UK Eye Care Services Project 2010

Phase Two: Organisation of Eye Care Services in the West Midlands
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Executive Summary

The UK Eye Care Services Project was carried out to identify the roles played by optometrists in the delivery of eye care in the UK. The study presented here was a pilot study carried out in one geographical region: the West Midlands Strategic Health Authority. The survey used as part of Phase 2 also examined different service delivery models and how optometrists worked within these. The study took place during a period of changes of both government and health policy. During the course of the study, major changes to the organisation of wider healthcare services were announced which will impact on the organisation of eye care services and the role of optometrists. The details of the healthcare reforms are currently under review so no firm conclusions about the future role of optometrists can be made here. Consequently we present the findings of our study which took place in 2010, providing a snapshot of eye care services operating in the early 2000s.

The eye care services study was carried out within the West Midlands Strategic Health Authority (WMSHA), covering a large geographical area with a population of 5.4 million, including rural and urban sub-regions. The WMSHA covers sixteen Primary Care Trusts (PCTs) which are responsible for the provision of community eye healthcare. Both SHAs and PCTs are being abolished under the government healthcare reforms.

The survey formed part of Phase 2 of a two-phase study. Phase 1 was a systematic review of the literature on the organisation of eye care services (Hawley et al, 2011). Phase 2 contained two main elements: the first part was to gather information from key individuals and stakeholders. The second part was to develop and pilot survey tools and methodology for gathering data about eye care services in the UK. The intention was to use a single Strategic Health Authority (SHA) area for this pilot. Phases 1 and 2 were designed to prepare the way for a future third study phase, which would be to investigate the organisation of eye care services throughout the UK.

For the first part of Phase 2, visits were made to optometrists delivering novel or enhanced services and discussions were held with Optometric Advisers (OAs) to establish how eye care services varied within different PCT areas. It became apparent that not all PCTs had an OA and that these individuals were often operating across large geographical areas. Local Optometry Committees (LOCs) within the West Midlands were also contacted and focus groups were held with LOC members.

A questionnaire was developed using the results of the discussions and interviews and insights from the Phase 1 literature review. The questionnaire was piloted with delegates attending the Optometry Tomorrow 2010 conference, and the questionnaire and results were discussed. The questionnaire was then revised and both a paper and online version created. In Summer 2010 all optometrists registered with the College of Optometrists, and living within the WMSHA area, were invited to complete the questionnaire either online or on paper. Invitations were sent to 753 optometrists, of which 310 replied. This represented a 41% response rate. The paper questionnaire was twice as popular as the online survey (200 paper/110 online responses). There were roughly equal numbers of males and female respondents. Half the respondents worked in independent practice (51%), over one third
worked in a franchise or corporate organisation (37%) and the remainder worked in more than one setting or in another capacity such as as a hospital optometrist or locum.

Two thirds of respondents said that they carried out additional procedures over and above the standard General Ophthalmic Services (GOS) examination. This was most commonly fundus work, retinal imaging and other imaging/photography. One third of respondents stated that they had an extended role in the delivery of eye care. Most commonly this was some form of referral refinement (67 individuals, 22% of total), or screening (28 individuals, 9% of total). 201 optometrists (65%) said that they were not involved in any extended role or enhanced eye care service model. The proportion of optometrists working in extended roles within each Primary Care Trust varied. Some PCTs, notably South Staffordshire, Warwickshire and Worcestershire, appeared to have more optometrists with extended roles than other PCTs.

The questionnaire also invited respondents to take part in a telephone interview to discuss issues they wished to raise. In the interviews with respondents and with OAs and optometrists with enhanced roles, some key issues emerged. These were relationships with the PCT, funding, lack of time, and training issues. Several optometrists reported that an extended services model had been tried in their area, but had failed due to withdrawal of funding or a key individual had left the practice or area. Some optometry practices operated a direct GP referral scheme, either individually or as a group of practices. GPs are central to the government health reforms and will be the main healthcare fund-holders. Therefore extended services which already link with GPs may be at an advantage over services which do not.

