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## Step-by-Step Guide to Commissioning Community Eye Care Services





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# SECTION 1

## Introduction

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### Purpose of this Step-by-Step Guide – Is it for you?

The purpose of this guide is to provide information and practical tools for PCTs and Practice Based Commissioners as they commission enhanced primary eye care services. It complements and builds on two previous community eye care services publications which support commissioners in fulfilling their responsibilities – The Department of Health Commissioning Toolkit for Community based Eye Care Services [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_063978](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_063978) and the NHS Primary Care Contracting Review of Local Schemes for Low Vision, Glaucoma and Acute Care [www.primarycarecontracting.nhs.uk/87.php](http://www.primarycarecontracting.nhs.uk/87.php).

This guide adds value by offering a more practical, analytical, 'how to' approach to some of the key issues in commissioning high quality community eye care services locally. It will help:

1. Practice Based Commissioners and PCTs take ownership of eye care commissioning priorities, mitigate commissioning risks as well as develop and evaluate alternative primary eye care services
2. Assess, in simple terms, what the patient demand is on hospital eye care services
3. Describe what alternatives there are to building capacity across the system to achieve the 18 Week Referral to Treatment target
4. Describe what investment may be needed in primary care and any potential commissioning savings
5. Develop skills and techniques to commission more effectively, including engaging patients and the public, making eye care services more accessible for an aging population.

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## The commissioning guide audience

This guide has been designed primarily for managers with commissioning support responsibility at Practice Based Commissioning (PBC) level as well as commissioning managers in PCTs. However, local eye care practitioners (for example community optometrists, Ophthalmic Medical Practitioners, GPs, Ophthalmologists), Local Optical Committees, providers of eye care services (for example acute trust eye services, the local authority, voluntary or third sector), and patients affected by this area of health and well-being may also be informed by the detailed commissioning processes which are outlined in this guide.



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## Key commissioning questions

The information, supportive tools and links contained within this guide has been developed and laid out with the aim of answering a number of key commissioning questions. These questions relate to the main steps in the commissioning cycle and the sections of the guide takes each question in turn.

COMMISSIONING QUESTION	WHAT THIS MEANS IN PRACTICE?
Section 2 What is commissioning?	The Commissioning Cycle, NHS reform and delivering NHS Operating Framework priorities
Section 3 Why change eye care services?	The impetus, assumptions, enablers and barriers to change
Section 4 Where are we now?	Determining eye health need, eye care service evaluation, the eye care workforce, and information deficits
Section 5 Where do we want to be?	Model of care for health and well-being and model eye care pathways for eye care problems
Section 6 How do we get there?	Mechanisms to support eye care service development and implementation
Section 7 Who decides what and when?	Professional and PCT decision making, procuring services, conflicts of interest and decommissioning
Section 8 How will we know when we've got there?	Performance management and measuring patient outcomes and experiences
Section 9 How long will it take to get there?	Suggested timeframes for some common commissioning activities



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### Roles and responsibilities for commissioning

This guide is focused on commissioning good eye care services in primary care. Specific stakeholders do have important roles to play in the overall commissioning process.

In summary:

**PCTs** – should commission high quality, cost-effective services which will offer sustainable choice to patients closer to where they live. They should support Practice Based Commissioners in their commissioning plans and local providers and practitioners to be able to deliver the services needed.

PCTs also have a role in delivering and sustaining the 18 week referral to treatment pathway. 18 weeks presents a challenge for local health economies, both in terms of the immediate demand to meet the goal by December 2008, and ensuring that it is commissioned in a sustainable manner. As such, delivering 18 weeks will provide opportunities to re-shape services and further improve commissioning and care for patients.

**Practice Based Commissioners** – should consider local commissioning need for the populations they cover and propose any plans for service redesign or change to the PCT. Relationships between GPs as commissioners, Optometrists and other willing providers to support commissioning and local provision should be a focus for PBC.

**Ophthalmologists** – should be receptive to service development which has been designed to satisfy local needs and become actively involved in any agreed clinical service pathway delivery or clinical protocol where it is appropriate to use this level of clinical expertise. Community Optometrists and Dispensing Opticians – should be receptive to service

development which has been designed to satisfy local needs and become actively involved in any agreed clinical service pathway delivery or clinical protocol development where it is appropriate to use this level of clinical expertise.

**Local Optical Committees** – should promote clinical engagement within local practices and support the development of ideas for local services. This should be in the context of wider PCT and PBC eye care commissioning. Promotion of any new locally agreed pathways among constituent practices would be helpful.

**Local Eye Care Forum** – should promote cross sector engagement and support the development of ideas for local services. This should be in the context of wider PCT and PBC eye care commissioning. Promotion of any new locally agreed pathways among constituent members would be helpful.

**GPs and Ophthalmic Medical Practitioners** – should have opportunity to provide chronic and acute eye care services as Practitioners with Special Interest, contribute to tightly managing ophthalmology referral demand and offer additional clinical leadership. As Practice Based Commissioners, GPs also have a commissioning role which needs to be managed carefully alongside any provider involvement.

**Other local health and social care professionals** – should be aware of local eye care services in existence and how patients should access these services. They should engage with PBC to support the future design of services.

**Patients and the public** – should be integrally involved in local commissioning decisions by contributing to new and redesigned services. They should have access to comprehensive information on how services will impact on patients and should be included in any membership of the Local Eye Care Forum. They may also be engaged through the Third or Voluntary Sector.

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## How are services currently being delivered and who provides these services?

There is a wide range of eye care services available to patients which span different sectors of the NHS as well as social care. Hospital eye services deal with acute and chronic eye conditions and also there are examples where long-term follow up of patients is done in secondary care. More recently, referral management, diagnostic and treatment services of eye conditions normally seen in secondary care have been developed within community settings such as GP or optometric practices and other primary care locations.

However, these are not universal and many PCTs and PBC groups are looking for alternative primary care provision of services for patients.

Further still, there are a number of voluntary and social sector providers of services such as diagnostics or rehabilitation. Local Authority social services departments also support patients with eye care problems particularly in the elderly population and children's services.

## Eye health burden – some brief facts

**Glaucoma** is more common in old age, affecting about two in every hundred people over the age of 40. This increases over the age of 70 to one person in ten. The two main types of glaucoma are open angle glaucoma (or chronic glaucoma) and acute angle closure glaucoma (or acute glaucoma). Open angle is by far the most common type of glaucoma.

**Cataracts** are a common problem in older people (but can occur at any age) and about 400,000 operations are undertaken annually in the UK. Cataracts may develop in one eye only or in both eyes at the same time.

## Age-related Macular Degeneration (AMD)

is the most common reason for people in the UK to be registered sight impaired (partially sighted) or severely sight impaired (blind). AMD is more prevalent in women and in smokers. Most AMD sufferers (about 85-90% of them) have the 'dry' form of the disease, in which the vision may slowly deteriorate or may remain quite stable for long periods.

**Low vision** is increasingly more prevalent due to an aging population. In England, there are approximately 306,500 people who are registered blind or partially sighted (ONS 2000). It is estimated that the number of people in England with vision poor enough to cause them problems with doing everyday tasks is about one million. There is a strong association between low vision and impaired quality of life, which may express itself as depression. There is also a correlation between falls and low vision.

**Diabetic retinopathy** is a complication of diabetes that can lead to significant loss of sight and even blindness. There is a locally-delivered, national diabetic retinopathy screening programme in which digital images are assessed by qualified screeners.

There are also a number of external eye conditions such as Blepharitis, Dry Eye, Infective Conjunctivitis, Allergic Conjunctivitis, Iritis, Keratitis and children's visual problems such as Strabismus (Squint) or Amblyopia (lazy eye).

More details on the clinical nature of these common eye conditions and their treatments can be found in the Department of Health eye care commissioning toolkit – Appendix A [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_063978](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_063978)



## SECTION 2

# Commissioning Basics: What is Commissioning?

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Commissioning is the means by which we secure the best value for patients and taxpayers.

By best value we mean:

- the best possible health outcomes, including reduced health inequalities, and
- the best possible healthcare provision within the resources available.

The Commissioning Framework published by the Department of Health in July 2006 states that 'effective commissioning is about care that adds maximum value for patients in a system that promotes fairness, inclusion and respect from all sections of society. By redesigning care around the patient so that we reliably provide all the right care first time, we improve clinical quality, avoid costly readmissions, improve patient and staff satisfaction and thereby release savings that can be invested in other services'.

This section briefly describes the commissioning cycle and how key aspects of NHS reform are supported by the activities within it. The developments within Practice Based Commissioning (PBC) are then described, followed by a Commissioning Self Assessment Matrix to illustrate any commissioning gaps as a means of delivering the main NHS Operating Framework priorities.

### The Commissioning Cycle

The commissioning cycle begins with the assessment of local need. Services specifications should then be reviewed and designed to meet these local needs with appropriate service providers procured under contract to deliver the service specification required. Finally, regular, proactive monitoring of the service and contract is required to determine the success of the service being delivered.



## SECTION 2

### Commissioning Basics: What is Commissioning?

continued

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Both PCT and practice based commissioners should now be familiar with the key processes of a robust cycle of commissioning to achieve better health outcomes. At the same time, this will help contribute to achieving progress in the main priorities for health and well-being services in the NHS as described in the DH publication 'NHS Operating Framework 2007-08'.

[www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_063267](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_063267)

#### Recent NHS reform

Recent aspects of NHS reform have had a significant impact in the commissioning of eye care services and in particular the contractual and operating relationships between commissioners, their strategic partners, and eye care provider organisations. The following summaries and links are taken from the eye care toolkit published by the Department of Health in January 2007.

Commissioning a Patient-Led NHS, published in July 2005, stated that the NHS should be moving from a provider driven service to a commissioning driven one. *The document set out the importance of expert and imaginative commissioning in order to achieve the aim of a patient-led NHS.*

[www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT\\_ID=4116716&chk=/%2Bb2QD10](http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4116716&chk=/%2Bb2QD10)

*Health Reform in England*, published in December 2005, described the different reforms that are being made to the healthcare system and explained how they are expected to interact. The document reinforced the importance of good commissioning in achieving services that meet the needs of the local population whilst also obtaining value for money.

[www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT\\_ID=4124723&chk=y2qIXE](http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4124723&chk=y2qIXE)

The White Paper on community services, *Our health, Our care, Our say*, emphasised the importance of good commissioning in providing integrated services, building on good local partnerships, and providing more care within the community. The White Paper stated that commissioners should commission for 'health and well-being' to ensure that health improvement is at the heart of the commissioning process.

[www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT\\_ID=4127453&chk=NXIecj](http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4127453&chk=NXIecj)

Health reform in England: update & commissioning framework, published in July 2006, provides a detailed framework for commissioning. The framework includes policy and implementation guidance on commissioning and practice based commissioning (PBC) and expectations of how PCTs, GPs and health and social care commissioners will work together.

[www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/Commissioning/fs/en](http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/Commissioning/fs/en)

#### The Commissioning Framework for Health and Well-being

The Commissioning Framework for Health and Well-being, published for consultation in February 2007, re-emphasised the priorities from the White Paper and provided further guidance on joint commissioning between PCTs and Local Authorities with a focus on more individualised healthcare, more integrated services and commissioning for improved health and well-being outcomes. This approach has now laid the foundations for all future commissioning processes with a shift towards more preventative healthcare.

The details can be found at [www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/Commissioning/fs/en](http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/Commissioning/fs/en)

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The NHS next stage review (Shaping health care for the next decade) was announced in July 2007 which will be led by Professor Sir Ara Darzi. He will examine how the NHS can provide better access to safer, high quality care for all, whilst delivering value for money for taxpayers. An interim report is due in Autumn 2007 with the final report available in July 2008.

[www.gnn.gov.uk/environment/fullDetail.asp?ReleaseID=296706&NewsAreaID=2&NavigatedFromDepartment=False](http://www.gnn.gov.uk/environment/fullDetail.asp?ReleaseID=296706&NewsAreaID=2&NavigatedFromDepartment=False)

## Practice Based Commissioning (PBC) development

As formal and informal groups of practices, practice based commissioners have begun to consider their local population and service priorities covering both urgent and non-urgent care. These priorities may or may not include eye care for several reasons including good overall eye health in the population or excellent local services with good patient outcomes and experiences. However, other reasons such as the challenge of obtaining robust service outcome information and the need to take a longer term eye health and well-being approach with more integrated services may also contribute to practice based commissioners decisions around eye care business plans.

There are examples where a more focused PBC approach has raised the priority of eye care and catalysed service redesign and development. Service analysis in primary and secondary care and PBC budget interrogation in early stages has led to the development of redesigned services in primary care. This helps to control demand for more urgent hospital services under PbR, providing more cost-effective services within the PBC budget.

