

» **OPTOMETRIC**
OPPORTUNITY
IDEAS **PRIMARY**
PARTNERSHIP
CARE SUPPORT
DEVELOPMENT
CHOICE **TOOLKIT**
IMPROVEMENT «



» FOREWORD

The AOP produced the Primary Care Resource pack some years ago which has proved very valuable to Local Optometric Committees seeking to develop new services. A common request since then has been for sample or skeleton business cases. Samples have been published but the problem with trying to produce a skeleton model has always been the great differences between areas, especially in respect of finance and the willingness to consider shifting services from secondary care.

The arrival of Payment by Results and the National Tariff of secondary care fees and charges has changed all this. The NHS wishes to increase the movement of services from the secondary sector into primary care and has now given Primary Care Organisations the tools to achieve this. PCOs can now identify exactly how much a service costs, how much they will save by moving a service and the money then follows the patient.

So the AOP have commissioned the development of this Primary Care Toolkit. It contains information, spreadsheets, documents, and examples. Most importantly it contains a generic business case that can be tailored to your needs, along with help and a calculation tool to assist with completing it.

So what does the toolkit do? It gives you links to websites that will help you to find out necessary information for a business case; fees, case mixes, waiting times and so on. Some information you will, of course, need to obtain locally. Some information on the websites may be a year or more old, but you can treat it as the best available if no more up to date information is available locally.

The calculator spreadsheet lets you input all this newly gathered information and then it drops out some final, calculated figures. These are then inserted into the appropriate sections of the Generic Business Case document (it's a bit like painting by numbers really) to produce a finished business case.

Don't forget to read your final document carefully to ensure that you have tailored all the generic bits and that you have deleted any sections that have no relevance to your particular proposal. It might be embarrassing to find 'Caring PCT' or 'XXXX' still lurking somewhere in your document!

Let us know how you get on with the toolkit, and send Patricia O'Sullivan at the AOP any business cases you develop as a result of using it. The intention for the future is to make these cases available via the website as further examples to assist others.

This toolkit is an exciting development that will help LOCs, optometrists, advisers and primary care commissioners to produce effective business cases for presentation to primary care management teams. The AOP must be commended for its foresight in funding the development of an original idea from Simon Browning and Susan Hoath. In conjunction with the AOP Professional Services Committee and a reference group of practitioners from around the country, Simon and Susan have worked hard to turn the idea into a reality.

Trevor Warburton

Chairman, AOP Professional Services Committee

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OPTOMETRIC PRIMARY CARE TOOLKIT

1 INTRODUCTION

The Association of Optometrists has specifically designed this toolkit to assist optometrists working in primary care to negotiate with NHS organisations to deliver modern eye care services.

Optometrists possess skills that PCTs are very keen to harness. The way care is delivered to patients has changed greatly since April 2005 and optometrists are ideally placed to be major players in the delivery of that care. The problem has always been that PCTs do not really know about optometry and optometrists have tended to sit back and wait to be asked to do things. Hence the two parties have never really worked with each other. Furthermore many past attempts at setting up new services have failed because of the intransigence of the secondary sector.

This toolkit shows that optometrists have the capabilities and the desire to deliver services. Many of these are not 'enhanced services' that require new training but are actually 'core services', part of our basic training that we would do every day if we were funded to do them. This toolkit gives you the means by which to tender for those services thus allowing the funding to be released to do this work.

The toolkit comes in two parts: printed instructions and a CD ROM containing excel spreadsheets to help you design your own service proposal. It also contains sample proposals which you can customise. It is deliberately written in an easy to read style and encourages you to stop and think about what it is you really want to do. The spreadsheets enable you to see if your proposal is workable and if not, to return to your planning and make changes so that it becomes workable. It allows you to begin to think like PCT commissioners.

When you have completed this you will be able to plug the data into the sample proposal. This is not cast in stone and you can amend it to suit your local needs. The toolkit is a very flexible device that allows you to design whatever you want, cost it and then present it to commissioners. These may be PCT commissioners or GP commissioners. Only you know your local needs and local infrastructure. Only you

know what may work better locally. The toolkit gives you the ability to take that knowledge and use it on behalf of your colleagues locally.

Good luck with your service developments! Read the toolkit fully and then start planning!

Simon Browning

Optometric Adviser, Bedford PCT

Susan Hoath

Associate Director of Strategic Planning and Service Improvement

The toolkit was developed by two people who work within the Primary Care Trust arena and therefore understand what is needed when it comes to setting up new services. Susan Hoath has had a long dynamic career in the NHS and has led on commissioning services for Primary Care Trusts since their inception. Susan has ensured that the business cases within the toolkit are written in a language that, although it may appear strange or alien to optometrists initially, is exactly the language that commissioners work with and understand. Clearly to present a business case in this style is very important. Simon Browning has been an optometric adviser to both PCGs and then PCTs. More importantly he is the Chairman of his PCTs Professional Executive Committee. This has given him a far greater insight into the working of PCTs as a whole but also shown him where the services of optometrists can fit into the primary care agenda given the vastness of the overall care delivery system that is primary care.

2 BACKGROUND

Outline of the NHS changes to commissioning which give rise to the AOP's Primary Care Toolkit for the development of primary care optometric services

The 1st of April 2005 saw a fundamental and radical change in the way that secondary care services are funded within the NHS. This new system is known as 'Payment by Results.' (PbR) It is envisaged that from April 2005 around half of the hospital and community health service spending will be covered by this new scheme and, typically for a large District General Hospital approximately 70% of the income will be derived from the new National Tariff for services.

At the same time the government is pushing hard for the introduction of 'Practice Based Commissioning.' Whilst PBC could well mean any front line primary care practitioner commissioning services for their patients it is fair to say that in reality PCTs and most primary care practitioners other than GPs are actually not in a position to begin commissioning services from April of this year. Further it makes sense for practitioners such as optometrists to be the providers of packages of service to those who wish to commission it.

