LOC SUPPORT UNIT

SUPPORT FOR PRIMARY EYE CARE DEVELOPMENT

LOCSU Annual Report **2008**

LOC SUPPORT UNIT
SUPPORT FOR PRIMARY EYE CARE DEVELOPMENT

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LOC SUPPORT UNIT
SUPPORT FOR PRIMARY EYE CARE DEVELOPMENT

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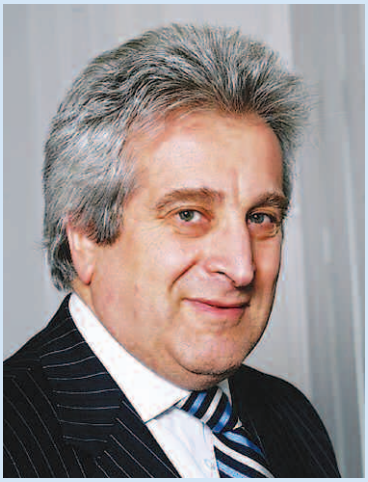

It is a great pleasure to write this foreword to the Unit's Report on its first eight months of operation.

At a time when the Optical Bodies have never worked more closely together, the Unit stands out as a practical example serving through LOCs, all practitioners and practices whatever their size and ownership.

Expectations will vary as to what should have been achieved and the measure of such achievement. My question to all LOC members that I have engaged with is "what do you want the Unit to do for you"? I could fill several pages with the range of responses but they clearly indicate the need for the Unit. It is our job to fulfil that need and meet our customers' expectations.

LOCs want the Unit to help them in practical ways and that is why we are developing our corporate commissioning strategy for enhanced services that will be presented at the National Optometric Conference. It will take the mystery out of local commissioning and provide all the practical help required by LOCs at whatever level they individually require. Above all it will reduce administration locally to the absolute minimum and remove the need to engage solicitors, lawyers, IT consultants etc which is often the stumbling block to developments locally.

Additionally the Unit is focused on the range of other areas of practical help that LOCs require. Whilst our publicity has focused on commissioning, the day to day work continues apace and all requests are being dealt with.

I have been involved over the years in the growth and development of a number of businesses both in and outside optics and in every case it has been about people, those who work in the business and those whom the business serves. The enthusiasm and dedication shown by those working for and with the Unit under Georgina Gordon's leadership leaves me with no doubt that they are totally committed to serving you, our customers. That has to be a very sound basis to take the Unit forward.

I look forward to reporting next year that the Unit will have made great strides forward and that its enthusiasm and dedication will have delivered exactly what LOCs require. Further, working with LOCs, that there will be a greater range of community eye care for the patients at the heart of our work.

LOC SUPPORT UNIT
SUPPORT FOR PRIMARY EYE CARE DEVELOPMENT

Head of Unit Report

I am delighted to report the good progress that the Local Optical Committees Support Unit (LOCSU) has made in its first accounting period. I took up my post of Head of Unit in September 2007.

In 2007 the Association of British Dispensing Opticians (ABDO), the Association of Optometrists (AOP) and the Federation of Ophthalmic and Dispensing Opticians (FODO) undertook a series of road shows throughout England and Wales to discuss the concept of the Local Optical Committees Support Unit and to seek the profession's support. They had the vision to see that growing success for optometry would only come about through increased collaboration. The Unit was formed to help LOCs meet the challenge for enhanced services as well as acting as a focal point for communication across and between LOCs in their ongoing work as the local voice of the profession. This approach had already been strengthened by the formation of the Eye Health Alliance of which the LOCSU is now a member.

A special meeting of the National Optometric Conference was held in March 2007 and resolved that the Support Unit should be established to help Local Optical Committees meet the new challenges of local contracting for enhanced services, as well as in their ongoing work as the local voice of the profession.

By an overwhelming majority, the meeting passed the resolution to establish the new Unit and fund it by means of a half per cent statutory levy on NHS fees.