After early development of the local PBC structures and governance processes across the country, it may now be an appropriate time to revisit eye health in the local population to decide where PBC efforts are focused in subsequent years.

In making these decisions, practice based commissioners should be further supported by PCT management resources, in particular financial and data support, following PCT reconfiguration.

[www.dh.gov.uk/practicebasedcommissioning](http://www.dh.gov.uk/practicebasedcommissioning)

## NHS Operating Framework priorities and Commissioning Self-Assessment Matrix

Eye care commissioners will need to be aware of three main NHS Operating Framework priorities for 2007-08. They focus NHS organisations on the delivery of national targets. These priorities will optimise high quality eye care service delivery and include:

1. Achieving good financial health
2. Addressing health inequalities, particularly in Spearhead PCTs and Local Authorities
3. Achieving the 18 week referral to treatment target.

The following Commissioning Self-Assessment Matrix describes how the commissioning cycle and the priorities relate to one another and also provides the top level areas which a commissioner should be able to measure, develop or report on in order to demonstrate simultaneous achievement of national priorities and effective clinical services.

A PCT or Practice Based Commissioner should be able to check against this self-assessment matrix to ensure there are no eye care commissioning tasks which have been overlooked and that any eye care service development stands up to internal and external scrutiny by describing the appropriate service implementation and performance evidence at each stage of the commissioning process.



## SECTION 2

### Commissioning Basics: What is Commissioning?

continued

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#### Operating Framework Priorities 2007-08

#### Addressing Health Inequalities

##### Commissioning Cycle Assessing Local Need

- Current service configuration for population and pattern of usage
- Public health profiles, trends, prevalence
- Unmet eye care demand
- Population targeting and deciding eye care priorities
- Distance away from best eye care practice

##### Designing Service Specification to meet need

- Service specification targeted at greatest need
- Making 'necessary adjustments' in services
- Patient involvement in design
- Appropriately skilled practitioners and primary care locations available
- Specific quality and outcomes indicators

##### Procurement of services to deliver local specification

- Improving patient access to primary care eye services
- Extending choice for patients

##### Proactive monitoring

- Improved health and well-being outcomes
- More and right people engaged in services
- Patient satisfaction

## Achieving 18 weeks referral to treatment

## Good Financial Health

- Current demand and capacity for Hospital Eye Services (HES)
- Consultant Ophthalmologist waiting lists
- New:Follow-up ratios
- Discharge rates

- Eye care priorities in PCT Local Delivery Plan
- Local Area Agreements and programme budgets
- PBC eye care priorities
- Who is the commissioner?

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- Redesigned Hospital Eye Service
- Eye care Referral Management and Clinical Assessment Services
- Capacity and skill mix in primary, secondary and Independent (ophthalmic) Treatment Centre
- Governance involvement of secondary care

- Cost-effectiveness and value-for-money
- Invest to save
- Cycle of reinvestment
- Local financial incentives to engage
- Setting appropriate prices
- Benefits realisation

- Primary care service alternatives
- Development of other eye care providers (all sectors)
- Primary care contracting processes
- Develop primary care skill mix

- Financial incentives to engage providers
- Financial thresholds or benchmark prices for services
- Contractual rewards and penalties

- Activity monitoring
- Risks and trigger points
- Penalties for performance

- Financial audit and evaluation
- Cost versus Value
- Regular communication of resource accounting

Commissioning Self-Assessment Matrix for eye care services

## SECTION 3

# Service Change: Why change eye care services?

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This section outlines the broad reasons why services may need to be changed, redesigned or developed.

It explores some of the enabling mechanisms for change and also some of the barriers commissioners may come up against when wishing to make services changes.

The impetus for service change is likely to arise because commissioning activity has uncovered an issue with the current service or lack of it. These activities are not mutually exclusive but relate closely to the commissioning cycle. One or more of the following areas are primary catalysts to change:

- Demand or capacity influencing patient access
- Financial issues
- Patient views or concerns
- Public Health and health inequalities.

### Demand and Capacity influencing patient access

Commissioners may find that demand for a service has risen or that changes have occurred in clinical practice, for example new to follow-up ratios have increased, which result in pressure on the capacity of the hospital eye care service. This might, in turn, impact on the ability of the health community to achieve the 18 week referral to treatment time target. Demand issues are likely to be identified as part of the routine service and performance monitoring on targets and contracts or through a Care and Resource Utilisation approach (see Section 4).

### Financial issues

Finance pressures on total or specific commissioning budgets can be a driving force in change as commissioners seek to balance the need for clinical services with a finite resource. Commissioners might change a service to release resources for use elsewhere, for instance sanctioning the move of secondary care services to primary care settings.

### Patient views or concerns

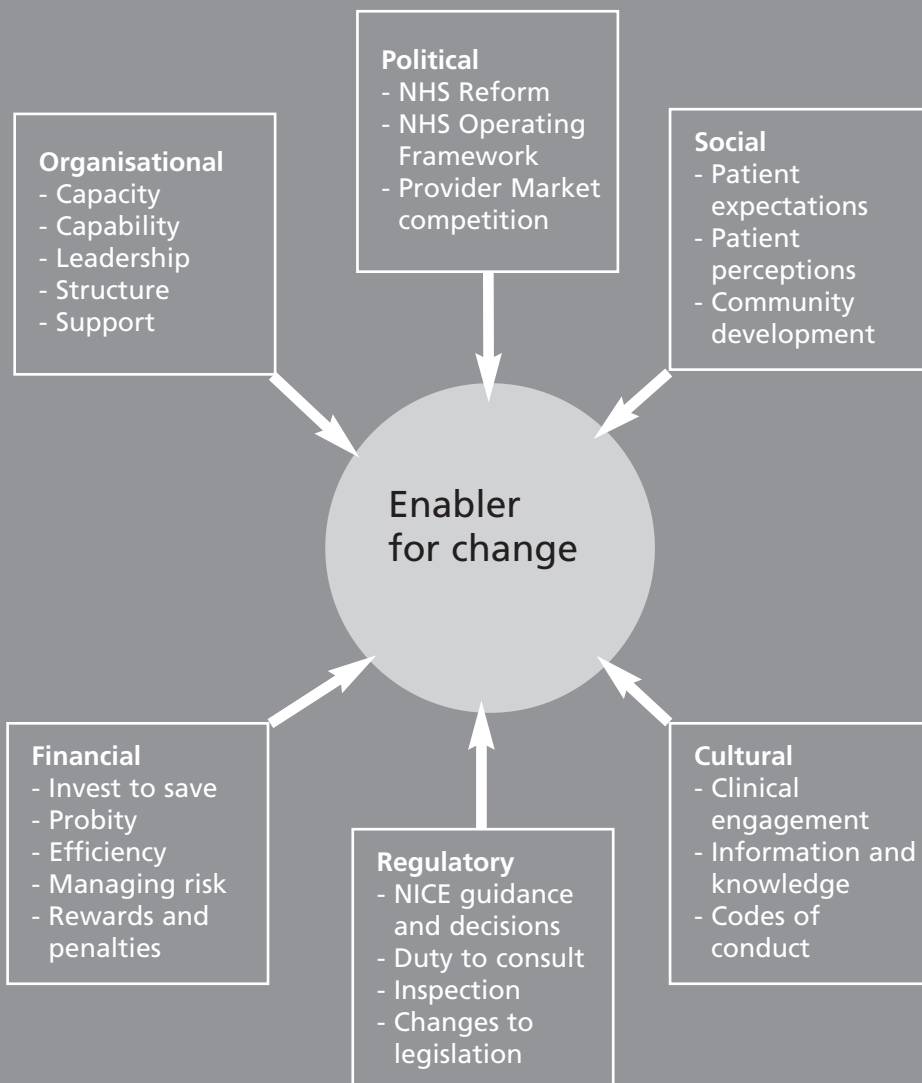
Patient views can be an important driver of change, identifying issues and raising them with practitioners who they come into contact with as well as service managers, advocacy groups or commissioners. These views are fundamental to services being changed to ensure that they meet the needs of the population and the drive to put patients at the centre of commissioning decision making.

### Public Health and health inequalities

Public Health expertise may catalyse change by identifying areas of unmet need or determining through needs analysis or audit that the needs of a population might be better met in a different manner.

### Enablers for change

To help commissioners make the necessary changes to local services, there are a number of 'enabling' factors that they may be able to use as tools throughout the process of change. These enabling factors will provide both *leverage* or *incentives* to change or redesign local services and may present themselves either individually or collectively, with differing gravitas, at any stage. The factors, which will help commissioners initiate or complete the changes necessary can be categorised simply under *political, social, cultural, organisational, regulatory, or financial*. The following diagram describes this range of factors with some basic examples to illustrate the mechanism of change locally.



## Barriers to change

For every enabler of service transformation there will also be a barrier to such change. These barriers occur at all levels of the system and will need to be minimised to allow new services to be commissioned or existing services to be developed. The examples opposite are barriers which are not necessarily specific to eye care services but illustrate the challenge for commissioners in delivering higher quality eye care services, closer to people's homes.

- Provider inertia and resistance to change
- Lack of local eye care providers
- Lack of clinical leadership and engagement
- Lack of capacity
- Financial constraints
- Lack of patient involvement
- Poor integration of eye care services
- Poor data and information transfer.

## SECTION 4

# Determining Need: Where are we now?

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The first and most significant stage within the commissioning process is about assessing local need.

This section explores the four main areas of need and each has an important function in improving health outcomes in the short and longer term. These are:

- **health need** – the scale of the health problem locally in condition-specific areas such as Glaucoma or Low Vision. Analysis of any inequalities in accessibility of services across all members of the population is essential as well as comparing this with other areas locally and nationally and also as good practice benchmarks.
- **service need** – the evaluation of current services which are available locally to provide care for particular eye health problems across all health and social care organisations. Not all health problems may be covered by local services and so gaps in service provision may need to be filled.
- **workforce need** – the capacity, capability and potential of local health and social care practitioners to deliver eye care services to meet local needs. There may be a lack of necessary skills, time or initiative across the local providers and this may need to be developed by commissioners as well as exploring untapped skills.
- **information need** – the availability and accuracy of quantitative and qualitative eye care data and information to assess and monitor local demographics, trends, service inputs, service outputs and health outcomes.

### Health Needs Assessment

In determining the eye health need of the local population, a variety of key assessment processes are often undertaken to support commissioning decisions. These are applicable to health in general and should be supported by other healthcare professionals such as Public Health experts or Information Analysts connected to the PCT or Practice Based Commissioning group. Commissioning managers should seek the help of this expertise as early as possible.

Health needs assessment is a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities. Therefore, health needs assessments not only support the identification of health priorities and thus evidence on which to develop local health service but also national priorities such as identifying areas of need in order to reduce the gap between disadvantaged groups and others across the population.

The National Institute for Health and Clinical Excellence (NICE) have published a 5 step process of a health needs assessment. This is reproduced opposite as an aid for commissioners. However, more specific details on all the steps are available at [www.nice.org.uk](http://www.nice.org.uk)

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**Step 1** – At the end of Step 1, commissioners should be clear about the population they are working with, and have clarified the aim of the assessment and its boundaries. They should also know whether or not they have the capacity to undertake the type and scope of such an assessment.

**Step 2** – At this point, a shortlist of health priorities should have been identified for the profiled population. Assessment should include their associated health conditions and determinant factors for impact, in terms of size, severity and changeability. A group consensus should be reached about the relative impact and priority.

**Step 3** – By Step 3, commissioners should be confident that the health conditions/determinant factors with the most significant impact on health functioning for the selected health priority are being tackled and that the focus is on reducing health inequalities for that priority. Commissioners should have identified acceptable and cost-efficient actions to improve the selected priority.

**Step 4** – By now, commissioners should be ready to implement their action plan to which will maximise the chances of effecting change and making sustainable health improvements in the target population.

**Step 5** – This is a chance to stake stock and ask reflective questions like what went well and not so well with the assessment process.

Besides the problems that may be encountered with accessing or obtaining accurate and relevant data on which to base commissioning decisions, the aim is to determine where resources may be best targeted to achieve the best health outcomes locally. Other advantages to undertaking this type of assessment are the likely cross-boundary working improvements, better communication and greater community involvement in local decision making.



# Health needs assessment at a glance

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## Step one

### Getting started

What population?  
What are you trying to achieve?  
Who needs to be involved?  
What resources are required?  
What are the risks?