Logically GPs will look to their very large patient bases and the economies of scale that can be achieved by commissioning services for groups of practices and then look to deliver those services within the primary care arena. These services will look more completely at the entire needs of a patient rather than different aspects in isolation. For example a group of GPs may want to commission a primary care diabetes clinic and in that may want to see retinal screening take place at the same time as foot care checks and dietetic checks. It will be for the optometrist to answer the call to deliver a retinal screening service. This is why it makes sense to be the provider of the care package rather than commissioner of that package.

With this background, and bearing in mind these changes are two of the biggest changes the NHS has faced in the whole of its history it is logical to consider the impact on Optometrists and the services they can

provide to Primary Care Trusts. It has become clear as Payment by Results has developed and the National Tariffs have been announced that there is a potential serious financial risk to PCTs as a result of the new system.

Hospitals are finding themselves ever more short of funds and anyone reading the Health Service Press cannot have missed how serious this problem is. It has been argued that financial managers in hospitals are already alive to the potential rich pickings of PbR. How does all of this impinge on Optometry?

Under the new system of PbR a new 'adult first attendance' in an ophthalmology clinic will attract a payment of £96 whilst a 'child first attendance' will attract a payment of £130. Follow up appointments will attract payments of £47 & £63 respectively. It has been demonstrated elsewhere that many referrals to an ophthalmology clinic are discharged at first visit. Thus, to a PCT it will become very important to minimise referral to the secondary sector in the first instance as this is 'dead money.' Furthermore with Practice Based Commissioning GPs being allowed to keep a proportion of the savings made by moving services to primary care the need to set up new services that are more cost efficient in primary care is paramount to many where before that need never existed. The greater problem arises when the out-patient department will not discharge the patient but continually recalls the patient for six month reviews. This is often the case with patients deemed to be at greater risk of developing glaucoma.

From a hospital finance managers point of view knowing that the hospital has a 'captive' audience that generates £47 a visit is actually very good news. The potential to hold on to, for example, glaucoma patients and see them every six months instead of every year allows the finance team to double the income to the hospital from these patients.

One thousand glaucoma patients on the books will equate to an extra £47000 income a year. Why not see them in January to check IOP and discs and then again in July to be seen by a technician to have their fields checked? Employing a technician at £20000 would mean an instant increase in income of £27000 per annum to the hospital! Ironically optometry has recently seen the DH introduce a system of 'rationing' NHS sight tests in order that money is spent appropriately and yet this new system will work in exactly the opposite way.

There is also an ideal opportunity for out-patient departments to look at the current numbers of patients seen once and then discharged and consider the opportunities that exist to bring them back one extra time to ensure that nothing has been missed. It may be argued that this is not a cost effective way of operating but creative thinking will soon demonstrate that many of these people may well be suitable to be seen in nurse led clinics considerably reducing costs and therefore potentially increasing revenue to the secondary sector. All of these activities present large financial risk areas to PCTs and incentives to Practice Based GP Commissioners.

There is nothing in the guidance that suggests that this way of activity will in any way be prevented. In the guidance it states that, 'Follow up attendances are those that are not first attendances. The episode (or series) ends when the patient is not given a further appointment by the consultant or the patient has not attended for six months with no forthcoming appointment.' This is a license to create 'patients for life' and as a finance manager I would actively be encouraging my specialities to hold on to their 'guaranteed income' wherever possible, and preferably find reasons to see these people more often!

Optometrists up and down the country know how difficult it is to get some ophthalmology clinics to open up their doors and countenance new work methods using the skills of optometrists. Unfortunately these new payment structures are wholly counter-productive in attempting to open up systems. That having been said it is clear that whilst these new payment systems may potentially benefit hospitals they open up huge financial risks to the PCT organisations. They may well find their out patient budgets spiralling as they have no control over the

number of times a year a patient is seen and hence the amount they have to pay for that patient under tariff. Further they may see an increase as patients are held on to and not discharged. Clearly PCTs will look to prevent these costs starting in the first place.

This is where optometry has the greatest opportunity to influence events. It will be vital for PCTs to maintain activity in the primary care sector wherever possible and also to create systems that allow for patients to return to the primary care sector as soon as possible. GPs holding indicative commissioning budgets may be expected to commission service from the PCTs own primary care resources prior to referral to the secondary sector. This means a great opportunity for the setting up of primary care eye clinics for the purposes of refining referrals to keep people away from the ophthalmology clinics. Secondly GP commissioners would be expected to commission 'short stay' episodes with secondary care clinics. This means that a patient with, say, suspected glaucoma would be sent to the eye clinic for confirmation of the diagnosis plus a couple of visits to ensure stability and then passed back to the primary care set up for monitoring with an appropriately accredited optometrist. Optometry needs to demonstrate its ability to offer services at the same level or less than the tariff as being able to do so will maintain the money within the primary care arena where it can be controlled better.

There are great opportunities currently for optometry to present strong business cases to PCTs around this area. Whilst PCTs are alive to the problem, solutions are not necessarily being promulgated.

In the past optometry has very much waited for other organisations such as PCTs to come up with solutions. Often, as in the case of diabetic retinopathy screening, these solutions have left optometry out and are unimaginative resulting in a poor, and often expensive solution.

Most PCTs are very heavily involved in the whole work of implementing Choose and Book and Practice Based Commissioning and the likelihood is that we will see new systems that, at best lack imagination and do not really address root problems or, at worst, merely tinker with existing systems without much effort to radically change modalities.

If optometry acts now it has the opportunity to present to Primary Care Organisations (PCOs) a blueprint for the transfer of many secondary care services into the primary care sector making use of the under-utilised optometrist. For the first time there is a real need on the part of PCOs to make this happen as they are aware of the serious financial difficulties they could find themselves in.