The Unit was set up as a wholly owned subsidiary of the three bodies. A shadow Board was put in place in April 2007. The Unit was incorporated on 27th June 2007. The Board membership comprises two representatives from each of ABDO, AOP and FODO, as well as three representatives from LOCs. The Board invited two observers to join it; one representative from the Central (LOC) Fund and one from the College of Optometrists.

LOC SUPPORT UNIT
SUPPORT FOR PRIMARY EYE CARE DEVELOPMENT

Progress Report

The Support Unit has performed well against the 12-month action plan that was agreed by the Shadow Board in April 2007.

The business plan stated that within five years the LOCSU would be an effective and highly regarded resource for LOCs.

Task	How achieved
Provide a range of training	This has been achieved in year 1 via the training event at the National Optometric Conference in 2007 and the Practice Based Commissioning workshops during 2008[1]
Be a reliable source of advice and support	A significant number of enquiries and requests for help from LOCs have been dealt with
Provide support to help LOCs develop and revitalise	Specific bespoke support to LOCs has been provided on demand[2]
Communicate regularly and proactively	Achieved via newsletters, web site, emails, telephone and personal visits to LOC meetings
Monitor LOCs ability to respond to primary care developments	A baseline assessment of LOCs was undertaken and discussed with the LOC officers involved
Assist LOCs with the process to enable them to raise the 0.5% levy to fund the Support Unit	Written and verbal advice provided on the payment system
Develop an inclusive model for an LOC constitution and agree it with the Department of Health	Negotiated by the ABDO, AOP and FODO. Guidance on the LOC Model Constitution issued by LOCSU
Develop research that would be of use to LOCs	Supported the development, final design and launch of an epidemiological model to identify the number of people affected by eye disease; LOCSU manages the website

[1] Individual training and guidance has also been provided to a number of LOCs.

[2] A number of moribund LOCs have been revitalised.

Progress Report continued

The appendices contain examples of some of the service developments and business cases achieved by the LOCSU, which will put the year's activity in context.

The NHS Environment

The NHS is undergoing more rapid change than ever before. A number of factors will continue to force this pace ever faster. Our population continues to age significantly - living longer and healthier than ever before. The increased expectations of people in our society and their improved access to information means that demand for high quality, evidence based health care will continually rise.

Patients are no longer content to accept whatever they are offered passively. They want health care that is effective, efficient and delivered in a way that is convenient to them.

As people live longer, greater numbers will require some health input at various stages of their lives. Funding of health provision will not be limitless so those responsible for the budget spent on health services will be forced to seek providers who are both innovative and cost efficient.

NHS policy over recent years has continued to focus on a shift from secondary to primary care. Individuals have challenged the NHS monopoly on provision of services to the point that Government is introducing a policy on 'top up' purchasing of services. The policy now is for the NHS to commission services from any number of providers, procuring services in the same way that a private enterprise would. This environment of competition, allows new companies to compete with traditional NHS services to provide a growing range of health and social care. The LOCSU is working to ensure that the profession stays at the forefront of opportunity within this new environment.

Progress Report continued

Assessment Tool

The Support Unit team developed an assessment tool for LOCs. The assessment process helps LOCs understand key developmental criteria that they could review against their progress. A summary of the review findings appears later in this report.

Model Constitution

The three negotiating bodies developed a model constitution for LOCs, in conjunction with the Department of Health. This has subsequently been agreed and placed on our website. I sent a letter to LOCs in August 2008 summarising the key action points from the constitution and offering a commitment to help LOCs implement the guidance. Updated guidance was issued in October 2008 and all queries to the Unit have been answered.

Corporate Governance

The Support Unit has provided confidential advice and support to a number of LOCs to facilitate governance that is effective and allows more proactive management.

LOC Training

One of the principal objectives of the Unit was to provide training to LOCs to enable them to negotiate better with PCTs. Workshops were set up on practice based commissioning in every region, which were well-attended. A full report on training activities can be found later in this report.