## Step two

### Identifying health priorities

Population profiling  
Gathering data  
Perception of needs  
Identifying and assessing health conditions and determining factors

## Step three

### Assessing a health priority for action

Choosing health conditions and determinant factors with the most significant size and severity impact

Determining effective and acceptable interventions and actions

## Step five

### Moving on/review

Learning from the project  
Measuring impact  
Choosing the next priority

## Step four

### Planning for change

Clarifying aims of intervention  
Action planning  
Monitoring and evaluation strategy  
Risk-management strategy

Reproduced  
from NICE

## SECTION 4

### Determining Need: Where are we now?

continued

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The NICE guidance also stresses the importance of having the required resources to carry out health needs assessment properly. This will ensure the effectiveness of the assessment process and that it completes on time. The resources required to start a health needs assessment include:

- Clear aims and objectives and an established need for the project (e.g., a recent assessment has not already been done)
- Involvement of the right people ie. those who know about the issue; who care about the issue; and who can make change happen
- Sign-up to the project from senior managers (and policy makers)
- A lead coordinator with project management skills and a committed and skilled project team
- Access to the target population and their willingness to engage with the project
- Key stakeholders identified
- Adequate time, space, equipment, skills and funding.

### Identifying local eye health priorities – Population Profiling

As well as demographic information that may be collected and analysed such as gender, age, ethnicity, or socio-economic group, corresponding information related to eye health should also be considered in this first stage analysis such as prevalence of falls, diabetes, eye tests, equipment issued, elective care patterns, emergency admissions, A&E attendances and contacts with Out of Hours services as a result of eye problems.

The following table has been adapted from the Department of Health Diabetes Commissioning Toolkit (2006). It outlines how a commissioner would determine the magnitude and burden of eye health problem(s) locally. This would help to provide a clearer picture of where and how much need there might be for local services, where these services would support national priorities, and where good quality information may be collected and analysed.



## SECTION 4

### Determining Need: Where are we now?

continued

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Topic	Question
<b>Occurrence</b>	How many people need local eye care services?
	What are the numbers of individuals with clinically diagnosed eye conditions in the local population? What is the % within the population?
	What is the number of new patients needing diagnosis and programmes of treatment, education, long-term care (incidence)?
	What is the breakdown of the local population suffering eye problems in terms of: <ul style="list-style-type: none"> <li>- Age</li> <li>- Gender</li> <li>- Ethnicity</li> <li>- Adults, children, young people</li> <li>- Prisons</li> <li>- Special needs and learning disabled</li> <li>- Illiterate</li> <li>- Patients in residential and nursing care</li> </ul>
<b>Risk factors</b>	What is the level of other clinical conditions in the population, and projected trends? e.g., Diabetes
<b>Health Inequalities</b>	What levels of deprivation exist in the area?
	What health inequalities exist between different groups within the local population?
	Does rate of improvement differ in these groups? e.g., uptake of retinal screening
	Where do people with eye health problems live?
<b>Local Health Burden</b>	How many eye health related hospitalisations in the last year?
	What is the average length of stay for eye health patients?
	How many complications have occurred to clinically diagnosed patients in the last year?
	What is the rate of uptake to Diabetic Retinopathy screening services locally?

## Data/Information Source

National prevalence data, SUS PBC Comparator database, [www.ic.nhs.uk](http://www.ic.nhs.uk)  
Public Health Observatories, QOF/QMAS, Practice level prevalence estimates, Numbers of sight tests, Local audit of current demand for sight tests

National prevalence data, Audit GP consultations related to eye care, Public Health Observatories, QOF/QMAS, Practice actuals, National audit/stats

National prevalence data, Public Health Observatories, QOF/QMAS, Local Audit of GP/Optomety practices, Local population health survey, National Health survey

National prevalence data, Public Health Observatories, QOF/QMAS, Local Audit, Local Health survey, National Health survey

Public Health Observatories, QOF/QMAS, Practice Registers, Prescribing (PACT) data

Index of Multiple Deprivation, Health Poverty Index, [www.hpi.org.uk](http://www.hpi.org.uk), [www.lho.org.uk](http://www.lho.org.uk)

Local Health Equity Audit (including asylum seekers, ethnic groups, transient groups, socio-economic groups), Public Health Observatories

Local Health Equity Audit

Health Informatics Services e.g., Dr Foster Intelligence  
Population modelling tools

Hospital Episode Statistics

Hospital Episode Statistics

Hospital Episode Statistics, Local Audit, National Clinical and Health Outcomes Database  
[www.nchod.nhs.uk](http://www.nchod.nhs.uk)

Diabetic Retinopathy screening service

## SECTION 4

### Determining Need: Where are we now?

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Topic	Question
<b>Cost</b>	What is the total current expenditure on eye health services?
	How does this breakdown into: <ul style="list-style-type: none"><li>- Existing total service costs (per patient)</li><li>- Staff costs</li><li>- Capital costs</li><li>- Prescription costs?</li></ul>
	What % of local NHS expenditure is spent on eye care services?
	What % of local prescribing spent on drugs or equipment is used in eye care services? Is this increasing or decreasing?
	What are the local Social Service costs related to eye care services?
	What are the forecasted costs for eye care services including new authorised treatments?
	Are there any committed service developments or changes which may have cost pressures and will need to be considered?
<b>Local trends</b>	Are numbers locally increasing or decreasing?
	What local people are at risk of developing eye health problems?
	What are the forecasted local numbers of cases and complications?
<b>Comparative level of risk and need</b>	How does local need for services and demographics compare to national and similar areas?

## Data/Information Source

Local PCT financial audit  
Shared Services departments for GOS payments/claims data

Reference costs, PCT workforce models, QOF/QMAS, Prescribing (PACT) data

Local PCT Audit

Prescribing (PACT) data  
Local PCT Audit

Local PCT Audit, Local Authority Audit

Local PCT Audit  
NICE cost-effectiveness appraisal data

Local PCT Audit, PBC development plans

National prevalence data Population growth plans, Patient registrations

Health surveys

National prevalence data

National prevalence data QOF/QMAS, ONS census data, Index of Multiple Deprivation, Health Poverty Index, [www.hpi.org.uk](http://www.hpi.org.uk), [www.lho.org.uk](http://www.lho.org.uk), Community health profiles [www.communityhealthprofiles.info/](http://www.communityhealthprofiles.info/)

## SECTION 4

### Determining Need: Where are we now? continued



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#### Annual Population Value Reviews

One of the core functions of commissioners is resource allocation to different population groups based on an analysis of need. Before the start of the next financial year (2008-2009), commissioners might want to reflect upon the distribution of resources among the different groups and how the distribution compares with the distribution of other commissioners, particularly commissioners who oversee populations that have a similar socio-economic profile. This can now be done by accessing [www.nks.nhs.uk/APVR.pdf](http://www.nks.nhs.uk/APVR.pdf).

This approach also offers commissioners economic appraisal techniques and spend comparisons against local and national benchmarks.

#### Service Evaluation

Having assessed local health need, the next stage in the commissioning process is to review the existing services that are available to patients. Three areas to consider in reviewing the existing services and their usage are:

- Resources and capacity
- Hospital eye services
- Current patterns of utilisation

The following table expands on the Commissioning Toolkit for Community Based Eye Care Services (Department of Health – January 2007) and considers the questions that need to be answered to develop a complete picture of local service provision and the possible sources of information.

Topic	Question
<b>Resources and Capacity</b>	How are eye care services organised? What services are provided by primary care? What services are provided in a community setting? What services are provided in secondary care? Is there any duplication of services? What choice of providers exist, if any?
	Are services for certain eye care problems effectively integrated across health and social care?
	What do patients, carers and the local community think about eye care services? e.g., what are their views on accessibility Is there any evidence that some groups are not accessing services?
	Are there any specific gaps in services provided against identified need, including necessary adjustments to be made to ensure equity of access?
	Are there any capacity deficits in secondary care that will impact on the achievement of 18 weeks referral to treatment target?

## Secondary care activity analysis

The National Health and Social Care Information Centre (IC) has a wide range of accessible data for commissioners including dedicated online Hospital Episode Statistics (HES) from 1998-99 to 2005-06 for every hospital provider. These datasets offer raw data and summary figures for each year (broken down by admission and age) and data about the more commonly recorded diagnoses and operations. Freely available HES data can be accessed directly at [www.hesonline.nhs.uk](http://www.hesonline.nhs.uk) where users can generate their own specific queries of the data. For example, queries can be set up to analyse utilisation for ophthalmology procedures such as cataract surgery if this is done in hospital.

HES data contains details of all admissions to NHS hospitals in England. It includes private patients treated in NHS hospitals, patients who were resident outside of England and care delivered by treatment centres (including those in the independent sector) funded by the NHS. HES also contains details of all NHS outpatient attendances in England. HES information is stored as a large collection of separate records – one for each period of care – in a secure data warehouse. HES data is freely available at the 'all England' level enabling benchmarking comparisons to be made.

Secondary Uses Service (SUS) is a system designed to provide timely, pseudonymised, patient-based data and information for management and clinical purposes other than direct patient care. The data is made available through the NHS Care Records Service. These 'secondary uses' will include functions



## Data/Information Source

Local PCT audit

Mapping of the patient journey

Patient questionnaire  
Local audit – working with Local Authority, local voluntary sector, PPI or advocacy groups

Comparison of service provision to identified need

Local audit  
Waiting times data – stage of treatment and Referral To Treatment return

## SECTION 4

### Determining Need: Where are we now?

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Topic	Question
<b>Hospital eye services</b>	What is the degree of specialisation in the local hospital? Does specialisation occur at a clinic or clinician level? Do consultants have special interests? Are clinics organised on a generic basis or eye care specific basis?
	What is the local provider's aim with respect to choice – are they looking to specialise in some areas? Is the provider looking to cease some areas of provision to concentrate on others?
<b>Current patterns of utilisation</b>	What is the current local demand for sight tests? (NHS and non-NHS)
	What proportion of sight tests result in referral?
	How many GP consultations relate to eye problems? How many of these end up with a referral to secondary care? How many are managed in primary care?
	What data is available on the quality of referrals from primary care?
	What is the pattern of outpatient utilisation in Ophthalmology? How many referrals? Who do referrals come from? How many first appointments? How many follow-up appointments? New: follow-up ratio DNAs (New, follow-up) % patients discharged after first appointment? How many procedures in outpatients? How many eye casualty attendances? What is the available capacity in clinic – how does this break down into first and follow-ups?
	How does this data break down by specific eye conditions?
	What is the pattern of utilisation for acute and urgent eye services? How many via referral, how many via eye casualty?
	What measures are available about how well these services are meeting identified need? Are there any quality measures?

## Data/Information Source

Local audit – working with secondary care

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Local audit – working with secondary care

NHS statistics:  
General ophthalmic services: Activity Statistics –  
[www.ic.nhs.uk/statistics-and-data-collections/primary-care/eye-care](http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/eye-care)  
Local Audit for non-NHS services

Local audit – working with Optometrists

Local audit – working with GPs

Local audit – sample referrals

National data return (QM08)  
Contract monitoring/SUS  
Local audit  
Outpatient Minimum Data Sets looking at source of referral

Local audit – working with secondary care

Local audit – working with secondary care  
Outpatient Minimum Data Sets looking at source of referral

Local audit  
Secondary care contract with PCT

## SECTION 4

### Determining Need: Where are we now?

continued

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such as healthcare planning, commissioning, public health, clinical audit, benchmarking, performance improvement, research and clinical governance.

The first priority for SUS is the implementation of Payment by Results (PbR). The second priority is to support the decommissioning of the NHS wide clearing service

(NWCS), the previous way that NHS organisations shared management information with each other and the Department of Health. SUS data is available to users based on their access rights, which would normally be related to the user's role and employer. For example, a PCT user would be able to see pseudonymised information about patients registered with their PCT but not information about patients registered elsewhere in the country.

IC also hosts the SUS practice based commissioning (PBC) comparators website. This uses existing data from SUS, standardises them for population and presents by GP practice to show activity and referral patterns and outcomes for a number of key conditions. Register by contacting the IC Contact Centre at [enquiries@ic.nhs.uk](mailto:enquiries@ic.nhs.uk)

### Clinical and Health Outcomes

Further indicator sets have been developed in partnership with the Information Centre. These indicators offer a range of measures which allow commissioners to evaluate service effectiveness in terms of clinical and health outcomes. They are particularly helpful as they are condition specific and consider outcomes over the longer term. For example, for cataracts, indicators related to complications following surgery, reduction/avoidance of inappropriate delay in diagnosis or treatment, and the return of eye function following surgery are provided.