The latest news around the re-configuration of PCTs in England should not be an obstacle either. The new PCTs will be much larger than they are now and therefore optometry can make a bigger impact on services and will have to argue its case less times. In handing over their provider services to other organisations PCTs will want to know that those services are robust and working to their maximum efficiency therefore they will want to position services prior to the changes when they can control the set up of the new systems. Also, no matter what the size of the PCTs in the new world, it will still be the Practice Based Commissioners who will be commissioning many of the services such as optometry can offer.

The purpose of this toolkit is to provide the means by which PCTs or other commissioners can be approached to pitch for delivery of modern services. It is written in a language that these people understand. It asks the questions commissioners will and it answers those questions and uses those answers to create a business case that is presented in a language that commissioners speak. Unfortunately NHS-speak is a fact of life and to get anywhere it needs to be used. This toolkit 'speaks the speak' but does it in a way that is easy for those who have not encountered the language before to understand and be comfortable with.

The toolkit has been developed using live data and has been road tested to see that it gives the information that is required. The good news is it works.

LOCs have never had a toolkit before directly aimed at NHS commissioners that will enable them to work on behalf of their local optometrists to develop new services. That toolkit is here now and every LOC in the country should have no difficulty in using it to develop the role of the optometrist in their own community.

3 PCT COMMISSIONING INFRASTRUCTURE

Your PCT will work with local authorities and other agencies that provide health and social care locally to make sure that your local community's needs are being met.

PCTs are now at the centre of the NHS and will get 75% of the NHS budget. As they are local organisations, they are in the best position to understand the needs of their community, so they can make sure that the organisations providing health and social care services are working effectively.

For example, your PCT must make sure there are enough services for people within their area and that these services are accessible. They must also make sure that all other health services are provided, including hospitals, dentists, opticians, mental health services, NHS Walk-In Centres, NHS Direct, patient transport (including Accident & Emergency), population screening, and pharmacies. They are also responsible for getting health and social care systems working together to the benefit of patients.

Department of Health, 2005

Commissioning frameworks are constantly evolving as service models and provider structures change. This is part of the constant cycle of change and development within the NHS, and although that makes it harder for us to write a definitive guide, it does mean that commissioning processes are in themselves constantly improving, making it easier to be commissioned.

Each PCT receives an annual resource allocation, from which all services need to be commissioned. Traditionally, this commissioning is, in the main, tied to an annual planning cycle which identifies needs, contracts with service providers, and commits funding to providers. Recent national changes in the commissioning framework have seen the adoption

of 'payment by results' which, with a nationally set tariff for many key secondary care processes and procedures, allows, arguably for the first time, a currency to be applied to the uptake of health care. The flow of finance around the health service can be demonstrated (in a simplified way) in the diagram opposite.

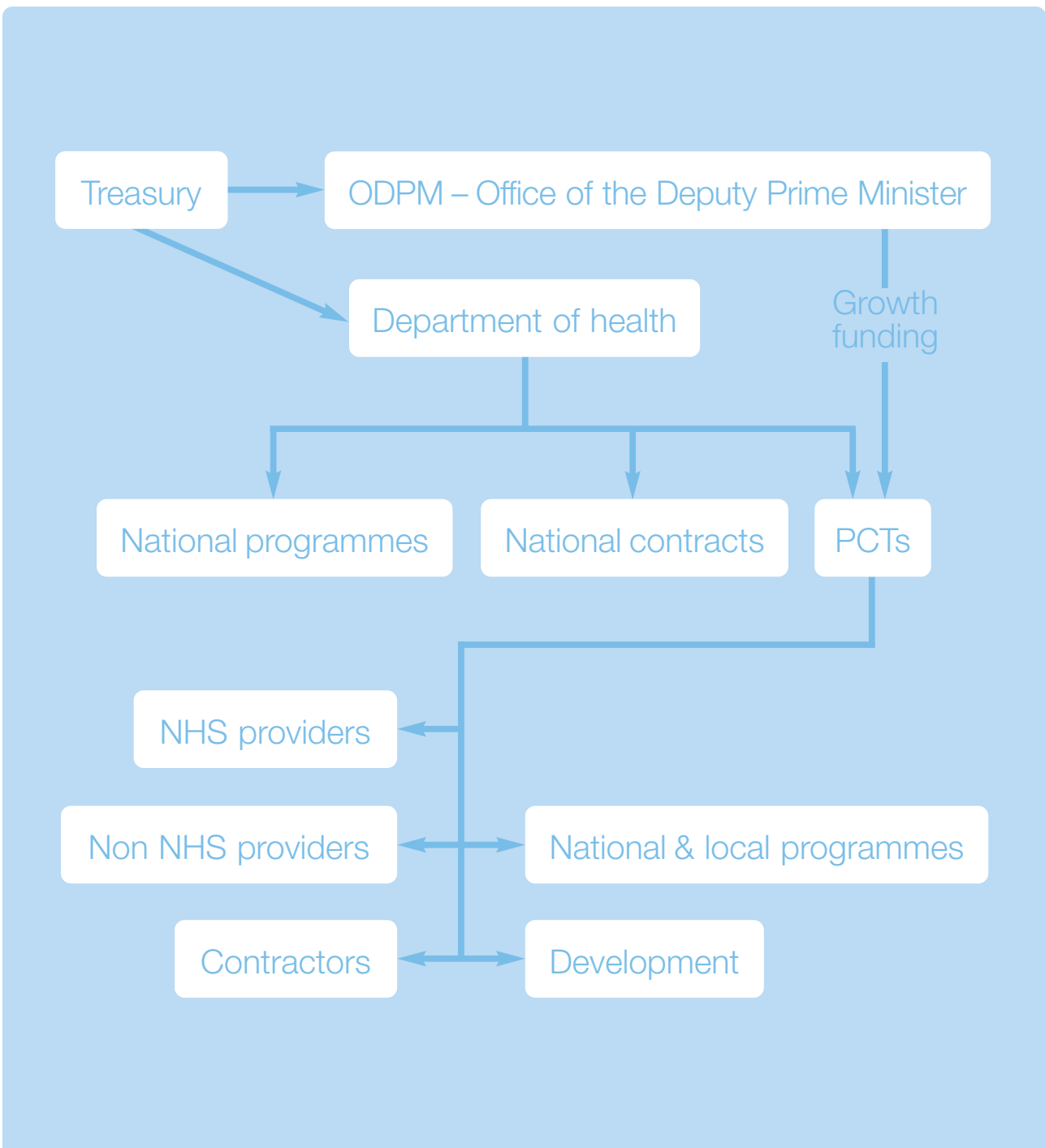
At the time of writing, NHS funding for optometry is worth around £345M per year, paid under the national contract between optometrists and the DH. This funding is termed 'non-cash-limited' because it has no cash resource limitation. This funding is not part of PCTs' resource allocations or baselines. PCTs do, however, meet the costs of all other areas of NHS funded patient care in relation to ophthalmology, orthoptist and optometric services, generally on a pay-per-patient-episode basis.

