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Guidance on Transparency and Limited Participation in Enhanced Services

2008

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1 Introduction

This paper is to give guidance on transparency in enhanced service schemes for LOCs/AOCs and primary care organisations specifically where participation is limited. It has been developed by the Association of Optometrists, the College of Optometrists and the Federation of Ophthalmic and Dispensing Opticians.

There are many benefits of participation in enhanced service schemes (formerly referred to as shared care or co-management) particularly with regard to better patient access and choice and developing wider NHS optometric services in a community optometric practice setting. There are of course some cases where not all practices can take part in a scheme for a variety of reasons. It is becoming increasingly apparent that there are potential issues with fairness and transparency in how services are set up and participating optometrists are selected. This guidance is designed to replace the *Guidance on Transparency in Co-Management (Dec 2004)* and is intended to be read alongside *The Corporate Governance Framework Manual for PCTs, produced by the Department of Health::*
http://www.dh.gov.uk/en/Healthcare/Primarycare/Primarycaretrusts/DH_4000579

It should be emphasised that although this advice is focussed on how LOC/AOCs should approach limited participation issues, individual practitioners or small groups wishing to deliver “niche market” services should give consideration as to the effect this has on fellow practitioners. This applies particularly, where some or all of the practitioners involved are committee members of LOC/AOCs so as not to compromise their integrity as members.

2 Key Issues

Whilst it is hoped that schemes remain open for most if not all optometrists to take part, it is inevitable that many future schemes will be based on limited participation for a variety of reasons. Such as the need to maintain sufficient experience, additional qualifications, equipment levels required, geographical constraints, fixed funding budgets and possibly even because the number of patients involved is small. It is very unlikely that optometry can progress much further in the modern NHS until it addresses this dilemma. There are a number of issues that are pertinent for optometrists as independent contractors, as well as LOC/AOCs within enhanced service schemes with limited participation and these include:

- Optometrists are independent contractors and often in direct commercial competition with each other. Participation in limited enhanced service schemes may have major impact on the businesses of local practices which is much wider than the immediate effect of the scheme. e.g. if all diabetic patients are directed to one practice in a town, it is quite likely that other members of their family may also switch to that practice for routine sight tests/spectacles etc., to the detriment of other practices in the area. Great care must also be taken not to infer a misplaced impression of superiority over others.

- LOC officers tend to be amongst the most pro-active and forward-looking members of the profession and instrumental in setting up enhanced service schemes. Their participation in limited enhanced service schemes is not surprising, but optometrists who are not LOC officers should have equal access and opportunity to compete for participation.

- Schemes that are within optometric core competencies should be open to all optometrists even if not all may ultimately be able to take part. Inevitably, some schemes require a considerable amount of extra training/equipment to participate and both economics and caseload may require limited participation to function. However, reasons for limited participation involvement should be transparent to all

- Some schemes are only designed for those with additional qualifications in mind. LOC/AOCs should be mindful of the time taken to achieve these and should communicate their plans well in advance where possible

- Accreditation of additional practitioners e.g. new to area, expansion of scheme, replacement for practitioners leaving the scheme, must be correctly managed and timetabled, to avoid “closed shops”

- Budgetary constraints from funders or low numbers of target group patients can limit participation geographically, the selection process and reasons for this must be well communicated to reduce risk of conflict

- Limited participation schemes may make the majority of practitioners feel excluded. Consideration should be given as to whether it would be more appropriate to deliver these services from a neutral primary care centre.

3 Effective consultation, planning, communication and apathy

The key overriding factor in limited participation schemes and indeed any scheme is the ability of the LOC/AOC to consult with members, plan ahead and communicate the progress of such plans effectively. Various methods of communication should be employed such as mailing lists, e-mail and web sites. Communication can be in the form of minutes, newsletter and/or questionnaires. It should not be assumed that attendance of LOC/AOC meetings is the sole essential requirement to participation no matter how desirable that may be to some.

Clear reasons should be communicated as to why schemes may only require a small number of participants. The more complex the scheme, the more time should be allowed in the planning stage to allow practitioners to make their own plans regarding further education or specific equipment investment.