Wales

The Support Unit is undertaking detailed work on behalf of Optometry Wales, in relation to a new contract in Wales. The work includes devising a full business justification case. We hope to be able to share details at a future date.

Regional Advisors

I undertook individual LOC assessments, attended workshops and made many visits to LOCs. My conversations and observations led me to conclude that the original model, based on service delivery via regional advisors needed changing.

In July I carried out a review of the Regional Advisors' structure. The review concluded that LOCs would now be better served by a group of Associates of the Support Unit, whose individual skills and experience can be targeted wherever they are needed rather than being restricted by geography.

The new Associates team comprises several members of the former Regional Advisors' Group plus others including experienced high profile optometrists, such as Trevor Warburton (who chairs the newly formed Enhanced Services Clinical Advisory Group of the Unit), Mike Broadhurst (who will chair the Operational Group rolling out the corporate strategy to LOCs) and Lyndon Taylor (who advises on Information Systems).

LOC SUPPORT UNIT
SUPPORT FOR PRIMARY EYE CARE DEVELOPMENT

The Future

As part of the Support Unit review, I recommended a new strategy and change of direction to the Board. The vision is to develop a single national model for enhanced service schemes backed by central support services, e.g. standardised service delivery, data and fee processing. This would allow inter-operability between areas that have contracts utilising the model, i.e. free movement of patients and practitioners. This would promote enhanced eye care services in England and would be a platform to achieve much wider availability of enhanced services, bringing England more in line with the service delivery in Wales and Scotland. The model presented is in keeping with Lord Darzi's vision of the NHS and meets requirements for keeping decision-making local and accountable. A number of meetings have taken place between project members and key Department of Health officials, such as Dr David Colin-Thomé; the early signs are positive from those meetings.

The Support Unit has set up a commissioning company 'Primary Eyecare Holdings Ltd'. This is the parent to subsidiary companies set up for each participating LOC.

This approach is inclusive to all LOC members regardless of their business status. It offers the opportunity for optometric services to respond to local health needs, to be recognised as a key partner in the provision of primary care services and as a quality business partner who is organised and at the cutting edge of service delivery methods. This strategy received the unanimous support of the Board in September 2008 and was immediately implemented.

The Support Unit is now moving ahead with developing a programme to enable LOCs to utilise the model. The model will be launched at the 2008 National Optometric Conference in November.

In Summary

In this short time the Unit has not only continued to provide quality guidance and support to LOCs throughout England and Wales, but has also expanded its brief to offer a new, dynamic business model to LOCs.

This concept puts optometrists, dispensing opticians and optical businesses in partnership with the Support Unit, at the leading edge of opportunity in eye health and community services provision.

Georgina Gordon

LOC SUPPORT UNIT
SUPPORT FOR PRIMARY EYE CARE DEVELOPMENT

How to spot a successful LOC

In spring 2007 the LOCSU identified the features found in successful LOCs. These features characterised a fully functioning LOC able to achieve its local aims and objectives:

The Unit set benchmarks to map the progress of LOCs set against criteria agreed by the sponsoring bodies. The following 7 features appear to be commonly found in successful LOCs:

1 An inclusive constitution

The constitution of each LOC needs to be inclusive and represent optometrists and dispensing opticians from the independent and corporate sectors, as well as both contractors and performers. Ophthalmologists, hospital optometrists, OMPs and university representatives should also be invited to meetings as appropriate.

2 Administrative back-up to arrange meetings and distribute papers

Each LOC needs adequate administrative back-up; it cannot succeed for long on the good will of individuals, however able they are. LOCs may also need to reimburse members or pay advisers for time spent advancing projects and developing LOC positions.

3 A business plan

Each LOC needs a business plan to deliver local objectives (as well as a basis for triggering the statutory levy). This should include:

- plans to achieve and maintain appropriate local representation for the LOC
- objectives for establishing and agreeing protocols for level 3 and any other primary care schemes that may be possible
- communications
- training.

