

Guidance on Provision of Enhanced Services by Optometrists

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Designing enhanced services can seem like a daunting task when working within the ever-changing landscape of the NHS, government legislation and target setting.

Optometry has worked in a unified manner under the terms of General Ophthalmic Services for many years. However, development of new techniques, equipment, skills and additional qualifications in recent times have allowed the optometric profession to take a serious look at the services it provides and ask what additional services it can safely offer whilst remaining within its own safety zone of competencies.

The AOP has compiled examples from various categories of enhanced services, provided by LOCs, AOCs and ROCs around the country, to support practitioners who are considering delivering such services locally.

The pathways/services focus on inclusiveness in an attempt to involve as many practitioners as possible. The finer detail of these examples can only be viewed as a snapshot in time. However it is hoped that they will assist in providing a more unified approach to service delivery around the country.

We would encourage anyone involved in established and successful schemes to share their information with the AOP so that we may in turn share those successes with others.

Current provision and requirements

When designing any new enhanced service, it is essential to consider what influences healthcare commissioners. The most recent national key “drivers” for commissioning are:

- World class commissioning
- 18-Week Waiting List
- Cost effectiveness and value for money (to the tax payer)
- Patient access / care closer to home
- Patient choice
- Integrated pathways
- Quality and safety
- Demand and capacity
- Reducing inequalities

In addition, there will almost certainly be key local drivers or performance indicators that your own primary care organisation (PCT/LHB) will want to address. These will be contained in the Strategic Health Authority and local PCT/Board development plans. For example, reducing waiting times may be an issue for some PCTs/Board, while reducing inequalities may be strategically more important in areas of high deprivation.

The more key drivers that can be matched in your design, the more chance there will be of success.

Scheme features and benefits

In commissioning terms, any product/service is sold primarily on the benefit to the purchaser i.e. the PCT/Health Board, rather than on its intrinsic features or, indeed, the benefits solely to the patient, or practitioner. The product has to be sold with a strong emphasis on how it can benefit the commissioner.

This may seem as if the patient is being ignored, but since the Department of Health's strategy is designed to be patient centred, addressing the performance indicators amounts to giving maximum patient benefit within that particular environment. For example, schemes that propose to detect conditions early can be justified within the context of these indicators; therefore serious consideration must be given to the holistic benefits. If, for example we added a national key performance indicator to reduce road accidents caused by poor sight, an obvious proposal would be to promote a scheme where all drivers had a full eye examination, explaining all the advantages of such an examination and the equipment used. However from a commissioning perspective, vision-screening devices placed at petrol pumps, which sent details directly to DVLA could be far more attractive. Both schemes could claim to hit the performance indicators, with clear benefits from the first scheme in eye health for patients and additional income for practitioners, but the PCO might prefer the second scheme if the screening device was more cost effective.

The templates/examples of enhanced services concentrate primarily on the features of the service. However, it is imperative that practitioners bear in mind that the features alone will not be enough to ensure a commissioned service. The examples provided by the AOP will have to be re-shaped and re-worked to address the needs of individual PCTs/Health Boards in order to demonstrate the required benefits.

Aspirational study

A useful approach to developing a plan for enhanced services would be to carry out an aspirational study of what colleagues would be interested in providing, perhaps using the templates as an example of what would be expected in terms of equipment and competency.

It may be helpful to have a few skeleton designs in place with registered interest from colleagues. This way, a raft of suggestions can be brought forward during discussions with your PCT/Health Board so that both sides feel confident in knowing that local practitioners both support and are potentially able to participate.

Funding

PCTs/Health Boards' funding is a complex mix of monies allocated for various initiatives and areas of healthcare. As funding "pots" become available, it may be that one scheme might be preferred over another for the benefit of meeting a PCT/Health Board's key performance indicators.