In order to maximise the utilisation of their allocations, all PCTs will look to commission the most cost and clinically effective models of service available to them and their patients, whilst delivering the highest standards of care achievable within those limits and improving health. This will, of course, be of particular relevance in health systems where cash resources are especially limited and commissioners find themselves facing over-spend positions.

Due to the cash-limited nature of their resources, PCTs that overspend in one year are expected to recover the value of this overspend on a recurrent basis in subsequent financial years. This requirement means that service developments are usually required to release resources and make savings.

More information on the way in which cash and resources are allocated and managed within the health service is available on the Department of Health Website www.dh.gov.uk.

HEALTH SERVICE FINANCE



4 USING THE TOOLKIT

Instructions

This toolkit has been designed to support individuals and organisations in the development and production of a business case proposing a new or enhanced service in primary care. It does this by pointing the users towards a range of data sources via Excel spreadsheets on the accompanying CD ROM.

Read the information contained in this booklet thoroughly. Then load the CD ROM and start by looking at the Generic Proposal Calculator spreadsheet and the Generic Business Case document, reading the various tabbed worksheets as indicated ('Read this First', then 'Step by Step Guide'). Fill in the boxes on the spreadsheet. The web links will help you to locate some data, although you will need to obtain some locally. The final figures drop out into one of the worksheets with reference numbers alongside. The reference numbers indicate where the figures go in the Generic Business Case document.

The CD also contains sample proposals for new services in glaucoma and children's cycloplegia, as well as a generic proposal which you can adapt to suit your requirements. Be pragmatic; if you don't think something adds to your case or presents a realistic picture, don't include it in your argument. Equally, if other, locally relevant information exists, make sure that you include it in your reasoning.

Assumptions

Whilst the toolkit contains a number of tools, it also makes some assumptions of its users, as follows:

- **Relationships and partnerships** the toolkit will be of most use to support health systems where joint working and mutual understanding already exist. It is not necessarily the best way to approach an aggressive take-over bid for hospital services, for example, although it will still support generation of a case for consideration of primary care based alternatives. LOCs who already have good working relationships with some or all of their PCTs will probably find this tool kit easier to use

than those who don't, simply because they will be better able to 'phone up and ask' their PCTs, however, the toolkit offers alternative sources for the majority of data-items that you may require.

- **Drivers for change** to be successful in supporting a case for change, we have had to assume that such a case can be made. If you are lucky enough to work in an area where the existing services are high quality, low cost and fully integrated across primary and secondary care then you probably don't need to read any further.

If you don't work in this ideal place, then identifying the key drivers for change will help not only to approach the design of your new service but also where you might identify champions, supporters and project sponsors.

These drivers are likely to include

- Reducing expenditure
- Releasing capacity in secondary care/shifting services from secondary to primary care/ expanding capacity in primary care
- Tackling health inequalities
- Improving services for key patient groups e.g. over 75s, children, people with diabetes

Build on what you know...

You should rarely need to start from scratch. Even if no plans exist to redesign primary care eye services, someone somewhere will be looking into or even piloting a new service that you can present a natural progression from. This could be the introduction of direct referrals from Optometrists, Choice, Cost Saving initiatives or Clinical Governance Initiatives.

Network around the local health system, find and talk to service redesign or modernisation leads or people working in the hospital eye service. Use your contacts to spy out the right people 'in the know'.

The value of local information must not be underestimated. Anecdotes or evidence collected from referrers to, or users of, a local service will be just as if not more valuable when presenting a case for change.

...and build up what you know

Wherever possible, undertake local audits (these do not have to be complex) to back up your argument, but could be used, for example, in relation to referral patterns. The calculations tool offers a breakdown of referrals from optometrists into categories that are likely to form the basis of common service plans. To audit local (and therefore arguably more relevant) practice, simply ask a number of local optometrists to record their reason for referral, behind a sample of referrals made to the Hospital Eye Service (or via GPs). If you don't have the opportunity or resource to do this, the figures in the spreadsheet were derived in this way and can be quoted as 'audits in other health systems have indicated the following break-down of referrals' or words to this effect.

Be pragmatic

Although this is (one of) the most important project(s) you are involved in, it is one of many things being presented to the PCT as a good idea. Confidence in your concept and case is important, and being able to back up your claims and assumptions relies on you being able to prove your point. This does not mean that you need to know every detail – simply that you need to be able to demonstrate why you believe your way is better.

