital eye care service if appropriate (for example, in routine cataract operations), copying the GP for information, rather than always needing to go via the GP (see also our response to Q9). This would of course need to be agreed nationally with the relevant stakeholders, however we would like to see it made possible in the design of the systems.

We also believe that GPs and other clinicians should be able to refer patients direct to NHS community eye care services provided by optical practices. We do however believe that there need to be controls in place on this option in order to prevent a clinical "free for all" occurring. While the principles should be consistent nationally in

consultation with relevant stakeholders, and as above, should only vary where clinically justified and in line with the pathways in place in a particular area.

9.) Will allowing any clinician to initiate referrals make the management of care pathways more efficient? If so, how?

Yes. We believe it would have a significantly positive impact on the efficiency of care pathways both for the care providers and also for patients. Approximately 4% of all sight tests result in a referral[1]; that is nearly 850,000 referrals per year and community eyecare providers make the vast majority of their referrals to secondary care ophthalmology services. Ophthalmology outpatient departments are amongst the busiest in secondary care accounting for 10% of all hospital outpatient visits[2]. Traditionally referrals have been made and continue to be made, via the patients GP. This causes unnecessary delay and inconvenience for the patient, an unnecessary burden for the GP and provides a potential for information to be not passed on or lost.

Direct referral of patients to ophthalmology would greatly improve the patient pathway and also reduce unnecessary burdens on General Practice. An e-referral system would enable patients to be referred efficiently, to the correct speciality, or sub-speciality, ensuring that all relevant information was received by the recipient with the patient given a booked appointment at the time of their consultation - all this would take place in an appropriate time frame. This is particularly important for a patient with an immediately sight threatening condition to ensure that they don't lose sight while waiting for an appointment.

We also believe that GPs and other clinicians should be able to refer patients direct to locally commissioned NHS community eye care services provided by optical practices where appropriate, in order to reduce the unnecessary burden on the hospital eye service.

10.) What impact might linked appointments have on the clinical and administrative processes within provider organisations?

While we do not expect a large number of Linked Appointments in community eye care, we believe that the facility will lessen the administrative burden within the provider organisation, as it would undoubtedly lead to a reduction of wasted appointment slots due to insufficient or missing information that is required for the consultation to take place.

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[1] Optics at a Glance, Optical Confederation , December 2011 -
http://www.opticalconfederation.org.uk/downloads/key-statistics/Optics%20at%20a%20Glance%202011.pdf
[2] Ophthalmic Outpatient Department, Royal College of Ophthalmologists, May 2012

11.) Do you think linked appointments will make provider organisations more efficient?

We believe they would drive efficiencies– please see reply to Q10 above.

12.) How might the ability to book follow-up appointments using the NHS e-Referral Service contribute to greater efficiency in provider organisations?

The ability to book follow-up appointments using the NHS e-Referral Service would be beneficial to certain NHS community eye care services. For example, patients in shared care schemes, who move between the hospital eye service and community optical practice, could be tracked more efficiently. We believe it would significantly benefit patients.

13.) What effect might electronic follow-ups have on demand and capacity management within provider organisations?

We have insufficient knowledge to comment on this question, but would assume that allowing the patient to book an appointment time and location of their choice would reduce waste caused by patients not attending appointments.

14.) Are there any risks or concerns about enabling patients to book their own follow-ups electronically?

The systems would need to ensure that patients are not double booked into hospital clinics, which may lead to several not showing up.

15.) What controls should commissioners have over self-referrals?

We believe that allowing patients to self-refer to certain services can be efficient for the commissioner and the patient. For example, a minor eye conditions service in the community that allows self-referral avoids wasting an unnecessary GP appointment or an eye casualty appointment (where the patient may present as an alternative). However commissioners should set a requirement for provider to produce robust data on activity and outcomes to allow monitoring of self-referrals. Clear eligibility criteria should be documented for such services, and providers should be required to take steps to ensure patients who self-refer are suitable for assessment and/or treatment by the particular service. Clear information explaining the service should also be made available to patients.

16.) Would self referral reduce unnecessary appointments in GP Practice?

We believe that allowing patients to self-refer to certain services can avoid wasting an unnecessary GP appointment. For example, a minor eye conditions service in the community.

17.) Should patients be able to decide whether their GP is made aware of attendance at self-referral services?

Yes.

18). Would enhanced (better quality and more timely) reporting support more effective commissioning and contract management?