Conclusions

This pilot survey found that paper-based questionnaires were preferred by the majority of optometrists and that telephone interviews were of limited value due to the often time-pressured working environment of busy optometric practices. Many optometrists were carrying out procedures over and above the standard GOS eye examination. However, only one third of optometrists said that they had an extended role in the provision of eye care. Therefore there is scope for increasing the role of the optometrist and the involvement of optometrists in the organisation of eye healthcare services. The current reorganisation of all health services could provide an opportunity for optometrists to redefine their role as professionals capable of providing more than the traditional services of refraction, assessment and prescription.
1. Introduction

The UK Eye Care Services Study was commissioned by the College of Optometrists to investigate the organisation of eye care services in the UK. The study comprised of two phases: Phase 1 was a systematic review of the literature (Hawley et al, 2011), and Phase 2 was a survey of the organisation of eye care services in one geographical region, the West Midlands Strategic Health Authority (WMSHA). The Phase 2 survey was intended as a pilot survey to test methods of data collection relating to the organisation and delivery of eye healthcare. Accordingly, several different methods of data collection were used: interviews, focus groups, discussion groups and a questionnaire. This pilot survey was carried out to inform the design and development of a third phase, which would be to study the organisation of eye care services throughout the UK.

In recent years there have been important developments in the organisation of eye care services. Scotland and Wales have developed their own eye care services which appear to be working well. These are the Review of Community Eye Care Services (2006) in Scotland and the Welsh Eye Care Initiative (2008) in Wales. In England there have been local initiatives and extended service models, but there are currently no consistent care pathways for eye care across the country (UK Vision Strategy, 2008). However, there have been some important national initiatives. The National Eye Care Services Steering Group set out four model pathways for cataract, glaucoma, age-related macular degeneration (AMD), and low vision (Department of Health, 2004). The National Health Service Eye Care Programme (2007) co-ordinated the piloting of the glaucoma, AMD and low vision pathway projects. Working with PCTs, local pilot sites were helped to develop new care pathways for the three eye care conditions. These care pathways needed to work across boundaries of health, social care and the voluntary sector. The Commissioning Tool-kit for Community Eye Care Services, published by the Department of Health in 2007, emphasised the need for developing and providing eye care services closer to the patient in preference to the traditional emphasis on hospital-based eye care services.

It was within the context of these developments between 2006 and 2008 that the current project was undertaken. A key aim of the project was to examine the extent to which optometrists had embraced the recommendations and whether eye care pathways were being developed and followed. To this end, contact would be made with key individuals who had either published articles on eye care service delivery and organisation or were known to be delivering an enhanced service or care pathway model in the West Midlands or close by.
2. Aims and Objectives

2.1 Aims

2.1.1 To identify the roles played by optometrists in a specific area of the UK and under service delivery models, currently active or planned for future implementation within the region.

2.1.2 To develop an appropriate approach to gathering data from relevant organisations and individuals throughout the UK by piloting the process of gathering data within a single region.

2.2 Objectives

2.2.1 To develop appropriate methods and tools for gathering data relating to the organisation and delivery of eye care.

2.2.2 To identify key individuals and roles within NHS bodies (including SHA, PCTs, CRNs) and other relevant organisations and to identify key organisations and stakeholders in the eye care sector.

2.2.3 To carry out a pilot study in one geographical area as preparation for a UK-wide survey of eye healthcare.

3. Approach

A pilot study was carried out in one geographical area as preparation for a UK-wide survey of eye healthcare (which will form Phase 3 of the overall project). The pilot study was carried out within the local Strategic Health Authority (SHA) for the West Midlands, NHS West Midlands. It is one of ten strategic health authorities created on 1 July 2006 to lead the local areas identified as a result of ‘Commissioning a Patient-led NHS’. It covers an area of 5.4 million people across Birmingham, Coventry, Dudley, Herefordshire, Sandwell, Shropshire, Solihull, Staffordshire, Stoke on Trent, Telford and Wrekin, Walsall, Warwickshire, Wolverhampton and Worcestershire (Figure 1). As the local headquarters of the NHS in the West Midlands, it manages 16 Primary Care Trusts (PCTs) and 1 Care Trust (which provides community healthcare such as Dentistry and GP services), 19 Acute Trusts (hospitals) including 8 Foundation Trusts, 7 Mental Health Trusts including 3 Foundation Trusts, and 1 ambulance service.

NHS West Midlands SHA covers a wide geographical area (both urban and rural) with a demographically diverse population, and therefore provided the ideal centre for carrying out the pilot survey. The pilot survey was designed to produce nationally representative data on optometry and eye healthcare service pathways that would be capable of informing the work to develop the survey tools and processes for the third phase of the overall project.
The pilot survey gathered information from the following:

- Local Optometry Committees;
- Primary Care Trusts;
- Hospital Eye Services (HES).