A compendium of these clinical and health indicators can be found at [www.nchod.nhs.uk](http://www.nchod.nhs.uk)

### Best Practice and National Institute for Health and Clinical Excellence (NICE)

The Department of Health documents 'Care and Resource Utilisation: ensuring the appropriateness of care' and 'How to identify opportunities for care and resource utilisation' offers some useful tools and techniques for eye care commissioners to help maximise the resources available to them and facilitate appropriateness of care, including benchmarking data.

[www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_063265](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_063265)

[www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_074960](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074960)

As an independent organisation, NICE is responsible for providing national guidance on promoting good health and preventing and treating ill health. Commissioners should ensure that commissioned services meet the requirements of NICE guidance and need to be aware of the significant financial impact on commissioning budgets that NICE rulings often result in. Additional drug related costs or consultant time costs may need to be considered such as those for Lucentis as a treatment for Age-related Macular Degeneration. Further consideration by NICE of this clinical and cost-effectiveness appraisal is necessary.

NICE guidance is published at [www.nice.org.uk](http://www.nice.org.uk) in a number of areas:

- Public health intervention guidance - recommendations on types of activity (interventions) that helps to reduce people's risk of developing a disease or condition or helps to promote or maintain a healthy lifestyle.

- Public health programme guidance – dealing with broader action for the promotion of good health and the prevention of ill-health.
- Interventional procedures guidance – recommendations about interventional procedures used for diagnosis or treatment are safe enough and work well enough for routine use.
- Technology appraisals – recommendations on the use of new and existing medicines and treatments within the NHS in England and Wales
- Clinical guidelines – recommendations on the appropriate treatment and care of people with specific diseases and conditions within the NHS in England and Wales. Clinical guidelines are based on the best available evidence.

## Service mapping

Having ascertained the answers to the above questions it would also be worth undertaking a *patient journey* mapping exercise of the existing services available to patients from referral to treatment (and subsequently discharge) in order to assess patient flow. This will enable the commissioner to understand how the services fit together and whether there is any duplication, blockages or missing stages in the treatment pathway. Mapping eye care condition specific quantitative and qualitative data to the patient pathways gives the commissioner a greater understanding of the patient pathway and where bottlenecks and opportunities for service development might exist.

One example where the technique of service mapping has been effective is Peterborough PCT. They mapped the process and patient journey for cataract surgery to improve their ability to achieve the 18 week referral to treatment target. This service improvement technique mapped all the steps in the process.

By reducing the non-value adding steps and making the patient journey much clearer, they were able to speed up the cataract service through direct referral access to surgery for patients through their Optometrist referral.

The changes have improved both surgery and outpatient waiting management. Timescales from optometrist referral to operation and discharge now range between 6 and 13 weeks with 1,184 new outpatient appointments available. Patient satisfaction surveys have been undertaken with over 95% of patients reporting satisfaction with the service.

More details about this example can be found at [www.nodelaysachiever.nhs.uk/CaseStudies/CaseStudyItems/CSAN10PeterboroughCataractService.htm](http://www.nodelaysachiever.nhs.uk/CaseStudies/CaseStudyItems/CSAN10PeterboroughCataractService.htm)

Details of all the service improvement techniques, in particular the No Delays Achiever resources, can be found at [www.nodelaysachiever.nhs.uk](http://www.nodelaysachiever.nhs.uk)

## Workforce needs assessment

Commissioners need to determine the current and future eye care workforce that will be able to deliver services if any changes are required. Workforce planning of employed and independent contractor staff can be onerous but is essential if appropriately skilled practitioners are positioned throughout community based services and available at the right time for patients. The following table outlines how the eye care workforce profiles and skills available in the health community might be captured in the first stages of analysis. Workforce capacity and capability will need to be linked into wider workforce planning and development which may involve other agencies such as the Strategic Health Authority or Local Authority.



## SECTION 4

### Determining Need: Where are we now? continued



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Topic	Question
<b>Workforce profiles and skills</b>	Which provider organisations are involved? What is the profile of the local eye care workforce? e.g., Community Optometrists, Orthoptists, dispensing Opticians, GPwSI, Ophthalmic Nurses, Ophthalmologists, Ophthalmic Medical Practitioners, other Practitioners with a Special Interest? Who are the clinical 'leaders'?
	What competencies currently exist within this workforce? Is there an identifiable workforce who could provide or are providing a community-based eye care service? Is there full cooperation of local practitioners to be involved in new service plans?
	What are the likely future workforce trends? What are the current or future special interests of local practitioners?

The recent review of community eye care services uncovered many examples where Practitioners with Special Interest (PwSI), either GPs, Community Optometrists or Ophthalmic Nurses, were employed to deliver enhanced primary care provision under local schemes – [www.primarycarecontracting.nhs.uk/87.php](http://www.primarycarecontracting.nhs.uk/87.php). Many were fully integrated services with demand management used as their primary main objective.

In April 2007, the Department of Health published new guidance on the professional accreditation process for all new and existing GPs and Pharmacists with Special Interest. This guidance is extendable to all Practitioners with Special Interest, including Optometrists. This process emphasises a 3-yearly cycle of accreditation but with annual appraisal at the appropriate clinical level. More details can be found at

[www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_074430](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074430)

### Information needs

What drives effective commissioning is high quality, regular information which is used to analyse service inputs, outputs, and health outcomes. The sources of eye care information are widespread across the health and social economy from individual practitioner contacts to large scale organisational repositories. However, evidence from previous local schemes suggests there are a number of important issues to be aware of in terms of data and information.

First, Community Optometric practices are a potentially rich source of information on patterns of care, patient demand and the current burden of eye health in the community. However, despite recent

## Data/Information Source

Current PCT commissioned services  
Local audit of Optometrist practices  
Local audit of GP or medically-led eye care services  
Local audit of hospital eye service  
Local Authority Social Services  
How many staff in each staff group? Full descriptions of specific eye care professionals are available in Appendix B of the Department of Health Eye Care Commissioning Toolkit (January 2007)\*  
Local Optical Committee (LOC)

Local audit of Optometrist practices  
Local audit of GP or medically-led eye care services  
Local audit of hospital eye service  
Clinical stakeholder meetings

Local surveys  
Reports from Deaneries  
Local Optical Committee (LOC)  
Workforce lead at the SHA  
Links to workforce plans

\*[www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_063978](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_063978)



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technological advances in some areas of the country such as Northumberland Care Trust's MIDAS tool, basic information systems in practices are often unreliable and information which is recorded by Optometrists can be both inaccurate and incomplete. Historically, little investment has gone into local practice IT development through any national contract or locally enhanced scheme.

Certainly it is unlikely that data collected would be able to clearly inform wider service development plans or commissioning decisions and is more likely to revolve around basic numbers of context rather than case mix, outcomes of treatment or patient experiences of services.

Furthermore, local practitioners may need help and support to systematically analyse and interpret data through local audits once data collection and extraction has been set up.

Second, where local optometric practice IT systems do exist, they are more likely to sit outside the family of systems compatible with Connecting for Health. This leads to subsequent problems with the ability to share patient information between services along a recognised eye care pathway. Until developments in the CfH programme are realised, local and bespoke IT solutions may be necessary but must be capable of N3 connectivity. If this is not possible, low tech, paper-based solutions such as fax or secure email may need to be developed.

Information governance issues will also be relevant here such as adherence to the NHS Code of Confidentiality, more details of which can be found at [www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf](http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf)

## SECTION 4

### Determining Need: Where are we now?

continued

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Third, whilst relevant patient information is shared with other services, such as GP and optometrist referrals to the hospital eye service, there remains a significant issue of quality assurance of the information received. There is often little time to validate referral data with individual optometrists and much of the robustness of the system of information transfer relies heavily on good relationships with hospital based Ophthalmologists. Where these working relationships do not exist, information can be viewed with some degree of scepticism. This often leads to hospital services repeating tests already carried out on patients to confirm any primary diagnoses.

Fourth, in order to reverse these problems, it may be necessary to incentivise, reward and support local providers of services which play a part in the patient pathway to collect more relevant and accurate outcome-based data. Commissioners can use this to complement any secondary care data extracted from the Secondary Uses Service.

Finally, information transfer between primary care commissioners and Foundation or Acute Trust providers is essential for more effective eye care service management and improvement. The model contract for Trusts and its appendices set out clearly the 'common acceptance of responsibility' with Trusts providing timely and accurate monitoring information to commissioners so that they can fulfil their (aims and) statutory responsibilities. This includes providing any information required for national reporting requirements, activity profiles and actual performance against forecasts, on a month-by-month and year-to-date basis. Trusts will also need to provide information on the locally agreed Commissioner Data Sets and Aggregate Data Sets as well as ad hoc requests. Responses are usually required within one month. These agreements are reinforced by a national code of conduct for Trusts.

### Summary

Determining need is a complex and time consuming process, particularly as the combination of health, services, workforce, and information needs are reviewed and assimilated.

By systematically assessing each area, commissioners will have a greater understanding about:

- the specific health priority and population to be targeted such as BME groups, the over 50's or under 16's, or those with learning disabilities
- the services required to satisfy these priorities effectively
- the specific patient pathway
- the utilisation of services throughout the system, and
- how these services compare to national best practice and benchmarks.



## SECTION 5

# Designing Solutions: Where do we want to be?



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After determining a range of possible eye care needs, appropriate local service solutions will need to be introduced, developed or redesigned to ensure patients receive high quality, accessible services at an appropriate time. This section describes the principles by which these services should be considered and the model patient pathways that are now recognised for eye care services.

### Models of care principles

For all services, and particularly those relating to eye care, commissioners may like to consider a set of high level principles in service design. These principles will guide a commissioner towards the most appropriate service solution for their local need, whilst at the same time recognising the nature of service transformation and delivery of local and national priorities.

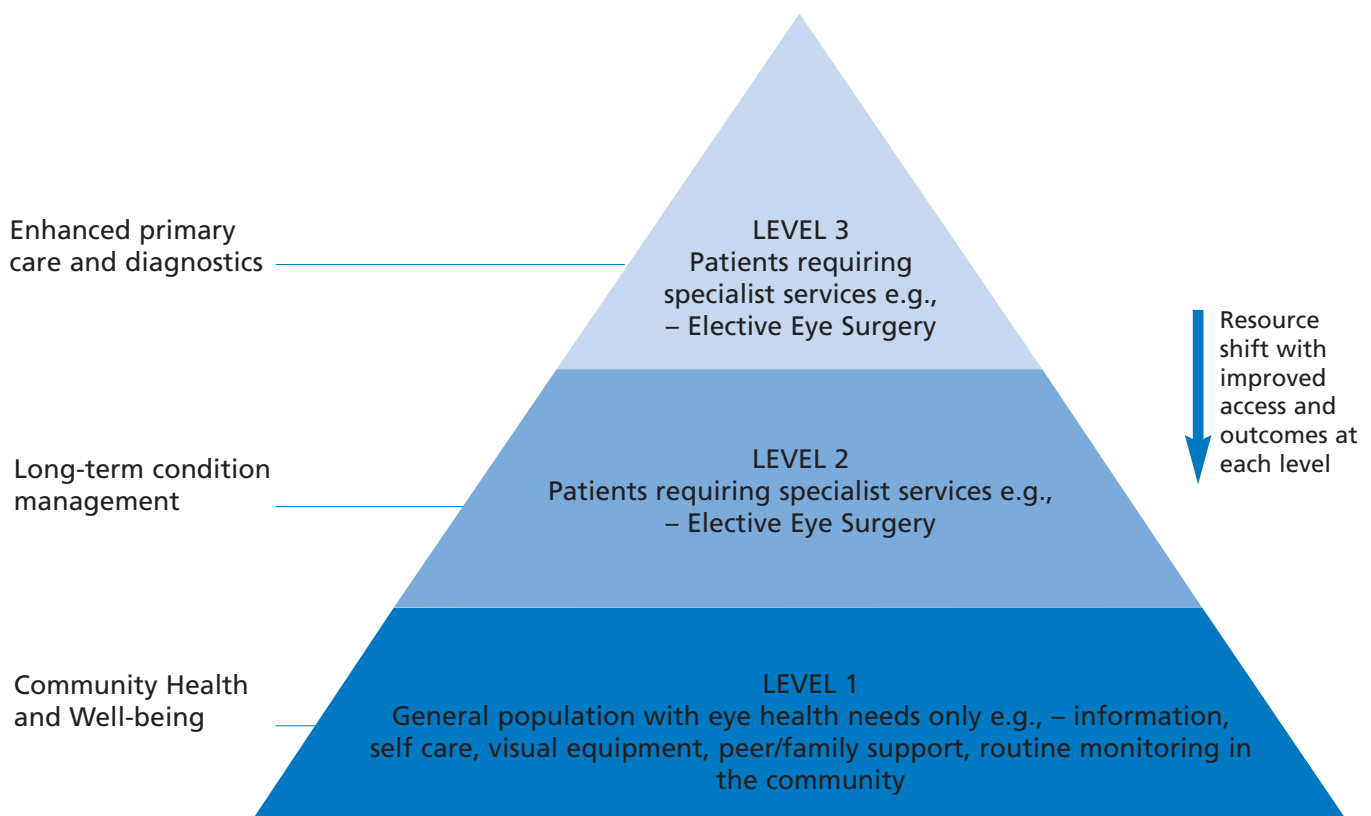
The following principles are not exclusive, or in any priority order, but do offer an appropriate means on which to base more targeted service solutions depending on local circumstance. There is a brief explanation behind each principle as a starting point for local discussion. There may be cross over between principles depending on local commissioning interpretation.