In general, we believe that it would help in that a requirement for a provider to produce robust data on activity and outcomes would allow monitoring of the value of the service. However, the 'quality' of the report is intimately linked to the data it is derived from. To be of significant value, the data must be accurate and appropriate. Only a fully integrated data exchange between referrer and provider would provide the necessary level of accuracy (see our reply to Q1 above).

19.) What type and level of benefit would there be from enhanced reporting?

The benefits we see relate to the optimisation of the eye care pathway, so that the right level of resources is utilised for the provision of specific eye care activity (see answer to Q20 below).

20.) What areas of reporting would be most useful to you in your role?

Reporting on the outcomes of referrals and what is anticipated in follow-up care (to the original referrer and GP) before the patient is discharged back to primary care (see our responses to Q1 and Q3).

21.) Who should have access to the enhanced reporting module?

This would depend on the nature of the information. Clinicians involved in the care of an individual patient would need access to detailed records of their investigation and treatment, whereas commissioners might only need generic activity data based on all patients referred via the system.

22.) Are there any other communication channels that should be considered for providing appointment-related information to patients? If so, which?

In general, any available communication method (email, phone, SMS, surface mail) should be used to communicate with the patient. The patient should be allowed to state their preference as to which communication method they prefer (provided their request is reasonable).

23.) What Information governance concerns do you have (if any) about using mobile technology to communicate with patients?

We do not consider there to be significant information governance issues related to this type of communication, provided that the mobile technology is encrypted in some way and procedures are in place to prevent it from being lost or mislaid. To ensure that the message is sent to the right person, there could be a simple 'challenge and response' type of initial communication which verifies the patient's identity (e.g. date of birth, first line of address and such like).

24.) How might professional users prefer to be alerted, if there is information to be reviewed?

Professionals should be able to register in the system and state their own preferred method of communication (ideally email, but as above, it must be a reasonable request), much like patients (see reply to 23 above).

25.) Do you use the current Choose and Book system?

No, community eye care practitioners cannot use the Choose and Book system.

26.) If you do use the current Choose and Book system, what do you consider to be the best elements of this?

N/A.

27.) Do you think the Vision for an NHS e-Referral Service is taking electronic referral in the NHS in the right direction?

Yes. We believe that a well designed and effective e-referral system would be of great benefit to both patients and practitioners. We have seen nothing in the proposed way forward to give us cause for concern, however we would like to reiterate the importance of nationally agreed systems and templates wherever possible.

28.) We are aware that patients are not always fully informed of their rights to access health care, so how do we ensure they are involved and aware of their constitutional rights and the NHS e-Referral Service?

This might usefully be part of a wider public information drive that could include guidance on appropriate self-referral as discussed in the response to Q15.

29.) Would all services and appointment slots being available online influence you to use a future NHS e-Referral Service as the means for referring patients?

Yes, we believe it would.

30.) How would you like to see support for implementing a future NHS e-Referral Service provided? Should this be at a national level, local level or support available from both?

We believe the implementation should be done at national level, but that support and input into each individual referral pathway may need to be made locally.

31.) We would like to understand what support you currently have for Choose and Book within your area, is there still local support that you can call on?

N/A. Please see reply to Q25 above.

32.) What do you think is the main barrier (real or perceived) that has prevented full uptake of Choose and Book in your area and how can we help to address this?

For community eyecare providers it is lack of physical connectivity to NHS networks that is the primary problem. We are happy to work with all parties to seek to address this.

33.) Some clinicians have said there was not enough input from them into the development of Choose and Book originally; how can we ensure clinicians' views are heard and their ideas incorporated in to a future NHS e-Referral Service?

Conducting workshops and discussions with both current users of Choose and Book as well as future/planned users. We would like to see a representative from community eye care included in Choose and Book's forum to engage with clinicians.

34.) Patients did not have a great deal of input into Choose and Book originally, so how can we ensure their views are heard and their ideas incorporated in to a future NHS e-Referral Service?

Consult patients, or patient groups, about what they would want from the system.

About us:

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 representative 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 Opticians (FODO). As a Confederation, we work with others to improve eye health for the public good. For more information, please visit: http://www.opticalconfederation.org.uk/

The Local Optical Committee Support Unit (LOCSU) provides quality, practical support to Local Optical Committees in England, to help them to develop and implement local objectives, in respect of primary eye care services. LOCSU has developed a number of eye care pathways including cataract and low vision to provide expert advice, associated business cases, clinical training packages and implementation tools to assist with the commissioning of these pathways. For more information, please visit: www.locsu.co.uk

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