The pilot survey was designed to maximise the potential for providing information to inform the refinement of the final design for the Phase 3 survey project across the UK. Overall, the pilot would offer insight into key considerations for Phase 3 such as:

- target individuals / institutions;
- survey approach and questionnaire design (scope, detail, key questions);
- challenges and risk factors;
- objective refinement for the full survey;
- realistic assessment of costs / timescale etc.

### 3.1 Ethical approval

This study received approval from the University of Warwick Medical School Biomedical Ethical Committee (2010).
4. Methods

A range of methods were utilised in order to gather both qualitative and quantitative data. These were:

- focus groups in order to identify key questions;
- interviews with optometrists: face-to-face or by telephone;
- interviews with optometric advisers: face-to-face or by telephone;
- meetings with key personnel to identify care pathways operating within the SHA;
- a survey questionnaire.

Data were collected on:

- details of existing eye healthcare pathways;
- organisation of care;
- information about past or planned pilots of alternative models / pathways;
- attitudinal data about pros / cons of various models and perceived / actual barriers to alternate models;
- where alternate models were in operation, data relating to review, assessment, research or performance measure related to the model for extended services.

4.1 Interviews with stakeholders

Interviews were held with key individuals located within and close to the WMSHA. All Local Optometry Committee (LOC) chairs within WMSHA were approached, but not all were able to participate in the study due to their time pressures. Similarly, all OAs operating within the WMSHA were contacted and discussions held with all OAs. A structured topic guide was developed for interviews, but the interviews were generally led by the interviewees. The main topics were: organisation of eye care service; enhanced roles; care pathways in the key areas of cataract, glaucoma, age related macular degeneration and diabetic retinopathy screening, and barriers and facilitators to providing such services.

An interview was also conducted with the Head of Commissioning of eye care services at one PCT. It proved difficult to carry out such interviews at other PCTs due to the short timescale for the pilot study. The focus of this interview was on a commissioner's view of the organisation of eye care services.

Meetings and discussions were also held with representatives from the Association of Optometric Practitioners (AOP) and the Local Optometry Committee Support Unit (LOCSU). The aim was to achieve as full a picture as possible of the issues, facilitators and barriers to providing eye care services.

4.1.1 Summary of results from interviews and focus groups

LOCSU provided information on the organisation of eye care services within the WMSHA. LOCSU provides support to LOCs wishing to develop enhanced roles for optometrists, and have developed standardised national eye care clinical pathways which may be used in the commissioning of local enhanced services. LOCSU also helps LOCs to develop a business case to present to their PCT.
Within the WMSHA, LOCSU has worked with Local Optometric Committees to develop enhanced roles for optometrists. Dudley LOC worked with LOCSU in 2008/9 to develop a glaucoma referral refinement pilot scheme. Wolverhampton LOC was also in the process of developing a proposal for a glaucoma referral refinement pathway. Worcester LOC worked with LOCSU to develop a glaucoma/intra ocular pressure refinement pathway, based on the LOCSU pathway, and a cataract post-operative service. Interviews with Optometric Advisers within the WMSHA region provided insights into the enhanced service models for eye care that were in development, existing, or had been tried but ended. In South Staffordshire, many years had been spent in developing a set of care pathways for various eye conditions. The LOC was strong and there was good buy-in to the use of these care pathways. The LOC had a very good relationship with the PCT which supports the care pathways. In some other areas, it was found that although some models for enhanced services had been established (e.g. direct referral for cataract), the funding had ceased and the extended services had been discontinued. It was also apparent that enhanced eye care schemes take a considerable amount of time to develop, refine and implement. In Worcestershire, for example, a primary eye-care acute referral scheme (PEARS) was still in the planning stages at the time of our interviews. In Coventry an optometric independent prescriber model had begun with one qualified optometric prescriber.

The PCT Commissioner highlighted the particular budget pressures faced by PCTs. The interview took place on the day of the announcement of the future abolition of PCTs. PCTs had already been asked to budget for severe cuts in the region of 40%. This PCT currently held budgets to commission enhanced services for glaucoma, cataract and diabetic retinopathy. However, future funding for such services was uncertain. At this PCT the Head of Commissioning worked closely with the LOC to plan optometric services. In this region, GP commissioning groups were already working with the LOC. Practice-based commissioning groups (PBCs) involve GP practices and other health and primary care professionals in the commissioning of services. In this PCT, there were five PBC groups working in distinct localities, meeting on a monthly basis to commission services.