Principle	Brief explanation
1 Engagement	Clinically driven and patient centred
2 Simple and safe	Straightforward patient pathway, minimal handoffs and bureaucracy
3 Tested	Based on good practice, piloted locally if necessary
4 Prevention focused	Addressing health and well-being
5 Outcome focused	Success measured by improvement in health and patient experience
6 Accessible	Equitable access by all population groups
7 Integrated	Managed networks of provision to improve outcomes
8 Resourced	Appropriately funded with appropriately qualified staff
9 Monitored	Regularly reviewed and performance managed
10 Value for money	Level of effectiveness for the level of resource needed

## Simple model of care pyramid – Commissioning for Health and Well-being

When commissioning eye care services across the whole of the patient pathway, there is now increasing emphasis on commissioning for improved health and well-being of the local population. This reflects many of the causes of poor eye health which are related to broader public health behaviours such as smoking and obesity. The drive to integrate commissioning across the whole health and social care economy is shown clearly in the new 'Commissioning Framework for Health and Well-being' (Department of Health, February 2007) and is a key challenge for current PCTs and Practice Based Commissioners (see Section 2).

As recognised in other clinical pathways such as long-term conditions or weight management, commissioning for better eye health spans the whole spectrum of potential population groups, providers of care, and commissioning organisations. Below is a simple pyramid model to emphasise the direction of travel for future commissioning. Each level of care will need to be commissioned but, over time, more services will be commissioned which support a health and well-being approach to care (Levels 2 & 3), leaving the most specialised services to concentrate on clinically appropriate activity (Level 1).



## SECTION 5

### Designing Solutions: Where do we want to be? continued

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#### Model eye care pathways

Following a series of national pilots and reviews of a number of eye care pathways, the most common model eye care pathways have now been represented (Department of Health, January 2007). Each pathway has identified where patient care could appropriately be delivered in a community based setting, adopting the health and well-being principle, making services more accessible to patients closer to their homes.

Model pathways for cataracts, glaucoma, Low Vision and examples of acute eye care schemes are described in detail and can be found at [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_063978](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_063978)

The Do Once And Share (DOAS) project developed a national glaucoma clinical care pathway template and a core national dataset. The pathway and dataset have had national multi-professional consultation, patient involvement, and have been formally approved by all professional bodies. The template and data set can be found at [www.doasglaucoma.org](http://www.doasglaucoma.org). NICE are also developing guidelines on the diagnosis and management of glaucoma which is expected to be published in 2009. The first report of the Eye Care Services Steering Group (April, 2004) proposed a number of national eye care service pathways which were focused on primary care. These care pathways were designed to achieve

- more integrated eye care services
- better use of skills in primary care
- increased amount of care for all in accessible primary care settings, and an
- increased role for professional groups in primary care

The pathway illustrations for the treatment of cataracts, glaucoma and Low Vision services can be found in Appendix 1.



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## SECTION 6

# Making change happen: How do we get there?

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This section focuses on a number of important factors to help commissioners implement the service change required. One methodology to achieve an inclusive approach to delivery of planned services changes is a benefits realisation approach. Building on this, getting the most out of engaging local stakeholders is critical to successful ownership of the issues. Developing a local eye care forum and encouraging further support for new providers into the local primary care economy are mechanisms to support this implementation.

### Outcome-based solutions – a ‘benefits realisation’ approach

Benefits realisation is an approach used in the Integrated Service Improvement Programme (ISIP) for clinical engagement and service redesign and allows for greater engagement and ownership across all stakeholder groups. It allows for an agreed outcome-based perspective rather than an input-based approach.

In this process, stakeholders agree upon the key priority areas for change, based on the gap between the identified current service provision and a desired future state. From this, clinical and service outcomes can be derived describing what needs to be in place to achieve the objectives of the community. As a result, benefits can be described that are expected to be realised from these outcomes and then projects can be identified to realise the outcomes and benefits. The benefits realisation approach can also be used to ensure that quantifiable measures for the outcomes and benefits are identified.

The diagram opposite has been adapted from the Integrated Services Improvement Partnership (ISIP) guidance – [www.isip.nhs.uk](http://www.isip.nhs.uk) – and details the steps in a benefits realisation approach which could be used to help implement a primary care eye care service.

## Activities

## Primary Care Eye care

### Assess current state, agree future state and identify gaps

- Describe the current and desired future state of the service
- Identify any gaps between the current and desired future state
- Describe what needs to be done to close the gaps

### Service Mapping

- identification of need to inform the future state e.g.,  
**current state:** entirely hospital based  
**future state:** increased community provision with gap closed by increasing community services

### Develop priority objectives

- Define and agree priority objectives based on what needs to be done to close the gaps
- Identify any quantifiable measures that can be used to demonstrate the achievement of the objectives

### Service redesign

- e.g., Priority objectives:**  
care closer to home  
measuring
  - location of services
  - volume of patients using the service
  - improved services

### Identify required outcomes

- Identify and describe specific and measurable outcomes for each objective. They should identify what needs to be in place or happening to achieve the objectives e.g.,
  - Processes, pathways and protocols
  - Technology, equipment, facilities and estate
  - Geographic scope
  - Policies and performance measures
- Identify any dependencies between outcomes
- Combine and sequence the outcomes in the most effective way to achieve the objectives

### Service redesign

- e.g., Outcomes**
  - Patients treated closer to home
  - Patients seen quicker
  - Increased range of service providers
  - Increased use of community workforce
  - Community training programme
- e.g., Dependencies**  
Training programme; community workforce; range of providers; patients seen closer to home

### Identify benefits

- Identify benefits (and dis-benefits) for each outcome (or group of outcomes). Ensure all key stakeholders are considered

### Service redesign

- e.g., Benefits**  
Faster access for patients  
Greater clinical stakeholder involvement  
More skilled workforce

### Identify projects

- Identify new and existing projects required to deliver the outcomes and enable the realisation of the benefits
- Identify dependencies between projects

### Service redesign

- e.g., Projects**
  - community training programme
  - community based patient pathways
  - clinical protocols

### Define measures

- Define how to demonstrate and measure the delivery of outcomes and benefits
- Create high level estimates to quantify the measures for each outcome and benefit

### Performance management

- e.g., Measures**
  - service utilisation
  - training attendance
  - waiting times for services
  - improved health and well-being

## SECTION 6

### Making change happen: How do we get there?

continued

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#### Stakeholder engagement

The most significant enabler of service change in any commissioning process will be the degree of effective engagement with key stakeholders of the service. This section describes three key areas of stakeholder engagement in eye care – **clinical, patient and public and organisational engagement** – and is applicable to all specific eye care pathways described in previous sections. The degree of time and effort on the part of commissioners given over to stakeholder engagement should not be underestimated. All areas of the PCT, or accountable PBC Board, should support the delivery of the plan to engage stakeholders. Some basic recommendations are made to improve engagement in these three areas.

#### Clinical engagement

Local clinicians will be the key to effective commissioning, local decision making and service change. Their enthusiasm should be captured as current or potential providers of local services as well as for gathering intelligence about local population needs. Those clinicians who develop as leaders will help to influence the local health community to deliver key service objectives and change. Excellent examples of clinical engagement can be found in local schemes including Gateshead and South Tyneside PCT, Manchester PCT and Bedfordshire PCT.

There is a range of local clinical personnel that would need to be engaged at different stages in commissioning eye care services in the community. These include Community Optometrists and Dispensing Opticians, Ophthalmic Nurses, Optometric Advisors, Ophthalmic Medical Practitioners, secondary care clinicians such as Consultant Ophthalmologists and GPs who may be developing GP with Special Interest skills.

- **Step 1** – engage Shared Services support, or whoever maintains the Optometrist independent contractor list to identify numbers and contact details of optometric practices locally. This may need to extend to practitioners (as referenced above) of other provider organisations. Also find out any special interest qualifications registered.
- **Step 2** – contact the Local Optical Committee, Local Eye Care Forum, or other local clinical sources to discuss any proposed service plans or data as appropriate. This would extend to close contact with secondary care ophthalmologists in local trusts to gather their perspective on any proposed service plans or data affecting the hospital eye services.
- **Step 3** – contact local optometric practices or other willing providers as necessary with a local audit of workforce capacity, skills and enthusiasm. A face-to-face stakeholder meeting with local practices may be more effective than a practice survey.
- **Step 4** – contact Social Care providers if considering integrated Low Vision schemes and public health colleagues if developing more preventive approaches to complement local treatment and management services.

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## Patient and Public engagement

Going hand in hand with the engagement of clinicians is the engagement of patients who may have been, or will be, in contact with local eye care services as well as the wider public. Patients can become experts in their own care and their experiences and ideas for service improvement should be captured where possible. The views of the wider public within the local community are also important in more detailed scrutiny of service provision as well as health and social care spending. The Low Vision Service in Camden and Islington and the glaucoma pathway in South West Kent have both shown how involving patients and the public have improved and developed their local services.

- **Step 1** – invite local patients who have recently been through local service pathways to contribute to stakeholder events or meetings about service development
- **Step 2** – contact the local Patient and Public Involvement group (shortly to be replaced by Local Involvement Networks – [www.nhscentreforinvolvement.nhs.uk](http://www.nhscentreforinvolvement.nhs.uk)). Commissioners can use this route as patients and the public will be supported in becoming more active in local service developments as well as create a further avenue for good communication about changes in services.
- **Step 3** – ensure wide publicity of the Expert Patient Programme. This is a national programme, tailored locally, which has developed as a useful network for patients to share their experiences and improve the management of their condition. More information can be found at [www.expertpatients.nhs.uk](http://www.expertpatients.nhs.uk)
- **Step 4** – develop a comprehensive communication strategy for patients and the public to explain key service developments, commissioning priorities, and local mechanisms to capture user feedback.

## Organisational engagement

Better engagement and closer working relationships with other local organisations has been shown to be essential to effective service development and provision and the delivery of better health outcomes. Partnership agreements may already be set up, such as the Local Strategic Partnership, between the PCT, the Local Authority and a variety of other local organisations. Local Authorities can, of course, be the commissioner and provider of services, such as rehabilitation or other social services, alongside the PCT. The relationship may be developed to the extent that shared commissioning and provision agreements can be made as well as pooled budget arrangements.

Each statutory organisation also has a duty of care and formal statutory responsibilities and targets for public service delivery which need to complement each other locally. Shared planning and decision making will avoid any undue issues or perverse incentives within the wider health and social care system. This will also help deliver key national and local priorities such as joint efforts to reduce health inequalities across local populations.

Similarly, providers of eye care services across all sectors should be engaged at the appropriate time. Commissioners need to learn how services are provided by expert practitioners and providers need to be clear what is expected of them by local commissioners, under contract. Engaging a wide range of providers may be a problem if services are limited. More wide ranging opportunities for provision are now available which may be taken up by the voluntary sector and local advocacy groups, the emerging social enterprise sector, and the independent sector. All offer distinct and diverse skills and opportunities to provide eye care services which can be utilised effectively where local capacity and capability needs to be improved.



## SECTION 6

### Making change happen: How do we get there?

continued

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Finally, new Practice Based Commissioning organisations, led by local GPs, are developing in all parts of the country, with some at very different stages of development. It will be important to engage with these groups as priorities for eye care services may have been identified and business plans for services drawn up or in development through PBC. GP referrals are a key source of demand on existing eye care services, particularly in a hospital setting. Through Practice Based Commissioning, GPs are becoming increasingly aware of these demands and their impact on delivering local and national priorities, such as the 18 week referral to treatment pathway. Engaging GPs in the design and implementation of alternatives to hospital care will increase the chances of these priorities being met. Local PBC groups will need to endorse service developments in line with their PBC budget and service priorities.

