

Quick Guide

Data Capture Guide

This guidance sets out clear, consistent expectations for administrative data capture across all COTS services. Accurate, complete data is essential for patient safety, service evaluation, equity monitoring, audit, and commissioner reporting.

This document applies to all COTS pathways, including (but not limited to): MECS, Cataract pre- and post-operative assessment, Glaucoma pathways, Narrow angle assessment, Paediatric pathways, and specialist monitoring services.

Core Principles

All administrative data capture must be:

- Accurate – reflecting what actually occurred
- Timely – recorded at the correct stage of the pathway
- Consistent – using agreed definitions and terms
- Patient-centred – with appropriate consent and explanations

Audit and Governance Expectations

All COTS records:

- Are subject to clinical audit
- Support commissioner reporting and payment
- Contribute to service evaluation and pathway redesign

Incomplete or inaccurate administrative data may:

- Delay payments
- Trigger queries or audits
- Undermine service quality and equity monitoring

Ethnicity Recording (Mandatory Data Item)

| | |
|---------------------------------|--|
| Why is ethnicity data collected | <ul style="list-style-type: none"> • Monitor equality of access and outcomes • Identify under- or over-representation of groups • Support population health planning |
| When to record ethnicity | <ul style="list-style-type: none"> • At registration / booking, where possible • If not captured at reception, it must be confirmed and completed during the clinical consultation |
| How to ask about ethnicity | <p>Staff should explain that:</p> <ul style="list-style-type: none"> • Ethnicity is collected for NHS equality monitoring • Patients are asked to self-identify using standard NHS categories • There is no impact on care if they decline <p>Patients should be offered:</p> <ul style="list-style-type: none"> • The full NHS ethnicity list • The option to select “Prefer not to say” |
| What ethnicity to record | <ul style="list-style-type: none"> • Do not guess or infer ethnicity • Record as indicated by patient • If not obtained, record as: “Prefer not to say” or “Not stated” (only if the question not asked) |

Source of Referral (Mandatory Data Item)

The source of referral identifies how the patient entered the COTS pathway.

Common sources include:

- Self-presentation
- Converted from eye exam
- Referred by another healthcare colleague and/or triage

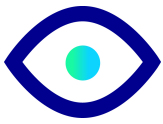
Recording standards ensure consistency with the referral documentation. Do not default to GP as source.

Waiting Time Calculation (Critical Performance Metric)

For all COTS services, waiting time is measured from the date of first patient–practice contact

Recording standards:

- Ensure the **date of first contact** is entered accurately
- Do not reset or amend this date if the appointment is rearranged
- Delays due to patient choice should still retain the original contact date



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Consent-Related Administrative Data

| Service consent | Consent to share information | Onward referral consent |
|---|---|---|
| <ul style="list-style-type: none"> Patients must consent to being seen under the relevant COTS service If service consent is declined: <ul style="list-style-type: none"> The consultation must not proceed Record the reason clearly | Patients should be asked separately for consent to: <ul style="list-style-type: none"> Share information within the COTS system (for audit and continuity) Notify their GP of attendance and outcomes Declining GP notification does not affect eligibility for the service. | If onward referral is clinically indicated: <ul style="list-style-type: none"> Explicit consent must be obtained If consent is declined, record this clearly along with the clinical advice given |

Discharge vs Referral – Correct Use of Terms

Clear and consistent use of outcome terminology is essential

| | Discharge | Referral |
|---------------------------|---|--|
| Correct Definition | <ul style="list-style-type: none"> The patient's episode of care within the COTS service has ended Ongoing care returns to their usual optometric provider No onward referral is being made | <ul style="list-style-type: none"> The patient is being sent on for further care outside the COTS service This includes referral to: <ul style="list-style-type: none"> GP Hospital Eye Service (HES) Other NHS secondary care services |
| Correct Usage | <ul style="list-style-type: none"> No further NHS ophthalmic pathway input is required Advice, reassurance, or routine follow-up has been provided | <ul style="list-style-type: none"> Clinical escalation is required Diagnostic uncertainty or treatment beyond COTS scope exists |

Common errors to avoid

- Marking a patient as “discharged” when a hospital referral has been made
- Using “referral” when the patient is simply returned to routine community care

Outcome selection must always reflect the **actual next step in the patient pathway.**

Summary Checklist for Practices

Before submitting a COTS record, ensure:

- Ethnicity recorded or appropriately declined
- Source of referral correctly identified
- First patient–practice contact date accurate
- Consent fields completed appropriately
- Outcome correctly recorded as **Discharge** or **Referral**

For queries or clarification, practices should contact POS office.