Focus group discussions and interviews with individual optometrists explored public perceptions of the role of optometrists. It was reported that the general public have a misconception of optometrists as predominantly testing vision and prescribing spectacles. The public were thought to be often unaware of the important roles optometrists play in the early detection of eye conditions such as cataract, glaucoma, diabetic retinopathy and ARMD. Patients were likely to consult their GP rather than an optometrist about an eye condition, when the optometrist is far better trained and qualified to assess and identify eye conditions.
4.2 Survey of optometrists in the West Midlands

4.2.1 Questionnaire development and dissemination

The survey questionnaire was designed and piloted with significant input from the Project Steering Group and with additional input from the following sources:

- focus group participants;
- conference delegates attending a research workshop at the Optometry Tomorrow Conference in April 2010;
- members of the Board of the College of Optometrists.

A wide variety of feedback and suggestions were received. Some were incompatible and the Project Steering Group made the final decision regarding the final content of the questionnaire. The aim was to keep the questions short and relevant. A tendency for some contributors had been to increase the number of questions. Whilst the information would have been interesting, these extra questions made the questionnaire too long and time consuming. Consequently the questionnaire was reduced to 18 questions over 3 pages. The questionnaire is shown in Appendix 1. The online survey was created in FormBuilder and placed on the University Medical School website.

The questionnaire was designed to capture information on practice characteristics, person characteristics, patient characteristics, and the procedures carried out over and above a standard General Ophthalmic Services (GOS) eye examination. Additionally, the questionnaire collected information on enhanced roles for four important eye conditions: cataract, glaucoma, diabetic retinopathy and age related macular degeneration (ARMD).

The target survey group was the 753 members of the College of Optometrists working in the West Midlands. To preserve anonymity of respondents, invitations to complete the questionnaire were sent by the College of Optometrists. The questionnaire was therefore circulated in the following ways:

- email linking to an online survey;
- second email reminding members to go online to complete the survey;
- letter sent from the College urging members to complete the survey if they had not already done so (a link to the online survey was given), along with a paper copy of the questionnaire and a freepost return envelope;
- a number of local practices were identified through the local NHS website and these were then telephoned with a view to completing the questionnaire by telephone.

4.2.2 Telephoning local practices

A list of optometric practices in Coventry was obtained from the NHS website. A researcher telephoned practices with a view to completing the questionnaire over the telephone. The researcher telephoned each practice to either arrange a time to telephone an optometrist to complete the questionnaire, or if that was not possible, to complete some basic data with the practice manager/receptionist. This basic data would be to ask if the practice carried out an extended role such as diabetic screening, cataract care or direct referral to hospital.
When calling the researcher explained that she was a researcher from the University of Warwick and that the University was working with the College of Optometrists on a study about the extended roles of optometrists. The researcher explained that we had already contacted optometrists via letter and email and that we were trying to improve our response rate. However the cold calling was not a success and five practices were called before abandoning the approach. The reasons that practices declined to provide information were as follows:

- receptionists reported that optometrists were fully booked with appointments and therefore did not have time to speak to the researcher;
- there was reluctance by receptionists/practice managers to share any information about the practice with researchers, unless information was sent to the practice in writing before calling (in fact the optometrists would have already received a copy of the questionnaire via email link or by post if they were members of the College of Optometrists, but the researcher was not able to speak to an optometrist to clarify this);
- receptionists felt that they needed to discuss our requirements with the practice manager and noted the researcher’s telephone number and said that they would call back but did not (the researcher sensed that they did not like the ‘cold calling’ approach and were reluctant to share any information over the phone).

5. Survey completion

The total number of completed questionnaires was 310, from a database of 753 College members. This represented a 41% response rate.

5.1 Online survey completion

Total number of ‘hits’ (page views) during the period from the start of the survey in June 2010 to the end of the survey on 29th September was 582. Figure 2 presents these data.

There were two distinct peaks in the viewing. The first was from 30th June - 2nd July 2010, with 136 hits, 72 hits and 17 hits on each successive day. The second peak followed the email reminder, with the period from 12th - 14th July 2010 seeing 104 hits, 40 hits and 22 hits on each successive day. Outside of these times there was a very low hit rate of between 0 and 15 hits per day.

There was no corresponding peak in page views following the postal mailing. Clearly respondents who had not already completed the online survey preferred to fill in the hard-copy questionnaire and post it back to the researchers.