- **Step 1** – identify which PBC group has an interest in community eye care as a priority for their registered population and any local GPs with Special Interests in eye problems such as cataracts, glaucoma or minor eye conditions.
- **Step 2** – present groups of GPs with data on referrals to hospital eye care services, local hospital services capability of delivering the 18 week target, and financial impact on Practice Based Commissioning budgets
- **Step 3** – ensure GPs are supported and engaged in any service development plans or business case planning which will be commissioned through Practice Based Commissioning
- **Step 4** – use the learning from your first PBC group as a driver for progress in eye care commissioning with all other PBC groups in your patch.

### Local eye care forums

There are examples of successful local forums which are inclusive and effective in dealing with both eye care commissioning and provision such as in Bradford or Buckinghamshire local schemes. They include clinical, organisational and patient representatives where the purpose of the forum is to be supportive, developing into a forum for innovation and ideas as well as governance, quality and systematic review of services. Local eye care forums can provide advice and solutions to commissioners in relation to service reviews, service redesign and the practical issues involved in commissioning new eye care services but it should not take a performance management role as this would be a contractual relationship between PCT commissioner and eye care provider.

### Provider development

Following recent reconfiguration of PCTs and the introduction of PBC, the Department of Health has emphasised the need for new PCTs to strengthen both the responsibility and opportunity to development new local providers of primary care services. PCTs are in a unique position to identify which services are needed while at the same time offering support to potential new providers of eye care services. For instance, cash incentives and/or service guarantees to potential new and willing providers to encourage them to invest time into extra training and their money into extra equipment. In offering incentives, PCTs will need to be satisfied that the benefit justifies the extra investment.

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There are no defined limits to the scope of this support. However, support for new, willing providers may be spread more diversely among the voluntary, social enterprise or the independent sector. This may be necessary if more local, more recognised providers such as GPs or Community Optometrists are either not available or are not willing to provide services under commissioned contracts.



PCTs, together with their local partner organisations and SHA, are in a strong position to commission the exact services they wish, with more innovative, flexible and effective contractual arrangements than those that currently exist. These are particularly relevant for providers delivering more enhanced primary care services or where services need to satisfy a very specific local need. For instance, PCTs may wish to encourage providers to open for extended periods when other services are closed.

Of course, local incentives may be necessary to support these contractual measures. The PCT may wish to offer new providers a defined primary care location to deliver services from, with reduced rental or rent-free terms. It may also wish to financially reward more difficult primary care outcomes for services such as faster access for patients or the reduction of inappropriate referrals to other services particularly those that incur a PbR tariff cost.

## SECTION 7

# Making key commissioning decisions: Who decides what and when?

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There are likely to be a number of times during the commissioning process described in previous sections of this Guide where key commissioning decisions must be made. Where and when these decisions happen, and who makes them, will depend on the origin of the service business case, idea or urgency of need. The decision making process may also be complex and time-consuming. This section outlines the two decision-making perspectives – Professional and PCT driven change – and describes basic procurement principles. It also looks at conflicts of interest and decommissioning services.

The role of the PCT is to support Practice Based Commissioners in the commissioning process. PCTs retain financial responsibility for commissioning decisions or suggestions made by Practice Based Commissioners and therefore the PCT must assess the plans for new services or pathways carefully. There are examples currently where service changes have been either professionally driven or led by the PCT itself.

### Professionally driven change – PBC and new potential provider business plans

Service business plans could be developed by a variety of stakeholders from individual GP practices, PBC groups, local Optometrists or indeed 'any willing provider' as indicated in the national PBC guidance ([www.dh.gov.uk/practicebasedcommissioning](http://www.dh.gov.uk/practicebasedcommissioning)). In assessing these business plans, a formal and transparent set of criteria for assessment should be developed. If the priorities of the NHS Operating Framework are to be achieved, business cases put forward to the PCT should be able to demonstrate the following in broad terms:

- Improvement in access to eye care services for all patient groups, particularly those that have been hard to reach in the past
- Improvement in eye health outcomes for all patients, and long-term management of conditions in the community
- Released capacity in other parts of the system such as hospital eye services or A&E
- Better Value for Money and use of healthcare resources, including eye care budgets specifically and staff related to ophthalmology
- Improvement in more integrated working and communication between providers along the patient pathway for that eye condition.



Each individual business case or service objective will require more detail for PCTs to be able to assess properly. Assessment processes may therefore differ in detail slightly but broadly they will be the same across PCTs. It should be clear which individual or group within the PCT governance structure has formal responsibility for signing off business cases for PBC and service development. This may be the Executive Committee or Senior Management Team as delegated by the PCT Board.

### PCT driven change – approaching the market

If, however, a business case has not been received by the PCT from Practice Based Commissioners or other potential willing providers, the PCT itself may still identify through its own needs analysis that there is a need for service change or development. The PCT may not have a recognised provider of such a service and therefore the onus will be on the PCT to approach the provider market to find out if there would be interest in appropriate providers delivering the service or services required (see Procurement of services below). Once providers begin to submit a business case for the service, then the assessment process described above would follow.

### Procurement of services

In many areas of the country, there is increasing capacity and range of eye care services which may be commissioned. The minimum-take contracts already set up at the various independent sector Ophthalmic Treatment Centres have supported this situation. Nevertheless, where new community eye care services are required, PCT commissioners will need to be familiar with procurement procedures laid out in PCT Standing Orders as well as any further statutory requirements for the organisation. Under certain circumstances, PCTs will need to advertise to any potential 'willing' providers any new services they wish to procure.

This process is detailed and time consuming and should follow EU procurement guidelines as appropriate.

The Practice Based Commissioning guidance (November 2006) helped set out the conditions for which PCTs and Practice Based Commissioners are able to expand the range services within their own local provider network, such as extending GP or Optometry services, or where formal tender processes would need to be followed.

In tendering for primary care services, it would be important for commissioners to consider European Union principles for tendering Part B medical services. Broadly these procedures cover transparency, equity, and fairness and essentially ensure that PCTs are non-discriminatory in the procurement process they adopt. The key facets of any tendering process can be based on these principles. The process will be designed to ensure

- the service has relevance to the internal market
- the service has sufficient, accessible advertisement and announcements
- defined stages in the procedure are adopted such as Pre-Qualification Questionnaires, Shortlisting, Invitation to Negotiate, and contract award (can be more informal and quicker if smaller, primary care services)
- adequate information is provided to applicants.

Further details about EU procurement rules for health care services can also be found in guidance developed by Primary Care Contracting – [www.pcc.nhs.uk/uploads/medical/pcc\\_provider\\_guide\\_\\_nov\\_06\\_final.pdf](http://www.pcc.nhs.uk/uploads/medical/pcc_provider_guide__nov_06_final.pdf) – which sets out the main rules around contracting for primary care services. This includes step-by-step guidance and helpful resources to support commissioners in this process. Similarly, national support is also available at [www.pasa.nhs.uk](http://www.pasa.nhs.uk) and [www.dh.gov.uk](http://www.dh.gov.uk)

## SECTION 7

### Making key commissioning decisions:

#### Who decides what and when?

#### continued



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New legislation requires the NHS to meet certain duties to promote equality in and through procurement; and it is central to NHS organisations playing their role as a good corporate citizen. Beyond Procurement – Connecting Procurement Practice to Patients is good practice guidance aimed at commissioners and procurement experts designed to achieve better procurement outcomes for the NHS by aligning equality and efficiency goals. Based on the experience and knowledge of specialist procurement and equality staff in 10 NHS Mosaic pilot sites this guide shares information and encourages innovation.

More information is available at [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_075724](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_075724)

### Conflicts of Interest

A further challenge to commissioners when making decisions about eye care services in the community is the potential conflict of interest which may exist through the development and delivery of new services. PCTs will need to evaluate and decide upon service business plans from practice based commissioners or other providers who may also wish to be providers of new local services they have planned. Where this is the case, the test will be whether these plans are approved by the recognised governance procedure at the PCT.

To deal with this issue, it is recommended that any GP or other provider who submits a business plan should not be permitted to sit on the decision making group, and should be excluded from the debate until a decision has been reached. This may be particularly pertinent if GPs (as practice based commissioners) or Optometrists are also members of the PCTs Professional or Clinical Executive Committee.

### Decommissioning services

PCTs and practice based commissioners need to recognise that the development of new models of care may result in multiple, overlapping systems of care and ultimately in the need to decommission an existing service. Similarly, in order for commissioners to realise the financial benefits of service change, an original service may need to be decommissioned.

Replacing existing services, or stopping them altogether, can be a difficult and time-consuming task for commissioners. Yet it is essential to ensure the right balance of high quality, affordable services are available to patients locally. Commissioners must still ensure that patients have access to a viable secondary care eye care service which will be able to achieve accreditation by the Royal College of Ophthalmologists.

Patients need to be involved early in designing any service change. Decommissioning a service, as well as making a substantial service change, may result in the need for formal public consultation and aside from any formal contractual requirement for notice will require a handover period to allow for one service to cease and for the existing patients (and/or staff) to be transferred to the new service.



## SECTION 8

# Performance Management:

## How will we know when we've got there?



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At this stage, commissioners will wish to determine the effectiveness of the services they have commissioned locally. Revisiting the Commissioning Self-Assessment Matrix described in Section 2 of this guide will act as a useful performance management framework. This section specifically illustrates the various elements of a performance management framework which commissioners could use to measure service performance and patient outcomes.

In general, commissioners should assess the performance of a new primary care eye care service by implementing two concurrent methodologies:

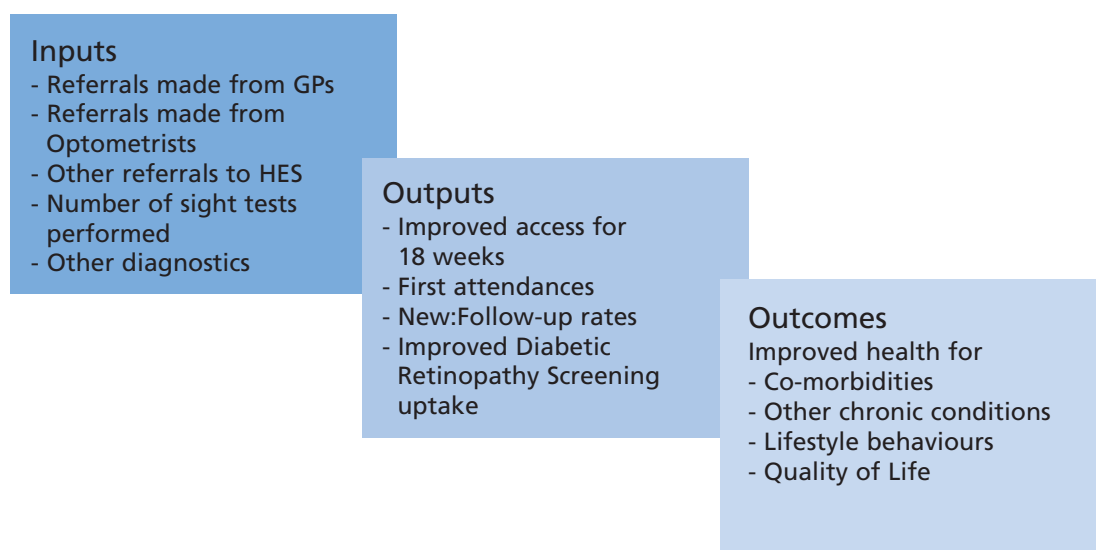
- an assessment of the achievement of the goals of the new service, and
- routine monitoring of the service.

### Assessment of service goals

Having developed a new eye care service it would be prudent to consider whether the service has achieved the objective of an improvement from the original state. To understand how the service has performed against this target, a reassessment of the state of eye care within the local health community should be undertaken using the tools described earlier. A service that has not altered the state of eye care services for the better from any perspective could be considered ineffective and the future of the service would be questionable.

### Routine monitoring of inputs, outputs and outcomes

To determine whether a service has made a difference to local provision, routine monitoring arrangements should be in place to demonstrate on-going performance. Metrics should be developed to monitor the inputs, outputs and outcomes of the service. The diagram below illustrates which relevant eye care service and patient outcomes might be used.



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If the benefits realisation approach was used for service redesign then the measures identified as part of that approach can be used as part of the monitoring arrangement. Monitoring of these measures will help to ensure that the service delivers the expected benefits to stakeholders.

Clinical performance i.e., quality assurance, also needs to be considered in developing a performance framework for a new service. Commissioners need to be clear in developing a service what the clinical governance arrangements for the service are, how the service will be audited, how patient outcomes are to be measured and how failure to meet the standards of the service will be identified and dealt with.