4 Skilled officers

To be effective LOCs need

- officers and members skilled in leading, negotiating, influencing and working with the PCT and local contractors, as well as lobbying, presentation and communications
- the ability to identify those who could develop those skills through training
- systematic 'talent spotting' amongst new LOC members and new practitioners working in the area.

How to spot a successful LOC continued

5 An adequate budget financed by the statutory levy

To function effectively an LOC itself requires adequate funds to allow it to deliver the LOC business plan, including buying in support services as required.

6 Good local communications and contacts

All LOCs need

- mailing and e-mail lists of local practices and practitioners
- a website (through the new national site, www.locsu.co.uk)
- liaison and communication with neighbouring LOCs
- a list of local pre-registration trainees (each LOC should make arrangements to meet pre-registration trainees on an annual basis)
- contacts with the PCT and a good working relationship
- a working relationship with other contractor groups and with opinion formers locally.

7 Clear relationships with the Optometric Adviser and PCT

There also needs to be clarity about the role of the LOC and that of the PCT/health board's Optometric Adviser (OA). This is essential if they are to work together effectively and avoid the danger of the OA supplanting the role of the LOC. It is the LOC who should advise the PCT/health board on behalf of contractors and the OA who should give specific and general optometric advice to their employer.

The OA should not be a member of the LOC but should be invited to attend the relevant parts of LOC meetings.

The PCT/health board and OA should be clear that it is the LOC which is elected by the profession locally and is an advisory committee established under statute. It is the LOC that represents optometrists and opticians and is empowered and entitled by law to speak on their behalf.

Therefore, one of the first tasks was to undertake a baseline evaluation with each LOC to determine their current level of development and to identify their future development needs.

Evaluations have been completed for 34 LOCs (39%), giving a reasonable representation of the national picture.

Evaluation took place during discussions between the LOC SU advisor and members of each committee. A 'traffic light' system was adopted to show the level the LOC could demonstrate for each indicator.

How to spot a successful LOC continued

This evaluation, together with an understanding of the LOC aims and objectives, enabled the regional advisors to help the committee formulate a plan of action to help the LOCs move forward.

Key Findings

The findings illustrate the varying stages of development of LOCs. The major issue is that LOC committee members do not have sufficient time to deal with the tasks required. In particular, developing relationships with local stakeholders is difficult and time consuming when also managing a practice.

- 15% stated that they did not have a working relationship with local ophthalmologists
- Only 15% had established a working relationship with local practice based commissioning alliances
- Only 36% were participating in a PCT 'eye health' group.

Key to making progress with the LOC's objectives would be additional support.

- 29% had an administrator to support the committee and
- 29% didn't have a fee structure for committee members to attend meetings.

Despite these handicaps and the lack of a business plan outlining the LOCs local objectives (just 26%):

- 29% stated that they had proactively presented optometry-led initiatives to the PCT (e.g. business cases for enhanced services)
- 59% had a least one optometry-led scheme already in place.

The evaluations illustrate that most LOCs still have some way to go to achieve the benchmarks for success. Most still require advice, support and training to help them establish themselves as fully functioning and effective LOCs.

LOC Training

One of the LOC Support Unit's early objectives was to provide a range of training for LOCs.

The first step in providing a successful training programme is to assess and understand training needs.

The LOC Support Unit has based its assessment of LOCs' needs on:

- Features of a fully functioning and effective LOC – Spring 2007
- Training Needs Questionnaire – completed by LOCs August 2007
- LOC Training Day – October 2007
- Practice based commissioning (PBC) workshops – feedback forms
- LOC evaluations – undertaken by regional advisors
- Feedback to LOCSU.

The Training Needs Questionnaire was completed by 60% of LOCs. Key findings were that 69% of LOCs did not have a business plan (or other document) setting out its overall plans and objectives. However, 67% of LOCs did have a budget to provide funding for its activities.