Audit & Clinical Governance

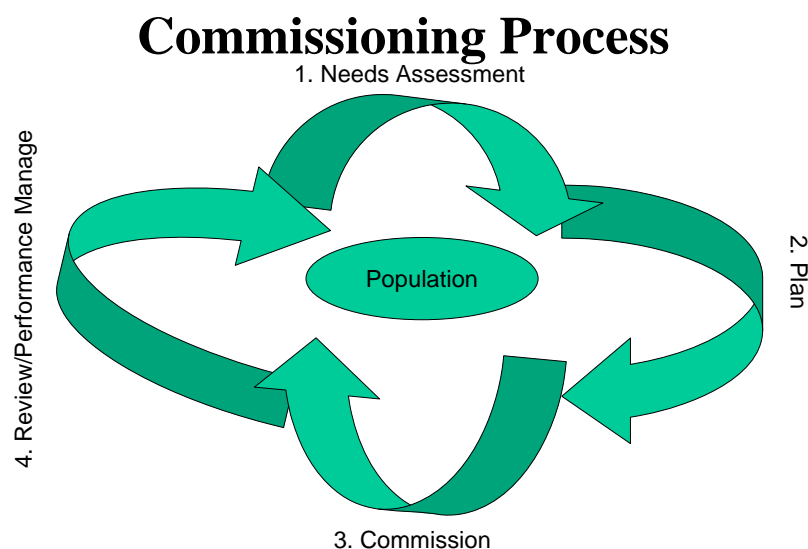
The Quality in Optometry Toolkit, issued jointly by the Association of British Dispensing Opticians (ABDO), the Association of Optometrists (AOP), the Federation of Ophthalmic and Dispensing Opticians (FODO) and the College of Optometrists, defines audit as seeking to improve the quality and outcome of patient care. This involves clinicians examining their practices against agreed standards and then modifying those practices where necessary. In effect it is an ongoing supportive process to improve the quality of service and patient care.

Any enhanced service should be monitored through various means. Audit seeks to improve the service and measure the quality and effectiveness of that service. The more effective a service can be proven, the better chance of its success both clinically and financially. Therefore audit should not be solely regarded as a means of others checking how a scheme is being managed. It can provide very strong evidence to support the scheme's continued existence and development.

A good start would be to prepare a baseline study of the current situation with statistical information about the service that you wish to develop. This can be compared with future results once a scheme is in place. It is true that this work comes at a price and therefore this should be considered in the costings for any scheme.

Large scale audits have already been carried out in Scotland and Wales which provide strong evidence for the maintenance of their current enhanced contracts.

Understanding the Commissioning Process



There has never been a more important time for optometrists to understand and be involved in providing enhanced services at local level. As members of the front line primary care team, optometrists are in a position not only to provide enhanced services but also to consider what new types of services they could offer.

One look at the changed roles that pharmacists have taken on within their new contract - all of which attract new payments - demonstrates how important it is to continually consider and review how to provide and bid for new services. Every effort should be made to create an environment where new and established services within secondary sector can equally be delivered in the primary care sector. Anyone who has responsibility for the development of optometric services locally - be they the LOC or individual clinicians – will need to understand the processes necessary to ensure success.

It is easy to be passionate about particular services that can be delivered by optometry but often such enthusiasm only leads to frustration when commissioners prove uninterested. Unless the service fits within the larger framework of primary care need, capable of delivering against measurable parameters, it is probably doomed from the outset. In other words, what may start out as a seemingly excellent idea from the viewpoint of the profession could end in failure and frustration because it was not conceived within the overall health care requirements.

It is therefore crucial to understand the process of commissioning services i.e. from the starting point of carrying out a local, needs assessment and arriving at a 'commissioning' business plan to present to the Practice Based Commissioning Group; to moving onwards to the point of tendering against that original plan by means of a 'provider' business plan directed at the PCT commissioners.

Practice Based Commissioning

This is the process whereby services can be commissioned, usually by GPs. PCTs will have allocated a budget to each GP practice to cover all the healthcare objectives. This is called an “indicative” budget in that the money is not handed directly to the GP practice but is managed on behalf of that practice by the PCT. Clearly a large part of that money is for buying services for the patient. These may be secondary care services provided in a hospital or primary care services provided in the community by community nursing teams, physiotherapists, optometrists. Many, if not most, GP practices have joined together to pool their budgets, providing a greater amount of pooled money and hence a greater purchasing ability. Such a group of GPs is known as a Practice Based Commissioning (PBC) Group.

Practice Based Commissioning Groups

These groups CANNOT commission the services that they wish to see provided in their area. It is their role to decide what they need to have commissioned on their behalf for the benefit of their patients. Once that decision has been made, the PCT/Health Board commissioners will draw up a specification for that service and will eventually commission that service for the PBC Group. You may see some PBC Groups forming their own limited company to provide services in their own right. This is quite acceptable and does not represent a conflict of interest as that company will have to bid alongside everyone else in order to get a contract from the PCT/Board to provide the service. In summary, therefore, the PBC Group will not be able to undertake the commissioning itself. It is for the PCT/Health Board to make any decision concerning that matter.