Any development strategy, delivery plan or business plans should support the conclusions reached in developing a limited scheme.

When designing enhanced service schemes, thought should be given as to how referring optometrists not involved in schemes, can have referral feedback from those in the scheme to assist in skill development and to benefit from positive communication, particularly from secondary care.

As many limited schemes rely on referral into such schemes from the very people that are being excluded, it makes good sense to plan for as much involvement of others as possible. This could involve consultation on the format of referral forms and bids may even need to take into account the cost of providing such a referral service in the business plan. Similarly, all practices should be consulted regarding information provided in patient leaflets, which should be sympathetically designed so as to not to exclude those practitioners who will ultimately be helping to make limited schemes a success by choosing whether they refer in directly or not.

There is clear evidence however of many organisations confusing the reluctance of others to respond to communication or consultation as general apathy or acceptance of what is being proposed. Apathy could be regarded as a general state of mind fuelled by lack of information and inappropriate communication. As this guidance is for LOC/AOCs, as representative of all modes of practice, a lack of response should not be seen as an excuse not to continue providing information, it may be more appropriate to review how the information is being provided.

Conversely, if individual practitioners feel excluded, then the most appropriate course of action is to get involved. A view can not be taken into account unless expressed by the individual and it is apparent that due to the intense activity taking place in enhanced services development, that LOC/AOCs face a heavy workload and would most likely welcome the extra assistance. Transparency can only really be proven if a light is shone through it at times, from both sides.

4 Process for selecting participants

In line with NHS values the process for selecting participants must be open and transparent. It must start by inviting **ALL** optometrists to apply if they wish. It may be necessary to include additional, formal qualifications but only with the agreement of the profession e.g. therapeutics. In this instance it must be clear that any proposal is not simply to benefit a chosen few.

There may be a requirement to include issues of geographic coverage and selection criteria should be specified in advance, perhaps with an invitation letter. In certain geographic situations, it may be that there are practices that could serve the need that reside adjacent to, but outside the PCO boundary. Consideration could be given as to how to possibly include these in the selection process.

Where pre-defined selection criteria do not automatically determine which practices take part e.g. practices in a town with similar facilities etc:-

- The process for deciding which practices take part must be agreed by the stakeholders; usually the LOC and NHS organisations funding the scheme
- Arbitrary choices without reasons are unacceptable
- All must have an equal opportunity – subject to considerations set out below to take part
- There must be a full declaration of interest by anyone involved in the decision process such as the participants or others with vested interest and these parties should not be involved in the selection process.
- As a general rule, neither LOC officers, optometric advisors who practice locally, nor any other local optometrists should have the leading role in the decision-making process. The process should be led by PCT managers, with the possible addition of an optometric advisor who practices out of the area. There is no problem with LOC officers being involved in the process but their input must be honest, open and transparent in line with *The Corporate Governance Framework Manual for PCTs (August 2003)*
- All involved must be fully informed of the decision-making process

5 Accreditation and levels of practice participation

Participation in a scheme, and the payment of a fee, may be conditional upon attending refresher courses or attaining an additional qualification. Consideration should be given as to how other excluded practitioners and practices could be involved in this process. This could include allowing those clearly unable/unwilling to take part to have the opportunity to attend the same training sessions as those involved, particularly those who may be unsuccessful in being selected.

Accreditation/training requirements need to be proportionate to the scheme requirements, however the more understanding those excluded have of the process, the more likely they are to be prepared to help in the delivery of the service.

Consideration may also be given to various levels of "supportive" participation to give a clear pathway to improvement such as organised CET specific to the limited area to assist in the quality of referral and reinforcing the genuine wish for others to be included.