The number of people who completed the online survey was 110.
5.2 Postal survey completion

The postal survey was carried out in August 2010. A letter from Michael Bowen, Head of Research at the College of Optometrists urged members who had not already taken part in the survey to either go online and complete the survey (a link was provided) or to complete and return the hard copy questionnaire enclosed with the letter. A first-class, postage-paid, addressed envelope was enclosed for return of the questionnaire.

200 completed questionnaires were received between August and the end of the survey on 30th September 2010. Some continued to be received after the deadline given in the mailing of the end of August, however these questionnaires were included in the analysis, with a final cut-off date of 29th September.

6. Survey results

Almost equal numbers of male and female optometrists responded (151 male (49%), 157 female (51%) and 2 did not state their gender). The postal survey was more successful than the online survey. Almost two-thirds of respondents completed the survey using the paper version, and this was true for both males (65%) and females (64%).

Respondents worked in either independent practice (159, 51%); as part of a franchise or corporate organisation (115, 37%); or in another capacity (36, 12%). This other category included hospital optometrists (9 solely and 3 who worked in hospital and community practices) and optometrists who worked in more than one location (e.g. independent and corporate).

The average length of time practising as an optometrist was 18.85 years (SD: 12.803; range <1 year to 52 years). 25% of respondents had been qualified as an optometrist for over 30 years.

Figure 2: Online hits from June to September
The majority of respondents worked as employee optometrists. Only two survey respondents were Optometric Advisers. The various categories of employment are shown in Figure 3 below.

### 6.1.Respondent summary data

Summary data were as follows:

- Male = 49%, Female 51%
- Mean 18.9 years since qualified (range <1 - 52yrs:)
- Dates first qualified ranged from 1958 to 2010
- Full-time work: Male = 80%, Female = 50%
- Part-time work: Male = 20%, Female = 50%
- Independent practice = 51%
- Corporate/franchise = 37%
- Other (more than one role; Hospital Eye Services; Academia) = 12%

![Respondent Employment Chart](chart.png)

**Figure 3:** Employment categories of respondents

Respondents came from across the WMSHA. Table 1 shows the number of optometrists from each PCT area who took part in the survey. There was some blurring of PCT boundaries, and some PCTs were better represented than others. In particular these were Warwickshire, Birmingham, South Staffordshire and Coventry.

A group of 24 optometrists (8% of total respondents) said that they practised outside of WMSHA, these were generally in adjacent PCT areas of Gloucestershire, Lincolnshire, Northamptonshire, Nottinghamshire, and Leicestershire. Optometrists were identified by the
College using home addresses, and therefore there were some individuals who worked in one PCT area but resided in another. Two respondents did not state where they worked, and one said that he/she worked as a locum at no particular place.

<table>
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<th>Primary Care Trust</th>
<th>Number</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Missing</td>
<td>2</td>
<td>0.6</td>
</tr>
<tr>
<td>Birmingham</td>
<td>6</td>
<td>1.9</td>
</tr>
<tr>
<td>Birmingham East &amp; North</td>
<td>14</td>
<td>4.5</td>
</tr>
<tr>
<td>Coventry</td>
<td>25</td>
<td>8.1</td>
</tr>
<tr>
<td>Dudley</td>
<td>14</td>
<td>4.5</td>
</tr>
<tr>
<td>Heart of Birmingham</td>
<td>21</td>
<td>6.8</td>
</tr>
<tr>
<td>Herefordshire</td>
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<td>3.5</td>
</tr>
<tr>
<td>no principal place</td>
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<td>0.3</td>
</tr>
<tr>
<td>North Staffordshire</td>
<td>9</td>
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</tr>
<tr>
<td>outside WMSHA</td>
<td>24</td>
<td>7.7</td>
</tr>
<tr>
<td>Sandwell</td>
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<tr>
<td>Shropshire</td>
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<tr>
<td>Solihull</td>
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<tr>
<td>South Birmingham</td>
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<td>South Staffordshire</td>
<td>28</td>
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<tr>
<td>Stoke-on-Trent</td>
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<tr>
<td>Telford &amp; Wrekin PCT</td>
<td>3</td>
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<tr>
<td>Walsall</td>
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<tr>
<td>Warwickshire</td>
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<td>Wolverhampton</td>
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<td>5.2</td>
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**Table 1:** PCT coverage of respondents
6.2 Practice characteristics

The questionnaire asked respondents about the type of practice they worked in.