The training areas that LOCs gave the highest priority were:

- Business case - eye care scheme
- Tendering
- Negotiating
- Practice based commissioning (PBC)
- NHS Planning & Financial framework
- Service Level Agreements.

This information was used when planning the training for the first LOC Training Day held in October 2007. 59 LOCs attended the event to hear speakers on the following topics:

- Convincing your customer to buy
- Negotiating
- Inside the head of a Primary Care Trust (PCT)
- Busting the jargon of the NHS.

LOC Training continued

On the feedback forms most delegates indicated positive actions they were going to take as a result of the training which demonstrated a successful outcome. Typically these were:

- Identify, develop and/or improve relationships with PCT as they realised the importance of these relationships and the need to communicate more effectively. Others said they felt more confident to be able to do that now they understand the NHS/PCT/PBC framework and jargon.
- LOCs were also inspired to develop and write their own business plan setting out their objectives.
- Others were intending to develop a business case for an eye care scheme after listening to speakers.
- LOCs felt that the tips they were given for negotiating were helpful and they intended to put these into practice.
- A number were intending to review LOC structures, capacity and employ additional support to assist them achieve their goals.

Suggestions for future events included:

- Presenting a business case to a PCT/PBC group
- More information on practice based commissioning
- Workshops in small groups rather than lectures
- Parallel sessions to provide choice.

Practice Based Commissioning Workshops

These suggestions were acted upon when designing a series of workshops on practice based commissioning (PBC). As understanding and operating within the PBC framework was so vital for large numbers of LOCs, the LOC SU commissioned workshops from the NHS Alliance. These were held during February, March and April in each region.

The response rate was excellent and 59 LOCs attended with129 LOC members benefiting from the workshop. The format combined information-giving about the nature of the PBC environment and sources of information and concluded with real hands-on experience. Delegates worked in small groups, on an eyecare proposal and then presented it to a PCT/PBC group board in a 'Dragon's Den' type environment. The board's feedback provided useful learning to take away. The opportunity to 'have a go' and practice in a safe environment was appreciated.

Training Summary

During this period the LOCSU has provided training events from which over 70% of LOCs have benefited. In addition a significant number of high quality resources have been provided to LOCs to support and assist them in their objectives i.e.

- Business Plan template
- Commissioning business case template
- Service provision business case template
- Practical solutions for PBC
- Budget guidance
- Prevalence data – using epidemiological toolkit
- Advice and support from Regional Advisors and Head of Unit.

This work provides a sound basis for further training and support for LOCs to enable them to achieve their objectives.

LOC SUPPORT UNIT
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Who's who – LOCSU Board members

Alan Tinger – Acting Chairman from 26 June 2007 to 18 September 2007, when appointed Chairman

Alan is a Chartered Accountant and a Companion of the Chartered Management Institute. In optics he is currently a Consultant to Optical Businesses, Treasurer of the Federation of Ophthalmic & Dispensing Opticians and Advisor to the General Optical Council's Finance & Procedure Committee.

Graham Ackers
LOC representative
Appointed 6 March 2008

Graham is a dispensing optician and employed by T H Collison Ltd a family owned group in the South East as the General Manager. He acted as Honorary Treasurer for the Surrey LOC for over 25 years and is currently Chair of the Optical Voucher Consultative Committee and serves on Vision 2020 and Optical Consumer Complaints Service.

Ian Jones
LOC/ROC representative
Appointed 6 March 2008

Ian Jones has been involved in Optical Committees in South Wales in one form or another since graduating from Aston University in 1983. He is now a Director with the Davies and Jones Optometrists group in South Wales and Chairman of South East Wales Regional Optical Committee.

LOC SUPPORT UNIT
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Who's who – LOCSU Board members continued

Hendrena Souten
LOC representative
Appointed 6 March 2008

Rena has been involved in all areas of optical organisation; from chairing the AOP through to chairing her LOC. She has been a member or officer of an LOC or AOC for most of her optometric career. She practises in a house practice with her husband, who is a dispensing optician.