If something within the toolkit does not appear to add value to your argument or perhaps when you go to look up the data some of it is missing, use what you have, and try to adapt. For example, the waiting times listed on the Dr Foster Website are by consultant. You will need to apply some local information to test the relevance of the data presented... is it up to date and if not, is it still right (or about right, right enough)? If there's a consultant with a published waiting time of 2 weeks while the rest state a waiting time of 16 weeks, is this a new appointment or someone nearing retirement perhaps? Maybe they only work 1 day a week! There are lots of things that can skew this kind of data, so use it wisely. Equally, if waiting times are not an issue locally to you,

there's not a lot of point in trying to sell your idea on the basis that it will be quick. You will need to find another benefit on which to focus – reducing costs, targeting inequalities, etc.

Be flexible

If you start to develop your plans and it becomes apparent that you are not going to be able to deliver the utopian service that is quicker, cheaper, cleaner and more clinically effective than the current one, there is little point persisting down a route that is highly likely to end up in frustration for all.

Resist the urge to reinvent a wheel

Enthusiasm is a valuable thing, but don't waste it on efforts that have already been made by someone else. Before you go too far down your redesign and business case process, check around the local health community to see if anyone else is looking at eye services, or even at shifting hospital services into primary care for other clinical areas. Use your networks, and those of others, to best advantage to achieve maximum impact for the efforts you put in.

Be prepared to learn

The toolkit contains a range of resources, including word documents; excel spreadsheets, power-point presentations and websites (accessed through web-links). Although the toolkit assumes a degree of computer and internet literacy, it also attempts to lead the user gently through the process. Each time you use it, it should get easier. Over time you will find that the tools in the toolkit no longer do what you want or need them to, and that's fine – all are able to be edited, copied and developed so that they stay useful.

Describe a patient experience

Describing a service in terms of patient experience can be a very effective way of exposing the short-falls and faults in a current system, and supporting your case for change. If possible, ask some patients to keep journals of their experiences, or consider compiling a photographed 'day in the life of a patient'. These are extremely powerful ways to demonstrate that a system is failing the patient.

5 DESIGNING A SERVICE

Before you start

10 questions to ask yourself:

- Do we really want to do this?
- Can we demonstrate a need?
- Can we reasonably expect a cost saving?
- Are we building a central service, or a practice-based one?
- Who will be the 'provider' organisation(s)?
- Do we have a team to implement this?
- Do we have enough staff/professionals to deliver it?
- Is our PCT pro-active around primary care development?
- What's the best time to launch this?
- Who are our allies and champions?

Hints and tips

One – let someone else do the hard work

There are already many examples across the UK and further-a-field where entrepreneurial individuals have driven and implemented service redesign. In most cases they have also been good enough to evaluate and publish their success so that it can be picked up for implementation in other areas. The Internet offers unprecedented access to this information and various journals publish up to date details of such services.

Two – think laterally

Even if a directly applicable example of a modernised service model is not available, there may be other tricks to be learnt by looking at current and best practice. A particularly innovative approach to delivering local dental services, for example, or the introduction of a community-based diabetes service may offer parallels that can be drawn into the design of a primary care eye service.

Three – use collective brain power

Involving the right people at the start of the process can help to smooth the way later on; from the design of a new model through discussions with commissioners to implementation. Identifying key stakeholders and how best to involve them is a key part of this.

Four – be pragmatic and flexible

There is little point in flogging the proverbial dead-horse. If your personal vision is not shared by others, or isn't attracting the attention of your commissioners then, although it will be galling to do so, your best bet is probably to put it on the shelf and try something else. After-all it will still be there next year when they are ready to listen.

Be ready to adapt ideas and to compromise where necessary in order to achieve a result. Holding tight to your argument may mean you achieve nothing when compromise would get a service in place that meets most of your aspirations.

Five – consider things from a patient perspective

Whilst this sounds obvious, you would be amazed at how many professionals and clinicians think of themselves first! Recording and reporting genuine patient experiences can be a powerful and informative way to support the need for change.

A top tip is to design something so that your mother-in-law would be happy with it, after-all your own mother will always forgive you and if you think patients complain wait until your mother-in-law starts!

6 TAKING A GOOD IDEA FORWARD

Translating a good idea into a service proposal is no mean feat and will require a range of thought and development processes.

Many of them can be supported by the tool kit and although the checklist below is by no means exhaustive it should ensure that proposals are well prepared and supported.

Objectives documenting the original idea and the objectives of your project will make it easier to gain support from stakeholders and help to keep everyone focussed on the goal. These can be generic ('Improving access to local services for older people') or specific ('reducing the waiting time for an early diagnosis from 12 months to 12 days').

Leadership clinical and managerial leaders will be absolutely essential in getting any idea heard, considered and implemented. Choose your leads and leaders with care and ensure that they are appropriately supported.

Stakeholders involving and consulting the right people in advance of attempting to implement a new service will not only help to smooth the process but also inform the details of your plans.

Process and accountability no-one really likes to attend meetings for meetings' sake, however it is important that any project has a clear line of accountability to an organisation that can take responsibility for it's development. This will usually be an LOC or host public sector or voluntary organisation, however it could be an independent one. A Steering Group made up of a small number of key individuals will support the project development and can facilitate actions to deal with any barriers or problems that arise.

Reporting progress reporting project process progress to interested parties will maintain momentum and can be a useful mechanism to build expectations and support.

Building the case collecting background data and information will take time at the beginning of the process but can save a lot of time later on. Being prepared with data to support your projected demand and uptake for a service will help robust costing and planning processes. There are some tools to support this process in the toolkit and signposts to some others.

Target audience we are all familiar with and understand our own professional language network, inevitably full of acronyms and jargon. It is important to remember that these terms are not as familiar to other audiences who will often have language-sets of their own. When preparing documents or presentations, it is important to consider the target audience and pitch your proposals appropriately. A room full of GPs may have different priorities and expectations of a service than a group of finance and commissioning managers, for example. If possible, look at documents being prepared by the audience group to get a feel for this.