6.2.1 Patients seen per average month

Figure 4 shows the number of patients seen by their practice in a typical month.

![Bar chart showing the number of patients/clients seen per month, on average.]

**Figure 4:** Number of patients/clients seen per month, on average.

6.2.2 Age range of patients and percentage of free eye tests

The majority of respondents said that their practice sees a high proportion of older patients. The mean percentage of patients over the age of 60 years was 61% (SD:17.03, Range: 10 – 100%).

Young children formed a small proportion of patients at most practices. The mean percentage of patients under the age of 5 years was 5% (SD:6.13, Range: 0 – 50%).

The majority of patients seen in practices received free standard eye tests. On average 74% of their patients had free eye tests, for some practices all patients received free eye tests (SD:17.47, Range: 0 – 100%).

6.3 Additional Procedures over and above GOS

The questionnaire asked respondents if they carried out procedures additional to the standard GOS eye examination. Standard care was defined as:

- taking history and symptoms;
- external examination of the eye;
• refraction;
• internal examination of the eye;
• basic binocular vision assessment;
• prescription for glasses;
• basic field screening and tonometry (for at-risk groups - by whatever means);
• standard referral if required (GOS 18).

Two thirds of respondents (66%) said that they did carry out additional procedures. Most commonly this was fundus work, retinal imaging, or other Imaging/photography. Figure 5 shows the main categories of additional procedures reported by respondents. There was a significant difference between Independent and Corporate/Franchise Practices (p< 0.005):

- Independents: 76% = Yes additional procedures
- Corporate/Franchise: 62% = Yes additional procedures

![Figure 5: Additional Procedures above Standard](image)

### 6.4 Extended roles in delivering eye care

Respondents were asked if they had an extended role in the management of four key conditions: glaucoma/ocular hypertension; cataract; diabetes, and age related macular degeneration (ARMD). If they did, they were asked to state what these extended roles were. Figure 6 below shows the percentage of respondents reporting an extended role in these areas.
Two-thirds (210, 65%) of respondents were not involved in any extended role or enhanced service model. For the third of respondents who were, the most common extended roles were:

- Referral refinement = 67 (22%)
- Screening = 28 (9%)
- Novel service model / scheme (e.g. acute eye care) = 4 (1%)
- Shared care (e.g. paediatric) = 3 (1%)
- Other = 7 (2%)

When analysed by PCT, South Staffordshire, Warwickshire and Worcestershire contained a higher proportion of respondents with extended roles.

**Figure 6:** Extended role in managing key eye conditions

### 6.4.1 Extended roles by PCT

Data were collected on the number of respondents from each PCT involved in an extended role for the four main eye conditions. As not all optometrists working within each PCT region responded to the questionnaire, the results are presented only as an indication of how many optometrists may have extended roles in each PCT. The data did show that extended roles for different eye conditions vary by area. The data are presented in Figure 7 (Cataract), Figure 8 (Diabetes), Figure 9 (Glaucoma) and Figure 10 (ARMD).
Figure 7: Percentage of respondents from each PCT with an extended role in Cataract Care

Figure 8: Percentage of respondents from each PCT with an extended role in Diabetes Eye Care
6.4.2 Training in extended roles

Respondents were asked if they had received training to carry out these extended roles. Figure 11 shows the results. Training was provided by a wide range of organisations, most commonly PCTs, LOCs, City and Guilds, or a combination of these. 71 respondents (23%) said that this training led to a transferrable qualification.
6.4.3. Barriers to extended roles

The questionnaire asked respondents to what extent certain factors were barriers to taking on extended roles. These included: time pressures; staffing shortages; training issues; lack of funding; lack of equipment; concerns over litigation; relationships with other health care professionals; relationship with employer, and relationship with PCT or NHS Trust. Figure 12 presents the results. The two greatest barriers were time and funding which were barriers for over half of all respondents.

Figure 11: Training in extended roles
6.5 Most common routes of referral

Respondents were asked to indicate the most common routes of referral of patients. The most common route was to an ophthalmologist via GP (50% of respondents). 22% of respondents stated that their most common route of referral was by direct referral to hospital Ophthalmologist. 19% of respondents referred to the GP, and for 4% the most common route was to a Community Optometrist with Special Interest (COSI).

7. Discussion

Phase 2 of this study identified important trends in optometric practice in the West Midlands. The study also demonstrated that a paper questionnaire is preferred to an online questionnaire by the majority of optometrists. This seems to be because the daily routine of many optometrists leaves little time for taking part in surveys during practice time, and a questionnaire sent to the home is more likely to be completed.