6 Accrediting new practitioners to an existing limited scheme

There should be a defined process within the scheme for adding new practitioners. This process will be much easier if there are practitioners who have been preparing themselves by virtue of a stepped approach.
This should include:-

- Review process to determine need for additional practices

- Process by which new practices/practitioners are selected, using similar criteria to the original set-up e.g. possibly a "waiting list" of vetted practices or trained practitioners unsuccessful in first round

- Provision to replace natural change in practitioners etc

- Specified frequency with which new accreditation arrangements or interim processes will be run e.g. attending an accredited practice by which a practitioner may become accredited

7 Pilot schemes

It is recognised that many schemes will need a pilot site or sites. It is likely that a pilot site will involve optometrists on the LOC who are involved in the scheme design process. This is not contrary to the principles above so long as:-

- Due consideration is made in the first instance of possible effects on other local practices and the final selection process
- The pilot is for a defined time period which is not then extended without consultation and explanation
- It is acknowledged that the pilot practice will be subject to the same selection process as other practices in due course
- Consideration is also given to pilot a limited scheme from a neutral site such as a health centre. This can be a means of keeping a service optometry-based firmly within the remit of an LOC/AOC while dealing with the issue of limited participation. Nobody feels threatened if the patient is going to NHS premises where GOS is not involved. It is accepted that whilst this will not work for everything, or everywhere, it is an attractive alternative that needs to be provided for in the case of clear conflict. Clear evidence exists that in the case of established out of practice contract work

such as mobile digital photography and on-site occupational/industrial safety work, these provisions have little or no effect on patient flow or patient choice in general optometric practice.

8 Conduct of optometric practices

Optometrists who take part in enhanced service schemes with limited participation should be careful not to abuse their position. It is accepted that enhanced services can undoubtedly be a catalyst in patient migration, however LOC/AOCs should make every effort to keep this to a minimum.

- Almost all enhanced service schemes are not linked to GOS sight tests. Patients should be free to choose to have their GOS sight test at a different practice if they wish and practices should not attempt to "poach" patients attending for enhanced service scheme appointments

- Practices should not send out general advertisements and practice leaflets to scheme patients (of course, literature directly relevant to the scheme may be sent)

- LOC/AOCs should give detailed consideration to the information provided to patients regarding limited schemes – this should include seeking general agreement and acceptance from those excluded from the scheme as to their suitability and accuracy.

- Practices should not infer superiority in any way over those excluded

- Practitioners should avoid situations which may compromise the professional integrity of others.

- LOC/AOCs should consider all pros and cons regarding provision of limited services from an independent site, particularly where there is the potential for clear conflict or poaching, no matter how unintentional.

9 Examples of good and bad practice (See Appendices 1 & 2)

These examples are based on situations put forward by members on actual experience of limited participation schemes at the time of producing this report.

10 Conclusion

There are a number of issues in LOC/AOCs establishing a limited participation enhanced service scheme and this guidance is to support local discussions in inclusiveness, establish transparent processes and emphasise the need for effective communication as representatives of the whole profession in your area. If you wish to discuss this guidance further, please contact the professional bodies.

Appendix 1

Limited Participation - A successful model should/could include

Effective communication – This can be through various mediums, via well publicised meetings, ophthalmic/supplementary lists, e-mail, web-site, distribution of LOC minutes. Committees should not confuse a lack of general response with apathy. Many people do not easily embrace change, so change must be well managed so as not to create a negative culture.

Awareness - Funding organisations and other associated professions should be aware of LOCs and who their representatives are.

Patient Leaflets – In instances of limited participation because of geographic, patient need, patient cohort size linked with competency requirements, budget or specific special interest factors, care should be taken as to explain why only limited numbers are involved.
This should not infer any form of superiority.

Aspirational study of practitioners – Asking what they would like to potentially be involved in, what equipment they had or would be prepared to invest in and if they would be prepared to train further if required.

Development strategy - There should be an agreed development strategy between LOC & PCO for everyone to understand the reasons for wishing to develop certain areas and for everyone to have input. This should in some way compare the aspirations and skills of practitioners against the aspirations and objectives of primary (or secondary) care.

Delivery Plan – It would be expected that there would be clear communication of a proposal from LOC and PCO – with a prioritised plan undoubtedly based on cost effectiveness and service delivery.

Business Plan – Any successful model should include a sustainable business plan that benefits the patient, the contractor and the fund holder whether it be GP Practice based commissioning, PCOs, or even secondary care.