Use and promote existing strengths as well as 'selling' the new elements of your proposal, take time to list and emphasise the existing strengths that are being brought in as part of the package – including existing competencies, other successful services, patient satisfaction, partnership working, etc.

Easy audits measurement of a baseline position will add not only credibility to a proposal but a point against which you can later demonstrate successful improvement. Choose your measures carefully. They should be quantitative (rather than subjective or qualitative) and any measurement process that counts something that is already being recorded will be easier to manage.

Forget GOS (yes brave we know) – there is a risk that one gets caught in the limitations of a familiar way of working to the degree where developing concepts that work outside it is uncomfortable and therefore less likely to succeed.

WIIFM – ‘What’s In It For Me’ to get support for any initiative, you will need to demonstrate to stakeholders that there are relevant benefits to be drawn. This could be reduced waiting times, improved access, better feedback to referrers, improved clinical governance, professional development, improved status or more money!

No-one knows everything! There are situations where an educated guess needs to be used, and it can be perfectly acceptable to do so (NHS Managers work on this basis all the time). In such situations think about the assumptions that you have made and their validity.

Negotiating at the margins if the cost gap isn’t big enough, consider ways in which better value for money could be demonstrated, using, for instance:

- Deferred payment
- Lease rather than buy equipment
- Seek an independent sector provider/sponsor
- Offer to redeploy NHS staff
- Include reduced demand on other service areas (eg: Social Services)
- Include health promotion services (eg: smoking cessation)
- Quantify the associated benefits:
 - improved patient independence
 - rapid access to diagnosis
 - feedback to referrers
 - workforce and professional development

7 STAKEHOLDER INVOLVEMENT

The NHS has often been criticised historically for not involving its staff, patients and other stakeholders effectively enough in service design.

Whilst many senior clinicians and managers will argue that such involvement can be a time consuming and difficult process, there is no doubt that projects that have successfully engaged patients and the public have also seen many benefits from the efforts put in.

Key stakeholders for a project around improving or developing primary care eye services may include representatives from some of the following groups:

- Health professionals
 - Optometrists
 - GPs
 - Consultant Ophthalmologists
 - Ophthalmic Medical Practitioners
 - Hospital Eye Service Staff
 - Orthoptists
 - School nurses
 - Health improvement specialists
 - Public Health specialists
- NHS staff
 - PCT Commissioners
 - Hospital eye service managers
 - Data analysts/managers
 - PCT Optometric Advisor (where applicable)
 - Primary Care Development leads
- Social Services leads for visual impairment services (if applicable)
- Voluntary sector
 - Organisations working with people with visual impairment
 - Organisations working with older people
 - Organisations working with target patient groups
- Patient and Public Representatives
 - Expert Patient leads (PCTs)
 - Patient Advisory Liaison Service (PALS) leads
 - Local Public and Patient Involvement (PPI) groups
 - Service users and carers
 - MPs, councillors and public officers

There are few 'rules' in relation to engagement and, as with any project team, it is important to get a mixture of skills and perspectives, rather than just trying to tick boxes. This can be done through a series of separate meetings, a virtual or email-based conversation, or getting everyone around a big table.

8 PROCESS AND PATHWAY MAPPING

These techniques have been developed by the NHS Modernisation Agency to capture a patient's journey through an NHS episode of care and the parallel information flows that facilitate this. There are 'standard' pathways available for many patient groups and these, or slight variations of them, often play a key part in the planning and evaluation of existing examples of best practice.

Service development teams in local health communities will often use a pathway map to engage stakeholders in discussions about the various stages of progression along a journey, such as thresholds for referral and transfers of care. Using the input from such discussions to develop a process map for your proposed service will strengthen the case for commissioners and support implementation.

Sample pathways included in the toolkit:

- Glaucoma referral refinement
- Children's services
- Cataracts (as per the National Pathway)

To develop a process map is a relatively easy process and relies on a few simple steps.

- Define, in advance, the 'pathway' you are going to map – for example a patient journey through an eye service. This will involve a point of presentation, a series of events and, eventually, an end point at which the patient leaves the service.

- Break down this journey into a series of steps, for example:
 - Patient makes appointment to see Optometrist
 - Patient attends appointment
 - Optometrist carries out assessment
 - Decision to refer (and choice offered?)
 - Referral sent to Hospital Eye Service etc...
- Assess each step again (if necessary) to define more detail. The third bullet point above, for example, will actually involve a series of examinations, investigations and discussions with the patient.
- Having broken down the existing pathway, you can then examine it objectively and identify steps which could be redesigned or even removed to make improvements to the service, patient experience and safety, and even the clinical outcomes.
- Now you can rebuild your new (proposed) pathway for the new look service and describe the way in which the service will work

9 GLOSSARY OF TERMS

Acute Services Medical and surgical treatment and care usually provided in hospitals.

Acute Trust An NHS organisation which provides secondary care or hospital based health care services. Acute trusts may include one or more hospitals.

Cash Limited Funding Funding devolved from central government to local organisations for the provision of health services. This is a finite resource and organisations have to operate within the limits of that resource.

Choose and Book A main government initiative allowing patients who require an elective referral to be offered a choice of 4–5 hospitals or alternative providers and a choice of time and date for their booked appointment at the time they are referred by their GP or primary care professional.

Clinical Network A network of health professionals from different NHS organisations working together across institutional and local boundaries, to provide optimum care for a particular disease or patient group.

Commissioner Representative Usually an officer – of a commissioning organisation (see below).

Commissioning The process by which health needs of the population are defined, priorities determined and appropriate services procured, purchased and monitored.

Contracting In the context of NHS contracting, this refers to entering into an agreement to deliver services to a pre-agreed specification or set of terms and conditions.