Although the majority of optometrists responding to the survey reported that they carried out additional procedures over and above the standard GOS eye examination, only one third reported that they had an extended role in the management of the Department of Health prioritised eye conditions of glaucoma, cataract, diabetes and ARMD. Individual PCTs differed quite significantly in the proportion of optometrists with an extended role in the management of these conditions.

From our discussions with Optometric Advisers (OAs) and Local Optometric Committee members, it was clear that setting up and maintaining enhanced eye care service models is...
a long-term process. Maintaining enhanced eye care services takes time, dedication, funding and a specific level of up-take for the services to make them viable over time. Where up-take is not sufficient, or budgets do not permit the maintenance of enhanced service models, they will be discontinued. Similarly, where key individuals driving a service model move on, the model can falter. Not all PCTs had an OA, but these individuals were seen as very important in forming a link between LOCs and PCTs and in facilitating the development of enhanced eye care schemes.

The main barriers to taking on extended roles were shown to be lack of time and lack of funding. From our focus group discussions, the latter appears to frequently refer to the fee paid for a standard GOS eye examination. The GOS fee covers the cost of a sight test, as defined in law (Opticians Act s.36(2)). This must include an internal and external examination and 'such additional examinations as appear...to be clinically necessary' for the purpose of detecting signs of injury, disease or abnormality in the eye or elsewhere. Many optometrists have sophisticated equipment which enables them to keep a photographic record of the patient's eye or - once signs of injury, disease or abnormality have been detected - to further investigate these signs, for example by repeating measurements. These tests fall outside the realms of the GOS fee and so patients may be asked to pay extra for such assessments, or a service model that permits remuneration for these services must be established.

Some of our interviews suggested that relationships between LOCs and PCTs could be a significant barrier to the setting up and maintenance of extended eye care roles. However, a poor relationship between LOC and PCT was only a major barrier for 30% of respondents. Our interviews also explored the role of optometrists within the delivery of eye healthcare. Respondents discussed the issues of patients being unaware of the range of skills and services offered by optometrists, for example being more likely to consult a GP than an optometrist for eye-related conditions, whilst assuming that high street optometrists prescribe spectacles. There is scope for raising the awareness of members of the public as to the services that optometrists can provide and the important role they play in identifying sight-threatening conditions such as glaucoma, cataract or ARMD.

8. Conclusion

The survey provided important information on the organisation of eye care services in the West Midlands. It is recommended that the survey is extended to the whole of the UK to create a more complete picture of the role of optometrists.

Most optometrists carry out procedures additional to the standard GOS eye examination. However, only one third of optometrists surveyed said that they have an extended role in the provision of eye care. There is clearly scope for increasing the role of the optometrist and the involvement of optometrists in the organisation of eye care services. The current reorganisation of all health services, and the particular emphasis on community-centred care, should provide an opportunity for optometrists to redefine their role as professionals at the centre of community-based eye care services.
9. Acknowledgements

The research team wish to thank all of the individuals who took part in and contributed to this project. In particular we wish to thank the College of Optometrists for commissioning the project and representatives of the AOP, LOCSU and the OAs, LOCs and PCTs who took part in our interviews and discussions. We are also grateful to the members of the Project Steering Group for their advice and support.

- Dr Kamlesh Chauhan (Chair of the College’s Research Committee - Optometrist)
- Michael Bowen (the College’s Director of Research)
- Dr Robert Lindfield (ophthalmologist)
- Ms Sali Davies (Optometry Wales)
- Dr Ross Henderson (Optometry Scotland)
- Tony Trowsdale (Research Committee member)

10. References


NHS Eye Care Programme (2007) www.eyecare.nhs.uk

http://www.scotland.gov.uk/Publications/2006/12/13102441/0

Eye Healthcare in the UK Survey

We are carrying out a project for the College of Optometrists to examine eye healthcare in the UK. Part of this project is to find out the roles played by optometrists in different areas of the UK under different service delivery models. Please help us by completing the questionnaire below. All responses will remain anonymous and no-one will be identified in the data analysis. The principal investigator is Dr Carol Hawley, Principal Research Fellow, Warwick Medical School, University of Warwick (c.a.hawley@warwick.ac.uk).