Enhanced Service Design Development – should include clear routes for feedback to referring optometrists not involved in a scheme, from either those within the scheme or secondary care, or both. Many practitioners complain of the lack of referral information from secondary care. Positive feedback helps practitioners develop their own referral skills. Designing a new service provides an opportunity to include the need for this and the importance of it.

Limited Participation Scheme Monitoring - As it is possible for non-participating practitioners to be expected in some schemes to refer directly into those participating. LOCs should attempt to feedback progress of the scheme itself to all members,

focussing on positive aspects of scheme and recognising success as being a result of everyone's co-operation.

Geographic spread/site specific – consideration should be given to appropriate geographical spread and also appropriate location as to whether services are best places in practice or indeed in medical health centres or clinics.

Expressions of interest – there should be a transparent "vetting" procedure for those willing to participate.

Levels of involvement – In schemes where there is a clear limited need, other supportive levels of participation should be closely looked at to engage those not likely to be involved at the higher level.

Participation in training
Where participating practice numbers are increased, those members taking part in schemes that have various levels of participation should be given the opportunity to participate at higher levels in the same transparent manner. It would seem reasonable for those who are not part of a limited scheme to be given the opportunity to attend training or refresher courses that relate to the scheme to nurture an interest and develop an understanding of the issues involved.

Providing services from a primary care centre - This can be a means of keeping a service optometry-based while dealing with the issue of limited participation. Practices can feel less threatened if the patient is going to NHS premises where GOS is not involved.

Appendix 2

Limited Participation - What <u>not</u> to do under the banner of your LOC

- Limited participation through stealth or for pure competitive gain/"poaching" must be avoided at all costs. Consideration must be given to using independent clinical/medical sites as a neutral option.

- Practitioners should avoid situations which may compromise the professional integrity of others – an example of this may be that a diabetic digital screening process may throw up some pathology that the patient is unaware of. It may be that this patient has recently had an eye examination and has not been informed of this pathology. Any attempt to undermine the initial examination could be misconstrued as claiming superiority. Situations such as this should be handled with great care as it creates a high risk of litigation wrongly or otherwise. Consultation with the initial practitioner is strongly advised to assess the situation.

- By broad definition, those most active in LOC/AOCs are potentially most likely to wish to develop their skills or practices collectively. To be a valid LOC lead initiative, this must not be done in isolation. Great care must be taken so as not to alienate other members by implying superiority. This can unwittingly, be achieved by small LOC/AOC committees who are keen to move forward with an enhanced service proposal, without meaningful consultation of other members.

- Generally, individuals will have their own specific interests that they wish to develop, so there can be a degree of frustration in having to go through the consultative hoops. However, it should be remembered that a good plan, will always demonstrate how these issues have been addressed and therefore should add to the strength of a service being commissioned.

- Failure in communicating why some schemes are limited is a key factor. Committee members should not automatically assume that they can develop a scheme in isolation and then not offer participation to others. Lack of positive consultative response should not be regarded simply as apathy, it may be that others simply do not like what you are doing but feel helpless to act.

- Regular communication of ideas, progress and requirements is an extremely important thing. It must be remembered that some practitioners may have to plan well in advance to purchase relevant equipment. It would be helpful to determine exact makes of equipment that would be required to partake in such schemes.

- Advanced qualifications will take time to attain, LOC/AOCs must be aware of this and wherever possible provide information about what potential competencies would be required and how to get started as early in the planning process as possible.

- LOC/AOC Minutes should clearly note the involvement or specific interests of practitioners and their progress should be clearly noted along with any proposals documented.
- Similarly if a small group wish to develop a project as a sub-group, a clear audit trail should be available and they should report back to the main LOC/AOC committee with progress.
- A compounding factor can be the apparent collusion between optometric advisers and participating practices. Whereas this again may be down to the sole interests of those involved in developing the profession as a whole, there must be clear evidence of a transparent application process.
- Members should never approach commissioning groups giving the false assumption that they represent the local profession.

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