Relationship between PBC Groups and Optometrists

The role of the PBC Group is to decide what services it needs commissioned on its behalf and this is where the first interaction takes place between optometry and that Group. If there is no consensus, local optometrists, be they a group/company represented by the LOC or individuals, need to carry out a needs assessment to see what optometric services are currently lacking or are being provided less efficiently elsewhere. Part of this work would involve making sure that any service being proposed to the PBC group fits into the overall aims and strategies of that group. If it does not fit, the proposal will go nowhere.

Having established that the service will fit with the strategy it will be necessary to put together a ‘commissioning’ business plan to present to the PBC Group. The aim of the business plan is to convince the PBC Group that they actually want and need the service being described.

It is important to remember that while the PBC Group may like the idea and ask the PCT/Health Board to commission it on their behalf, there is no guarantee that you will end up as the service provider. It is quite possible that the PCT/Health Board could commission the service from a rival provider. The best way to ensure success is to get the ‘commissioning’ business case

accepted by the PBC Group in the first instance but at the same time, prepare and have at the ready a 'provider' business case to present to the PCT at the appropriate moment.

Commissioning Business Case

The 'commissioning' business case will need to contain the following:

- The service proposed
- The current delivery method of that service
- The new delivery method for that service
- The proposed capacity of the new service
- The capacity of the current service (current activity levels)
- The cost of the current service
- The cost of the new service (highlighting all cost savings)
- The benefits to patients of the new service over the existing service
- The desire for the new service from patients
- Assurances around standards of care
- Assurances around standards of staff qualifications
- Assurances around audit

It will be vital to have statistics to back up your 'commissioning' business case. This is where the legwork is required – if you fall down on gathering the necessary data, you will seriously undermine your chances of success.

Presentation of the case is important. It should be as professional as possible. PowerPoint presentations containing practised, reasoned arguments are essential. It is a similar process to that undertaken in the "Dragon's Den". A good way of ensuring that it is up to standard would be to present it to your colleagues in advance so that you have the opportunity to iron out any inadequacies that may come to light. This will ensure that on the day, your presentation is as succinct and relevant as you can make it. The AOP has sample presentations which can be adapted to suit local requirements.

If you have done your homework you will have found a service that the PBC Group definitely needs, which hopefully can be provided at a lower price than is currently the case and with greater efficiency and benefits to both the patient and the PBC Group.

If the PBC Group agrees that it wants this service it will ask the PCT to commission it on their behalf. At that point you will be in a very strong position to influence developments. If you can provide the PCT/Health Board commissioners with a full service specification and a detailed, costed 'provider' business case for the proposed service, there is every chance that the PCT may not even go out to tender. Often, if the service is below a certain annual cost e.g. £200K, the PCT/Health Board may be happy to run with just the one business case. This is why it is important to have the two business cases – commissioning and provider - prepared simultaneously.

As PBC groups represent small groups of GPs, there are possibly two or three groups that may cover your area. It is important to find out who they are and to begin building relationships with their chief executives. Ask for a meeting to discuss things in general; find out what the PBC Group sees as its main areas of priority. These groups are very important to you and are the key to developing local enhanced services for optometry. If you can influence the agenda with regard to the provision of eye care services, there is much less opportunity for others to control or impinge on the services you can provide.

For more information you may like to visit the link below and to explore more of the DH website links relating to this topic.

http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Practice-basedcommissioning/FAQonly/DH_065204

World Class Commissioning – More NHS Jargon?

The NHS is a mass of jargon and as you read the title of this section you are probably thinking “here we go again”. Most of the jargon is used by NHS managers e.g. commissioners but you have to get to know that jargon if you are going to influence and succeed. To ignore it is to risk speaking a different language and that can lead to a greater chance of being misunderstood and to not getting your message across. We have always had our own jargon but it is now important to learn the jargon of others.

World Class Commissioning (WCC) is a fairly new term but it represents a major change in the way that services are commissioned. It is essential that you understand the reasoning behind WCC and use that reasoning in developing your business strategies. In the past, services tended to be commissioned as they always had been, simply because that was the custom. Then there came a time of questioning whether those ways of delivering care were really the best way, but again the methodology was still very much driven by tradition and reducing costs and waiting lists.

World Class Commissioning signifies a departure from that way of doing things. It is based on a very simple quote, all about “adding life to years and years to life. *Better health and well being for all, better care for all and better value for all*”.