Section 1 - About you

1. In which year did you first register with the GOC?

2. Please indicate your gender
   - Male ☐
   - Female ☐

3. Please indicate if you work full-time or part time, as any of the following:
   (tick all that apply)

<table>
<thead>
<tr>
<th>Role</th>
<th>Full-time</th>
<th>Part-time (hours per week)</th>
</tr>
</thead>
<tbody>
<tr>
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<td>☐</td>
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<tr>
<td>Partner</td>
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<td>Self employed</td>
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<tr>
<td>Employee optometrist</td>
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<tr>
<td>Locum</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Community optometrist with special interest</td>
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<td>Hospital optometrist</td>
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<td>Optometric adviser</td>
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<td>Voluntary sector</td>
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<tr>
<td>Academic/research post</td>
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</table>
Non-practising  □  □  _____
Retired  □  □  _____

4.  a) Nearest town to your principal place of work:
________________________________________

   b) Postcode prefix of your principal place of work:

5.  Within which Primary Care Trust is your principal place of work?
______________________________________________

Section 2 - About your practice

6.  Principal place of work *(tick all that apply)*:
   Independent  □  Franchise  □
   Corporate  □  Hospital  □
   University/teaching eye clinic  □  Domiciliary  □

If you highlighted corporate, which company?_________________________ (optional)

7.  Approximately how many patient consultations, for any reason, do you conduct in a typical month?
   None  □  Less than 50  □  50-99  □  100-149  □  150-199  □  200-249  □  250+  □

8.  Approximately what percentage of your patients are aged >60 years? *(in a typical week)*?
   %

9.  Approximately what percentage of your patients are aged <5 years? *(in a typical week)*?
   %
10. What percentage of the eye tests you carry out are free to patients? (e.g. NHS-funded eye tests)

\[ \% \]

11. The GOS (England) defines optometric care to be the following:
- taking history and symptoms
- external examination of the eye
- refraction
- internal examination of the eye
- basic binocular vision assessment
- prescription for glasses
- basic field screening and tonometry (for at-risk groups - by whatever means)
- standard referral if required (GOS 18)

In YOUR practice do you carry out additional procedures not listed above?

[ ] Yes
[ ] No
[ ] If yes, please list below

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

**We assume that acceptable standard of care would be referring unusual or uncertain cases to GP**
Section 3: Additional Responsibilities

12. Currently, do you have an extended role in the management of any of the following, if yes please describe:
   - Glaucoma/Ocular hypertension
   - Cataract
   - Diabetes
   - Age related macular degeneration
   - Other (please state what)

13. To what extent are the following items barriers to taking on these extended responsibilities? (please indicate on a range of 1 (no barrier) to 5 (major barrier))
   - Time
   - Staffing
   - Training
   - Equipment
   - Lack of funds
   - Litigation
   - Relationships with other healthcare professionals (GPs/Ophthalmologist/Other)
   - Relationship with employer
   - Relationship with PCT/NHS trust
   - Other (please define)

14. Are you training in an extended role?
   - Yes in training
   - Yes trained
   - No, not involved

15. If yes to Q14:
   a) Training in what?
   b) Who is providing the training?
c) Is the training specific to your PCT? Yes ☐ No ☐

d) Does this training lead to a transferrable qualification (e.g. City & Guilds, College of Optometrists course)? Yes ☐ No ☐

Section 4: Referral & Communication Processes

16. Which is your most common route of referral? Please rank in order of 1 (most common) to 4 (least common)

To GP ☐ To Ophthalmologist via GP ☐
To Ophthalmologist via A&E ☐ To Ophthalmologist privately (directly) ☐
Optometrists with special interests ☐ Direct referral to hospital ophthalmologist ☐

17. Do you communicate with the following professionals for reasons other than referral?

GPs ☐ Ophthalmologists ☐
Optometrist ☐ Optometrists with special interest (SI) ☐

18. In reference to question 17, for which purposes do you communicate with other professionals?

<table>
<thead>
<tr>
<th></th>
<th>GP</th>
<th>Ophthalmologist</th>
<th>Optometrist with SI</th>
<th>Optometrist</th>
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<tr>
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<td>Other __________________</td>
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</table>

Any further information you would like to give?

________________________________________________________________________
________________________________________________________________________
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If you have any comments you would like to discuss with us please provide your contact details *(optional)*

Name: __________________________  Email address: __________________________

Phone number: __________________________  Best time to contact by phone: __________________________

THANK YOU VERY MUCH FOR COMPLETING THIS QUESTIONNAIRE