David Hewlett
FODO representative
Appointed 26 June 2007

David is Chief Executive of the Federation of Ophthalmic and Dispensing Opticians which represents most of the UK optical market.

Mike Cody
ABDO representative
Appointed 26 June 2007

Mike is a contact lens optician with 20 years' experience in optics. He manages the contact lens business for an independent, family-owned group. He sits on Staffordshire LOC.

Sir Anthony Garrett CBE
ABDO representative
Appointed 26 June 2007

Sir Anthony is the General Secretary of the Association of British Dispensing Opticians, one of the founding members of the LOC Support Unit.

Who's who – LOCSU Board members continued

Robin Banks
AOP representative
Appointed 26 June 2007

Robin has been AOP councillor for Kent and S.E. London since 1998. Recently retired from full time independent practice he continues to work as a locum optometrist as well as undertaking a number of LOC and AOP posts.

Bob Hughes
AOP representative
Appointed 26 June 2007

Bob Hughes has been Chief Executive of the Association of Optometrists (AOP) since the beginning of 2005, having served for seven years in the same position at the Federation of Ophthalmic and Dispensing Opticians (FODO).

Invited Observers

Roy Brackley
Central (LOC) Fund Observer

Roy is an observer on the Board, representing the Central (LOC) Fund.

David Parkins
College Observer

David is Treasurer of the College of Optometrists and a trustee of the College/AOP Benevolent fund. He is also Joint Chair of the Professional Executive Committee of Bexley Care Trust and works in independent and hospital practice.

LOC SUPPORT UNIT
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Who's who - LOCSU Staff and Associates

Directly employed staff are kept to a minimum with a Head of Unit and one administrative assistant. The AOP provides office and establishment facilities to the Unit including finance and human resources services under a recharge basis. Advisors and associates are employed as appropriate, using consultancy agreements.

Georgina Gordon
Head of Unit

Georgina was appointed as the first Head of the LOC Support Unit in September 2007. She has a substantial track record in the NHS having held both clinical and general management Board level positions.

Support Unit Associates

Jane Bell

Jane is a self-employed optometrist with over thirty years of experience. She is Chair of her local LOC.

Trevor Warburton

Trevor is an optometrist in independent practice in Stockport and a Clinical Advisor to the AOP Legal Department. He is Chair of his local LOC.

Mike Broadhurst

Mike is an optometrist in independent practice and Secretary of his local LOC. He is also an Optometric Adviser.

Katrina Venerus

Katrina is an optometrist in independent practice and an Optometric Adviser.

LOC SUPPORT UNIT
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Support Unit Associates continued

Lyndon Taylor

Lyndon is an optometrist. He is working towards integrating optometry into NHS IT systems.

Dawn E C Roberts

Dawn has worked for multiples and independents and also run her own practice. She is an Optometric Adviser.

Rebecca Sparks

Rebecca has thirteen years' experience at Board level in the NHS, including as a Chief Executive.

Paul Williams

Paul manages his own company, working with the NHS to provide advice on primary care and business cases.

Janis Loose

Janis is a former NHS Director of Finance and works as a business manager for an LOC.

Harold Atkinson

Harold has worked as a dispensing optician and optometrist. He is an Assessor at the College of Optometrists.