Initially this may sound rather trite but just take a minute to stop and reflect on what this actually means. It is now accepted that getting people to live longer for the sake of it is not necessarily the be all and end all. Whilst we want people to live longer we also want them to live fulfilled, active lives. Who would really want an extra ten years of life with multiple illnesses, being housebound, constantly out of breath whilst also being deaf and/or registered blind? The whole idea of World Class Commissioning is to look at ways of delivering services that not only cure people but also keep people active and participating in activities. It is about quality of life.

Opportunities for Optometry

This new approach presents so many opportunities to optometry when considering new ways of delivering services. Many of these considerations may move the profession away from the usual “sight testing” role but would very much fit in with the role of optometry being part of the front line for primary care services.

Activities such as managing smoking cessation in your patients, or looking for patients with a tendency towards obesity to refer to the local GP obesity clinic would all be acceptable areas to consider. A statement from the Department of Health says “World Class Commissioning is a statement of intent, aimed at delivering outstanding performance in the way we commission health and care services.” PCT/Health Board commissioners are being trained to deliver against this background and new way of working. Commissioners will be expected and required to take a strategic and long term approach to commissioning. They will be required to shift away from the traditional models of commissioning that have, in the past, often seemed like barriers to those who were trying to develop novel approaches to care delivery.

PCTs will be required to develop innovative partnerships with clinicians and providers as well as patients, general members of the public and local authorities, in order to achieve their aims. By developing closer links with all the service providers, they will be able to meet longer term priorities, thereby shifting the focus of care from the traditional stance of diagnosis and treatment to one of prevention and well being. This aspiration fits extraordinarily well with what optometrist can offer in modern primary care services.

World Class Commissioning states that clinical involvement will be a key to success. It acknowledges that clinicians have an important role to play in assessing local needs and shaping priorities because clinicians understand patient needs. They will, therefore, be crucial to designing high quality, personalised health and care services. This is where it will be vital for optometrists to form close links with their PBC groups, for it is within those groups that the decisions on commissioned services are taken.

To reiterate, in considering any approach to a PBC, it is vital that this whole concept of World Class Commissioning is understood. If you are able to demonstrate that all new services fit with the wider concept of WCC, any new proposal is already well down the road of acceptance. If you can demonstrate how a new service “fits the bill” you can be sure you will be knocking on an open door when it comes to consideration by a PBC group. At the same time, if the ‘provider’ business case presented to the PCT commissioners is written in the language of World Class Commissioning, you can be sure that the right language will have been used and that you have increased your chances of being heard.

Competencies in World Class Commissioning

Currently, many PCT commissioners are going through training to ensure that their PCT can meet the requirements of World Class Commissioning. You can, therefore, be assured you will not be met by blank faces when you start using WCC terminology. In fact you may well be pleasantly surprised to find you could well be ahead of the game.

When trained, these world class commissioners will have to be able to achieve results against a set of competencies:

- locally lead the NHS
- work with community partners
- engage with public and patients
- collaborate with clinicians
- manage knowledge and assess needs
- prioritise investment
- stimulate the market
- promote improvement and innovation
- secure procurement skills
- manage the local health system
- make sound financial investments

World Class Commissioning - Tips for LOCs/ROCs

With these competencies in mind, make yourself familiar with what drives commissioners locally. Why not encourage the LOC/ROC to invite a lead commissioner to come and present at a meeting of local optometrists on their role as a commissioner? You could then find out what they really expect of you. Involve them in your planning processes. You may well be amazed how much useful information you can gain, both in terms of vital, local statistical information and also in terms of information about rival systems being proposed. As an LOC/ROC you may like to consider employing the services of a commissioner to assist in developing both 'commissioner' and 'provider' business cases.

Find out the real "hot buttons" that drive thinking behind commissioning locally. It may be achieving the 18-week wait targets, or cost savings, or developing new services. If you can find as many of these hot buttons as possible and hit all or most of them in your business cases, you stand the maximum chance of success.

Remember this is about learning to operate on the opposition's home ground. It may feel a little alien to start with but it is a very necessary skill to learn. If you do nothing, you can be very sure that others will do the work you should be doing. It will not be long before they come and play on your pitch and ultimately move you out altogether.

There are many links and downloads with information regarding enhanced services and commissioning guidance on the AOP web site:

http://www.aop.org.uk/primary_care.html

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