### Contractual leverage – secondary care

In developing contractual frameworks for the new service, commissioners need to consider whether they wish to include tools to assist and encourage performance such as rewards or remedies. The clauses in the NHS contract for acute care about performance against the 18 week target, for example, provide commissioners the opportunity for remedies. If the service is depended upon to deliver the 18 week target, commissioners may wish to discuss the inclusion of similar clauses in their local contracts including resource utilisation management techniques such as Prior Approval.

### Contractual leverage – primary care

As alternative eye care services are developed in the community, such as glaucoma referral assessment or more acute services to ease the pressure on A&E, a variety of primary care contracts may need to be adopted depending on the nature of the service and the type of provider delivering care. The range of appropriate primary care contracts and the detailed implementation issues which commissioners need to understand are

now well rehearsed. More information on the type of contracts can be found at [www.primarycarecontracting.nhs.uk](http://www.primarycarecontracting.nhs.uk)

Once these contracts are adopted, they may need to be used in a way to maximise the effectiveness of each service. There are a number of ways that these contracts can be used to ensure all the objectives and requirements of the contract are achieved. Periodic review of the contract should be the norm with commissioners using their contractual responsibilities to ensure the following factors are being met:

- Professional regulation demonstrating fitness to practice
- Clinical governance and patient safety
- Service quality and Standards for Better Health quality indicators
- Organisational management
- Financial accountability.

Importantly, local service remedies may need to be used by commissioners where services fail. These may be contingencies related to such things as IT infrastructure, staff cover or patient safety. It would be useful to adopt a robust network of governance in primary care around the service provision to ensure continuity and quality services are sustained. This may involve retaining other staff, clinical space or equipment on stand-by cover in case these may be needed.

### Incentives, rewards and penalties – a ‘balanced scorecard’ approach

Local provider incentives, rewards and penalties can play an important part in the delivery of high quality primary eye care services. To manage the distribution of any reward available to providers, or indeed to recognise sub-optimal performance, the balanced scorecard approach had been used successfully by commissioners. This allows for accurate performance assessment against a set of agreed indicators and standards.



## SECTION 8

### Performance Management:

#### How will we know when we've got there? continued

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Tower Hamlets PCT have developed a useful example of a balanced scorecard. Criterion-referenced indicators (ie., Absolute standards) are used rather than peer-referenced indicators to minimise variance in interpretation or need for appeal and to maximise transparency. Providers are rated on whether they achieve well above the standard in that area (rating A), whether they meet the minimum standard (rating B), or whether the minimum standard is not met and remedial action is required (rating C). There is no universal way of measuring performance against each indicator. Ways to measure this could be compliant/partially compliant/non-compliant, distance away from percentage performance, or demonstrating how well a provider is working towards a particular standard. The areas used in this particular example provide a useful focus for eye care services in the community and could include:

- Healthcare Commission requirements or Standards for Better Health
- The provider environment e.g., premises or infection control standards
- Accessibility and availability of service
- Health outcomes for patients
- Clinical and cost effectiveness e.g., prescribing or referral behaviour
- Patient satisfaction.

**Appendix 2** has an example how performance can be assessed using a selection of these areas in a balanced scorecard approach. Additionally, this approach will allow commissioners, at a glance, to ascertain any service development areas or practitioner support throughout those providers who have been assessed using the balanced scorecard. Usually levels of reward are commensurate with providers reaching an agreed number of high level ratings or standards across the full range of indicators, not just in any one area.

The Commissioning Framework published as an Annex to NHS Reform in England in July 2006 recognises the potential value incentives can have in developing the

local service provider market. The decision to use local incentives is a matter for local discretion and to justify their use it is expected that these incentives

- encourage services that would not otherwise be able to be provided
- are time limited
- are based on decisions which are transparent and auditable and open to any willing provider
- produce specific and measurable benefits and are supported by a robust business case.

Different incentives may apply in different circumstances. They could include paying a supplement to the tariff, providing guarantees within the contract or reducing the capital investment required by the provider.

### Financial evaluation

The 2007-08 NHS Operating Framework prioritises improved financial health across the local health community, with each NHS organisation having a responsibility to contribute to the delivery of this priority. More efficient and effective eye care services across health and social care will help support this goal. Commissioners should look for savings opportunities through greater cost-effectiveness and value-for-money. The cycle of reinvestment will continue with savings generated at the end of one year being used to reinvest in services the following year. Many practice based commissioners believe this is a particularly important flexibility and incentive for delivering local commissioning priorities.

**Appendix 3** provides an ‘*at a glance*’ and *interactive example* of potential commissioning savings in shifting a glaucoma referral assessment service from a hospital setting to one which is provided in a primary care setting by trained and supervised community optometrists. This example is based on the service having 1,000 new patients every year.

**- Direct (Costs)**

Financial accountability and prudence for PCTs coupled with more effective use of PBC budgets at local level are important mechanisms to achieve good financial health. They rely heavily on *direct* cost comparisons between secondary care services (now tariff-based under Payment by Results) and the equivalent services that could be provided as an alternative closer to patients homes in a primary care setting. These direct costs may be one-off or more short-term, and may be considered under the invest-to-save principle.

However, with setting up any new service, there may be longer term revenue costs associated with service continuity or development which will also need to be considered.

**- Indirect (Value)**

At the same time as how much commissioners actually pay for services, more indirect measures of healthcare value may also be important to consider. A service’s value to patients, the wider community or health and social care professionals and contribution to local and national priorities may not easily be recognised in the short term but may manifest itself over a longer period. Neither may it be measured by purely attributing a direct cost next to it.

The following table describes some of the direct costs and indirect value for eye care services. Both columns, in themselves, are not intended to be directly comparable.



<b>Costs (more direct evaluation)</b>	<b>Value (more indirect evaluation)</b>
Cost of hospital eye care service or sub-specialty under PbR	Quality of life improvement for individual patients
Cost of GP or Optometrist with Special Interest or other eye care practitioners	Better access to patients in a better range of primary care locations
Cost of providing increased activity in primary care	Better overall eye health for the local population
Primary care premises	Happier, more engaged practitioners
IT, equipment or other set-up costs and depreciation	More integrated and coordinated services in partnership with other agencies
Increased prescribing in primary care	Benefits to wider society
Cost of double-running any primary care pilot phase while still paying for secondary care	

## SECTION 8

### Performance Management:

#### How will we know when we've got there? continued

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Even this short list of examples shows the potentially difficult decisions commissioners will need to make when it comes to financial evaluation of services. If a new primary care service is cost neutral, makes a significant saving in relation to secondary care PbR, or the value of that service is more obvious, it is likely to be a straightforward decision for most PCTs or practice based commissioners.

Whilst financial incentives may be used to support providers to deliver the required quality and performance level within a service, financial thresholds, cost improvement plans under contract, prior approval techniques and use of benchmarked prices for services are all ways in which commissioners can generate extra savings which will contribute to improved financial accountability and better financial health.

#### Patient involvement, experiences and outcomes

Local Involvement Networks (LINKs) are new ways for people who use health and social care services to have their say in how they are planned and run. LINKs replace Patient and Public Involvement Forums. There will be a LINK in every local authority area and are closely linked to Overview and Scrutiny Committees. They will be a network of people, organisations or groups representing a diverse range of views and ideas and a host organisation will be responsible for setting up a LINK and giving practice support. There is now a regular LINKs Bulletin produced in 'easy read' format on the Department of Health website – [www.dh.gov.uk](http://www.dh.gov.uk).

Additionally, the Department of Health has recently issued guidance on planning and setting up LINKs. The following useful documents can be found at [www.nhscentreforinvolvement.nhs.uk](http://www.nhscentreforinvolvement.nhs.uk).

- Getting Ready for LINKs: Planning your Local Involvement Network
- Getting Ready for LINKs: Contracting a host organisation for your Local Involvement Network.

Measuring patients' views about a service and the level of satisfaction they might have with the service is fundamental in determining service performance and whether what has been commissioned is working for patients. With more primary care services developing more standardised user surveys will be designed and utilised. Many current services, such as the Low Vision Service commissioned by Camden & Islington PCT or the community glaucoma service in SW Kent & Maidstone PCT, have an integrated and on-going approach to using patient experience outcomes. This is evident by patient representatives on local decision-making groups or undertaking routine patient satisfaction surveys. Learning from the experience of other sectors, such as local authority approaches to capturing user views, would benefit eye care commissioners.

To support commissioners in their efforts to demonstrate improved patient outcomes in eye care services, the National Clinical and Health Outcomes Database - [www.nchod.nhs.uk](http://www.nchod.nhs.uk) – has numerous Patient-reported Health Instruments for measuring patient health. These instruments range from wider population health outcomes to condition-specific and health utility measures.



  
**Victim Support**  
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11 Borough High Street, London SE1 1RF  
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Email: [anna@southwark.vsp.org.uk](mailto:anna@southwark.vsp.org.uk)

## SECTION 9

# Timelines for Commissioning – How long will it all take?

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In developing new pathways for eye care services, commissioners need to be aware of some broad timeframes which will affect the overall time commitment needed to develop and implement any new or redesigned eye care pathway. This section sets out some example timeframes below to support commissioners with their project planning and implementation.

### Example timelines for commissioning activities

#### - Initial engagement of clinicians [Time: 6 – 8 weeks]

Due to forward planning of secondary care services, many hospitals require clinical staff to give them between six and eight weeks notice of any leave. This means that in order to effectively engage secondary care colleagues, adequate notice of any meetings would be necessary. Meeting arrangements and annual leave are also applicable to primary care clinical colleagues.

#### - Data collection and analysis [Time: 3 months]

Many items of information and data required to ensure that commissioners make effective decisions will need to be collected by local audit. Commissioners should not under-estimate the time needed to design a collection, collect the data and then undertake any required statistical analysis. Unless commissioners have access to a ready store of detailed referral analysis, for example, an audit of referral information would take at least one month to gather a true picture of referrals. Data over a 3 month period may be necessary to cancel out seasonal variation or random fluctuations.

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- Redesign of pathways  
[Time: 3 – 12 months]

The redesign of patient pathways requires full stakeholder engagement. Several meetings and iterations of a proposal may be required to ensure that all stakeholders are happy with the redesigned pathway.

- Consultation with patients and the public [Time: 3 – 6 months]

If the new patient pathways involve significant change to the existing services – for example, re-provision of a secondary care service in primary care, patient and public consultation may be required. There is a duty on PCTs to involve those affected by service change under Section 11 of the Health and Social Care Act 2001. A duty to formally consult under Section 7 arises where there is a proposal which is likely to require a substantial service change. A good start would be asking stakeholders the most appropriate arrangements for involvement.

The Department of Health guidance states that involving and consulting means discussing with patients and the public their ideas, commissioning plans, their experiences, why services need to change, what patients want from services, and how to make the best use of resources. It is more about changing attitudes with the NHS and the way the NHS works than laying down rules for procedures. Local Overview and Scrutiny Committee meeting schedules will also determine additional time necessary for formal community consultation about major service changes.

- Notice period in existing contracts  
[Time: 1 – 12 months]

If commissioners need to serve notice on part of an existing contract, or decommission services, for the provision of healthcare there may be a notice period within the contract. The notice period is likely to depend on the type of contract and the scale of change. For instance, a small change would be expected to have a smaller notice period than a large change such as service closure.

- Implementation of new pathways  
[Time: 6 – 12 months]

If new pathways are to be implemented then sufficient time should be allowed to ensure they are fully operational. Commissioners should note that where a new pathway replaces an existing pathway there may be a period of dual running of both the new and old services. Alternatively where the pathway is entirely new, time for recruitment, training, identification of service locations and communication with patients should be factored into the timeframe.

- Business Plan sign off  
[Time: 8 – 12 weeks]

Time taken for local PCTs to review and agree practice based commissioning business plans through their preferred PBC governance procedures will need to be considered.



# SECTION 10

## Useful Resources and Links

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### Sources of support for commissioners

- Primary Care Contracting has an online discussion forum for eye care at [www.primarycarecontracting.nhs.uk/forums/forumdisplay.php?f=22](http://www.primarycarecontracting.nhs.uk/forums/forumdisplay.php?f=22)
- Framework for procuring External Support for Commissioners (FESC) – the Department of Health will hold a pre-selected list of potential support organisations which PCTs and SHAs can call upon to support their commissioning activities. The menu of expert services provided through FESC can be used to support assessment and planning, contracting and procurement, performance management and patient and public engagement.
- Local Involvement Networks – [www.nhscentreforinvolvement.nhs.uk](http://www.nhscentreforinvolvement.nhs.uk)
- Other commissioning and service development resources are widely available through the Department of Health arms length bodies such as NHS Primary Care Contracting – [www.primarycarecontracting.nhs.uk](http://www.primarycarecontracting.nhs.uk), the Improvement Foundation – [www.improvementfoundation.org](http://www.improvementfoundation.org) or the NHS Institute for Innovation and Improvement – [www.institute.nhs.uk](http://www.institute.nhs.uk)

### Managers in Partnership

The Knowledge Exchange – [www.knowledgexchange.co.uk](http://www.knowledgexchange.co.uk) – is a service aimed primarily at managers and other professionals/clinicians with management responsibilities who work in the NHS and in social care. It allows users to post queries into an exchange where other users can then post replies to the queries. There is also a facility to search the archive to see if others have asked similar questions in the past.