DGH – District General Hospital

A generic term for a non-specialist acute hospital which, although still widely used is technically no longer appropriate.

Dr Foster A reference resource that offers comparative data and information to patients and professionals regarding the performance of NHS services against a range of quality and service delivery measures. www.drfooster.co.uk

Elective Referral A referral made by a primary care practitioner because the patient needs further investigation or specialist treatment/surgery.

ESP – Extended Scope Practitioner Clinicians in any recognised speciality with an extended scope of practise, often requiring additional training and accreditation.

FFCE – First Finished consultant Episode This term is used to describe an episode of care within a consultant-led service i.e.: including outpatient, treatment, procedure and follow-up appointments.

GOC – General Optical Council The statutory body responsible for registering optometrists, OMPs and dispensing opticians and regulating the practice of optometry.

GP – General Practitioner A doctor providing primary care services.

GPwSI – General Practitioner with Special Interest These GPs may deliver a special service beyond the normal scope of general practise, undertake advanced procedures, or develop services. They do not offer a full consultant service.

HES – Hospital Eye Service Specialist ophthalmic units in major hospitals providing consultative, specialist medical and surgical services.

HES Activity – Hospital Episode Statistics Activity Nationally collected and reported data on the activity undertaken by Acute Hospitals in England and Wales.

HRG – Health Resource Group A collection of surgical procedures that take the same amount of NHS resource as each other to deliver. These are grouped together for financial and data collection purposes.

LOC – Local Optometric Committee The statutory body representing optometrists (?and dispensing opticians?) at a local level.

LSP – Local Strategic Partnership A statutory partnership between the statutory organisations serving a common population (usually at Local Authority Level) and responsible for the coordination of service delivery across agencies.

Also

LSP – Local Service Provider Under NHS Connecting for Health LSPs are identified as the providers of IT services and networks. See also NHS Connecting for Health below.

MFF – Market Forces Factor A nationally calculated figure used to modify the National Tariff to account for local differences in costs.

Modernisation Agency A national body charged with improving ways in which NHS services are delivered which was merged with other NHS leadership and improvement organisations as part of the arms length bodies review.

NSF – National Service Framework Frameworks, which bring together evidence of clinical and cost effectiveness and the views of service users to ensure consistent access to services and quality of care right across the country. These are ten year programmes setting out the standards which the health service must meet in major care areas and disease groups, and contain specific targets that commissioning organisations need to achieve.

National Tariff A nationally calculated monetary figure for procedures that are carried out within the secondary healthcare sector, offering consistent costs to commissioners across NHS and non-NHS providers. This is calculated per attendance and is divided into first visit and subsequent visit costing.

NHS Connecting For Health A national programme (superseding NpfiT – see below) to redevelop and modernise IT within the NHS. This overarching project comprises a number of separate delivery streams including:

ESR – Electronic Staff Records

EHR – Electronic Health Records

The ‘Spine’ a central and common data-transfer mechanism.

PACS – Picture Archiving and Communications System that allows the capture, transfer and storage of digital clinical images.

NPfiT – The National programme for Information Technology Now superseded by NHS Connecting for Health (see above).

NHSNet aka N3 (the New NHS Network)

The IT Network that operates, in effect, like a NHS intranet. All IT systems commissioned by and connected to the NHS need to be compliant with the terms and conditions required for the NHSNet.

NSF – National Service Framework

Frameworks, which bring together evidence for clinical and cost effectiveness with the views of service users to ensure consistent access to services and quality of care right across the country. These are ten year programmes spelling out the standards the health service must meet in major care areas and disease groups and contain specific targets that commissioning organisations need to achieve.

National Tariff A nationally calculated monetary figure for procedures to be carried out within the secondary healthcare sector, offering consistent costs to commissioners across NHS and non-NHS providers. This is calculated per attendance and is divided into first visit and subsequent visit costing.

NHS Alliance A national organisation, representing primary care practitioners. Traditionally very GP based in its outlook but lately adopting a much wider remit to take into account the wider face of primary care. The Alliance describes itself as a national membership organisation rooted in primary care drawing its membership from both primary care organisations in the UK and individuals working in primary care.

NHS Confederation The Membership body for organisations comprising the NHS, the NHS Confederation offers strategic support, direction and advice both to NHS organisations and the Department of Health.

NHS Portal www.nhs.uk The website through which the public can access information about the NHS on a national and local level.

OMP – Ophthalmic Medical

Practitioner A doctor who is qualified to carry out sight tests and is registered to do so with the GOC.

OPD – Out Patients Department

Outpatient A patient attending for treatment, consultation and advice, but not requiring bed-based care or staying in hospital.

Ophthalmologist A doctor who specialises in the medical and surgical treatment of disorders of the eye.

Optometrist Also known as an ophthalmic optician, is a person trained to carry out eye examinations, sight tests, fit contact lenses, recognise disorders of the eye and surrounding regions, recognise other abnormalities that may be related to eye disorders and treat or manage accordingly. Optometrists also supply spectacles. Optometrists are registered with the General Optical Council.

Orthoptist A practitioner specialising in the treatment and correction of squint and amblyopia. Orthoptists often work in association with ophthalmologists but increasingly work as part of an enlarged team in a primary care setting.

Patient Pathway The route followed by the patient into, through and out of, health and social care services.

PBC – Practice Based Commissioning

Practice-based commissioning enables GPs to commission care and other services that are directly tailored to the needs of their patients. Practices can keep up to 100 percent of any savings made by agreement with local primary care trust (PCT).

PBR – Payment By Results

A mechanism of financial flow by which the 'money follows the patient'. In practice this means that a hospital is paid for every outpatient appointment and procedure undertaken, but equally does not receive funding for those that are dealt with in an alternative service model. In effect this helps commissioners to 'take money out' of the acute sector.