Within the NHS, organisations pay a subscription to open up access for their staff. Knowledge Exchange is available to NHS staff via organisational or SHA-wide subscriptions. Membership is free to members of the union Managers in Partnership.

### Other eye care links

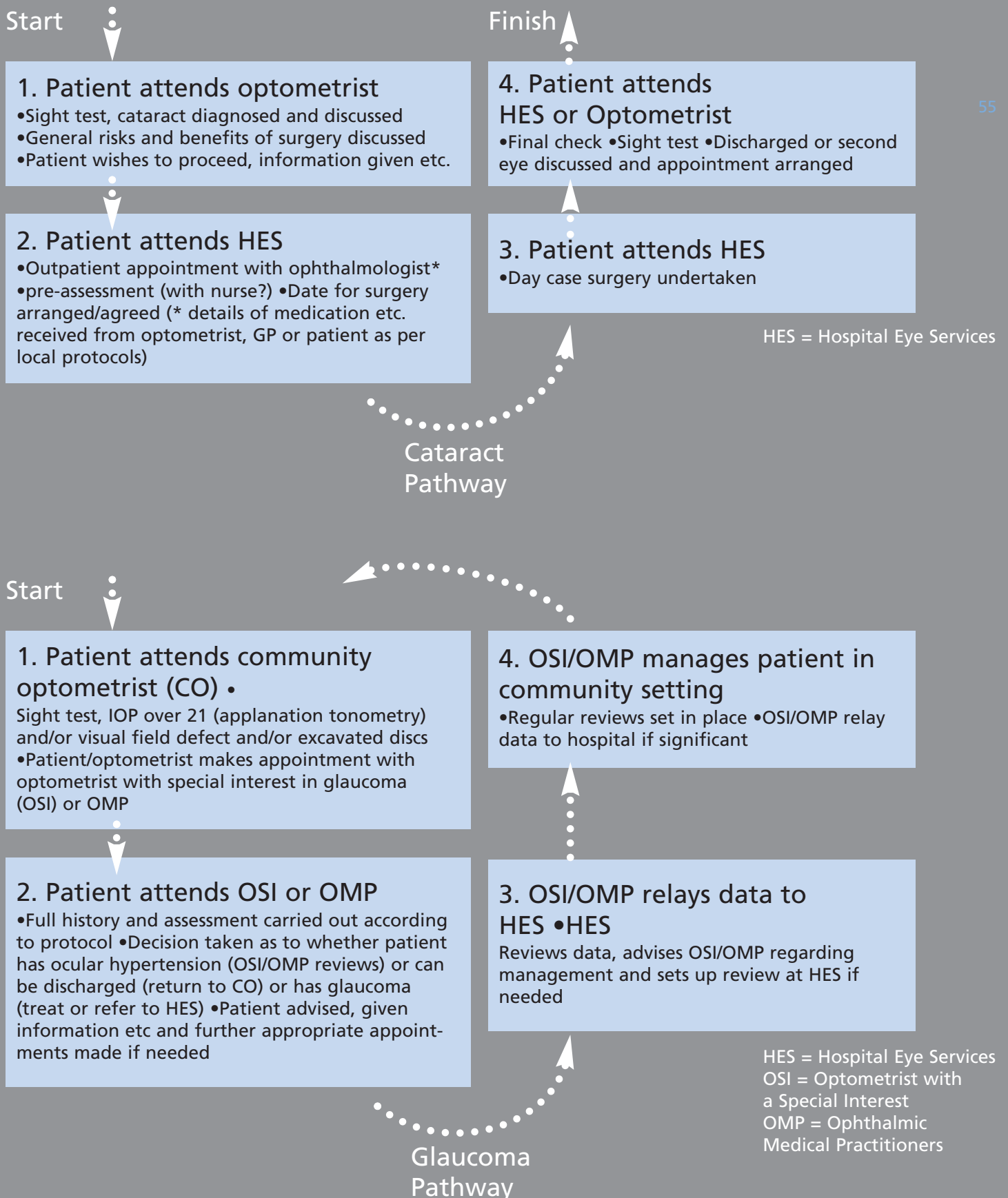
More specific eye care-related support is also available from existing national organisations including:

- NLH Eyes & Vision Specialist Library – [www.library.nhs.uk/eyes](http://www.library.nhs.uk/eyes)
- The NHS Information Standards Board – [www.isb.nhs.uk](http://www.isb.nhs.uk)
- NHS Connecting for Health – [www.connectingforhealth.nhs.uk](http://www.connectingforhealth.nhs.uk)
- Royal National Institute of the Blind (RNIB) - [www.rnib.org.uk](http://www.rnib.org.uk)
- Royal College of Ophthalmologists – [www.rcophth.ac.uk](http://www.rcophth.ac.uk)
- Royal College of General Practitioners (RCGP) - [www.rcgp.org.uk](http://www.rcgp.org.uk)
- Royal College of Nursing (RCN) – [www.rcn.org.uk](http://www.rcn.org.uk)
- College of Optometrists – [www.college-optometrists.org](http://www.college-optometrists.org)
- The International Glaucoma Association (IGA) - [www.iga.org.uk](http://www.iga.org.uk)
- The European Glaucoma Society (EGS) – [www.eugs.org](http://www.eugs.org)
- Cochrane Eyes and Vision Group (CEVG) – [www.cochraneeyes.org](http://www.cochraneeyes.org)
- Nurses Eye Site – [www.nurseseyesite.nhs.uk](http://www.nurseseyesite.nhs.uk)
- The Association of Optometrists (AOP) – [www.aop.org](http://www.aop.org)
- Federation of Ophthalmic and Dispensing Opticians (FODO) – [www.fodo.com](http://www.fodo.com)
- Association of British Dispensing Opticians (ABDO) – [www.abdo.org.uk](http://www.abdo.org.uk)

Please note the interests of professional bodies may not coincide with those of the Department of Health or PCTs.

Further links can be found at [www.primarycarecontracting.nhs.uk/87.php](http://www.primarycarecontracting.nhs.uk/87.php)

## Appendix 1



Start

### 1. Patient referred to Low Vision Service (LVS)

- Referral may be from secondary care, GP, social worker, rehabilitation officer, community nurse, OT etc. or may be self-referral
- Patient may have an LVI, RVI or CVI
- All patients are contacted by LVS within 10 working days

### 2. Patient attends LVS

- Service is seamless across health, social care and the voluntary sector
- A full sight test forms part of the assessment
- Patient is given information on eye condition, entitlements etc. as well as local services
- Counselling and advice on employment or education is available
- Spectacles, LV aids, advice (esp. lighting, contrast and size) and home adaptations are discussed and made available as appropriate
- Referral to other areas of health and social care as needed, including certification

### 4. Service enables re-access

### 3. Patient has follow up visits as needed

- Visits may take place in the patient's home or elsewhere
- Visit will be by appropriate member of the LV team

## Low Vision Pathway

HES = Hospital Eye Services

OT = Occupational Therapist

LVI = Letter of Visual Impairment – an information leaflet for patients newly diagnosed as blind or partially sighted. It has been replaced by the Low Vision Leaflet (LVL). Both documents do the same thing, but the LVL is more a standard patient information leaflet rather than a referral form. LVIs and LVLs are issued by high street optometrists and they feature a tear-off form that patients can fill in themselves and send to their local social services to request an assessment.

RVI = Referral of Vision Impairment – This form is completed by Hospital Eye Service staff to notify social services formally about a newly diagnosed blind or partially sighted patient, request and a assessment of their need for support and state how urgently they think the patient requires help.

CVI = Certificate of Vision Impairment – Completed by a hospital ophthalmologist to notify social services formally that a patient is eligible to be registered as blind or partially sighted.

## Appendix 2

### An example 'balanced scorecard' approach for eye care services

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Area	Data	Rationale	Rating A	Rating B	Rating C	Provider Rating
e.g., Healthcare Commission standard	Practice and PCT assessment; HCC inspection	National requirements for all Providers	80% and above of HCC requirements	65-79% and above of HCC requirements	<65% of HCC requirements	
e.g., Access and Availability	Service Business Plan; Provider contract; Practice visits; Patient survey; Mystery patient	Improved patient access	Operates to agreed contract (compliant)		Operates outside agreed contract (non-compliant)	
e.g., Clinical and Cost-effectiveness	PCT data HES data PBC data Practice audit	Reduction in inappropriate referrals to HES; Increased referrals managed in primary care	Reaching national benchmark rates	<1% difference from national benchmark rates	<5% difference from national benchmark rates	

### ANYTOWN PCT – Primary Care Glaucoma Referral Assessment Scheme – Costs & Savings example

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#### Commissioning Assumptions

1. Current Hospital Eye Service (HES) capacity issues, unable to meet 18 weeks RTT target (currently 26 weeks)
2. Agreement from secondary care Trust to manage glaucoma referral demand by adopting referral assessment scheme
3. Agreement from Secondary care clinicians to provide clinical governance support to community optometrists
3. No double running pilot work necessary, commission primary care enhanced service directly from Community Optometrists
4. Good engagement between primary and secondary care clinicians
5. All glaucoma referrals and suspects are adults
6. The number of re-referrals of stable glaucoma patients from optometrists back to the HES is low at say 10%

Note - blue boxes indicate where local figures can be inserted

#### Demand

Number of patients seen as First attendance	1,000
One third discharged	333
One third suspected glaucoma	333
One third diagnosed	333

Potential Savings to be made from Secondary Care	Patients	Tariff	Total Cost
<b>All Patients</b>			
New Appointments	1,000	£103	£103,000
<b>Patients with suspected glaucoma</b>			
25% need interim follow-up	83	£49	£4,067
100% need follow-up (assumed within 6 Months)	333	£49	£16,317
<b>Patients with diagnosed glaucoma</b>			
10% referred back to secondary care	33		
90% need interim appointment	300	£49	£14,700
of which 50% need second interim appointment	150	£49	£7,350
of 100% need follow-up (assumed within 6 Months)	300	£49	£14,700

Total Appointments needed in primary care 2,166

Other costs in secondary care

£5,000

**Total potential saving**

£165,134

Average cost per appointment

£75

#### Primary Care Costs

##### Capacity

Optometrist with special interest (1 session/week = 3 hours)	1	Units
patients per session	9	session patients
Operates ? weeks per year (allows for annual leave and sickness)	42	weeks
<b>Anticipated annual capacity</b>	<u>378</u>	patients

**Appointments needed**

<b>Total New Demand</b>	1,000
<b>Percent of demand to be seen in primary care</b>	100%
New Appointments	1,000
<b>Patients with suspected glaucoma</b>	
25% need interim follow-up	83
100% need follow-up (assumed within 6 Months)	333
<b>Patients with diagnosed glaucoma</b>	
10% referred back to secondary care	
90% need interim appointment	300
of which 50% need 2nd interim appointment	150
100% need follow-up (assumed within 6 Months)	300
<b>Appointments needed</b>	<b>2,166</b>
Optometrists Needed (1 session each)	5
Surplus/(shortfall) in appointments	(276)

**Costs**

Session Cost	£ 240	
Optometrists needed	5	
total session cost over 42 weeks		<u>£50,400</u>

**Set Up Costs****Non Recurrent**

Equipment Needed per Optometrist	£1,000	
IT Support per Optometrist	£2,000	
Non Recurrent Set Up Costs per Optometrist		<u>£3,000</u>

**Recurrent Costs per Optometrist**

Training per Optometrist	£ 500	
Recurrent Set Up Costs per Optometrist		<u>£500</u>

Total Set Up Costs		<u>£17,500</u>
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Total Cost of Primary Care Service		<u>£ 67,900</u>
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**Savings comparison**

Comparison	Average Cost per appointment Primary Care	Average Cost per appointment Secondary Care	Saving
Y1	£35.93	£75	£74,029.63
Y2	£27.99	£75	£89,029.63

# Notes

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## **Acknowledgements**

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