PCO – Primary Care Organisation

A generic term for Primary Care Trusts, Care Trusts, Local Health Boards and other primary care organisations that have commissioning responsibility.

Primary Care Health Services delivered in or near a person's place of residence to which patients have direct access. These services include those provided in GPs' practices, health centres, specialist centres such as primary care eye clinics, children's centres, community hospitals or patients' places of residence, by a team of professional staff including GPs, practice nurses, community nurses, optometrists, therapists and others.

PCT – Primary Care Trust

A freestanding statutory NHS body responsible for delivering better health and care to its local population. PCTs have their own budgets for local healthcare and are able to develop services for patients. In their own right they exercise many of the functions of the former health authorities concerning primary care and in commissioning services. They may also manage facilities such as health centres and community hospitals.

Process Map/Mapping A systems analysis technique that works well in describing the organisation of, and patient flow through health care services in terms of referral routes and information flows.

PSU – Practitioner Services Unit/ Payment Agency A unit contracted to monitor probity and handle the pay of those providing NHS services.

QOF – Quality Outcomes Framework

A framework to assess the performance of a GP against a selected number of clinical and managerial criteria and to reward achievement of those criteria within a framework of financial incentives.

Secondary Care Patients whose needs are too complex to be managed in primary care are referred to more specialist services. Secondary care includes local hospitals and specialist services.

SHA – Strategic Health Authority

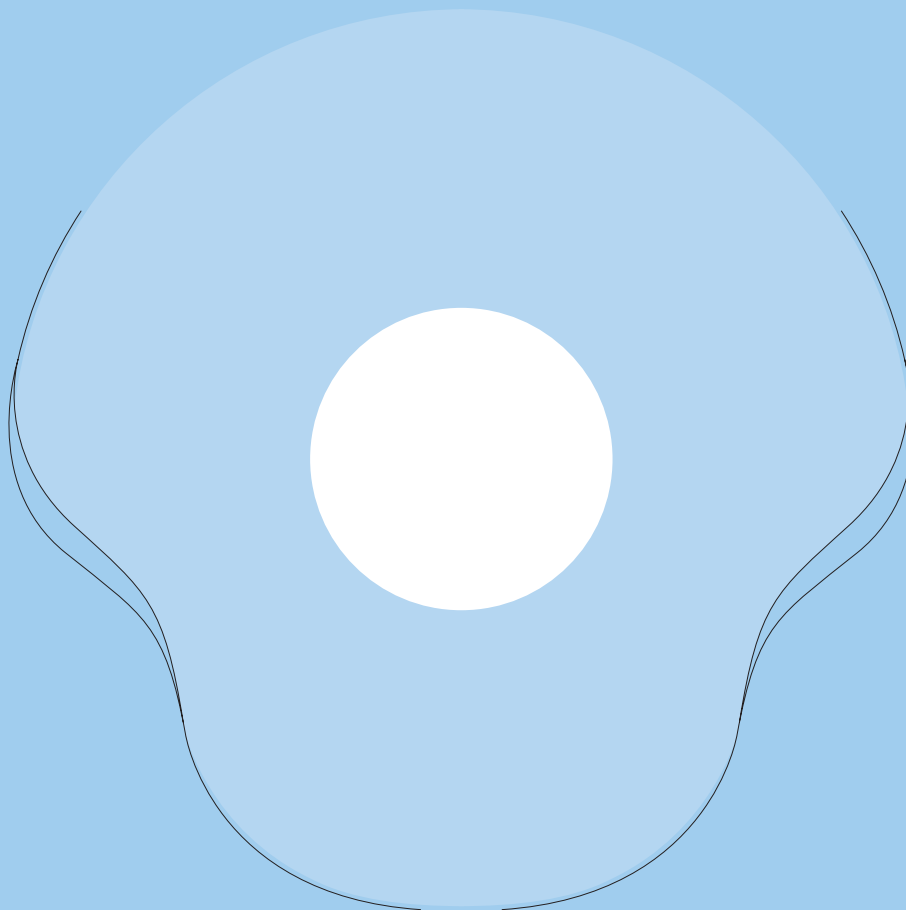
As the 'outreach' offices of the Department of Health, these replaced health authorities in England. They provide strategic leadership and performance manage NHS trusts and primary care trusts.

Stakeholder In the context of the NHS, a stakeholder is an individual or organisation with a direct or explicit interest in an area of service delivery. These will include users and providers of a service, public representatives, advocacy organisations, statutory bodies and commissioners.

10 TOOLKIT CD

What's on the CD?

- Generic Proposal Calculator spreadsheet
- Generic Business Case document
- Example spreadsheet and business cases for children
- Example spreadsheet and business cases for glaucoma
- Resource pack spreadsheet
- Optometric Fee Calculator
- Sample Powerpoint presentation



Instructions

This toolkit has been designed to support individuals and organisations in the development and production of a business case proposing a new or enhanced service in primary care. It does this by pointing the users towards a range of data sources via Excel spreadsheets on the accompanying CD ROM.

Read the information contained in this booklet thoroughly. Then load the CD ROM and start by looking at the Generic Proposal Calculator spreadsheet and the Generic Business Case document, reading the various tabbed worksheets as indicated ('Read this First', then 'Step by Step Guide'). Fill in the boxes on the spreadsheet. The web links will help you to locate some data,

although you will need to obtain some locally. The final figures drop out into one of the worksheets with reference numbers alongside. The reference numbers indicate where the figures go in the Generic Business Case document.

The CD also contains sample proposals for new services in glaucoma and children's cycloplegia, as well as a generic proposal which you can adapt to suit your requirements. Be pragmatic; if you don't think something adds to your case or presents a realistic picture, don't include it in your argument. Equally, if other, locally relevant information exists, make sure that you include it in your reasoning.



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