Summary Financial Statements

SUPPORT FOR PRIMARY EYE CARE DEVELOPMENT

LOC CENTRAL SUPPORT UNIT

Summary unaudited statement of financial activities for the financial period from 27th June 2007 to 31st March 2008

INCOME & EXPENDITURE ACCOUNT

		2008 £	2008 £
LEVY RECEIVED			427,208
EXPENDITURE			
Recruitment costs and payments to staff and consultants		178,508	
COSTS SUB-CONTRACTED FROM AOP:			
Office accommodation	25,260		
Staff costs	66,180		
Telephone, fax etc	2,021		
Printing ,postage and stationery	7,043	100,504	
Travel and subsistence		12,245	
Board attendance & expenses		3,871	
Advisor attendance & expenses		20,737	
Office expenses		4,978	
Staff training		2,188	
Training event and road show		30,257	
Legal and professional fees		30,943	
Auditors remuneration		8,500	
Depreciation		3,589	
TOTAL COSTS			396,320
SURPLUS FOR THE PERIOD BEFORE TAX			30,908
Taxation			(4,885)
SURPLUS FOR THE FINANCIAL PERIOD			26,023

BALANCE SHEET

	£	£
FIXED ASSETS		
Tangible assests		35,801
CURRENT ASSESTS		
Debtors	4,541	
Cash at bank	73,700	
	78,241	
CREDITORS: Amounts falling due within one year	88,019	
NET CURRENT LIABILITIES		(9,778)
TOTAL ASSETS LESS CURRENT LIABILITIES		26,023
RESERVES		
Income and expenditure account		26,023
MEMBERS' FUNDS		26,023

NOTE:

The auditors have completed their work but have suggested that the taxation issues under consideration with HM Customs & Revenue concerning VAT and Corporation tax, could have a material affect on the final results for the period ended 31 March 2008, and the balance sheet position at that date. For this reason, and until the matters under consideration have been cleared with the relevant authorities they are unable to offer an opinion on the above.

LOC SUPPORT UNIT
SUPPORT FOR PRIMARY EYE CARE DEVELOPMENT

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Appendix A:
North of Tyne School Screening Pathway

Appendix A: North of Tyne School Screening Pathway

The following is an example of the work undertaken by the LOC Support Unit in the last year.

North of Tyne School Screening Pathway

For historical reasons, many Optometrists in Northumberland, Newcastle and North Tyneside had been providing an enhanced service for following up children who fail Orthoptist school vision screening to an agreed protocol. After discussing with the LOC the need to negotiate payment for such services, one of the Unit Associates went on to establish links with the North of Tyne Primary Care Commissioning Lead for Optometry. Following an initial meeting, he agreed to put the Associate in touch with the Head of Children's Services and the Head of Screening.

The Associate drafted a business case outlining the benefits of the pathway, including the costs if children were to attend secondary care rather than an Optometrist, and presented it to the PCT Leads. They agreed that children who fail school vision screening should have appropriate follow up and that this is a service which PCT should support. The Head of Children's Services apologised that the PCT could not commission the service straight away as there was no budget for it, but did put the pathway forward as a priority for the Annual Operating Plan 2009-2010 to ensure funding.

Meanwhile, the LOCSU associate established a North of Tyne Children's Vision Group which consisted of representatives from Ophthalmology, Orthoptics and the LOC, as well as PCT staff. This group examined the proposed pathway and protocol to ensure that all stakeholders were happy. Information on the proposal was also sent to all North of Tyne Optometrists to measure the interest across the region. The LOC is in the process of agreeing the final details and the service is due to launch at the start of the new financial year.

Appendix B:
Sunderland School Screening Pathway

Appendix B: Sunderland School Screening Pathway

The following is an example of the work undertaken by the LOC Support Unit in the last year.

Sunderland School Screening Pathway

Children who failed school vision screening in Sunderland were being referred to Sunderland Eye Infirmary for follow up. In 2006, the Optometry Modernisation Group identified this pathway as one that could be improved by using Community Optometrists to provide the follow up. The work was put on hold due to PCT restructure, but resumed earlier this year under the direction of the Commissioning and Reform Department of South Of Tyne and Wear (SOTW) PCTs.

The Children's Vision group consisted of the PCT Lead, an Ophthalmologist, an Orthoptist, an LOC representative, the Optometric Advisor for Sunderland, and the LOCSU associate. Throughout the process, she assisted the PCT lead in the development of the pathway and clinical and admin protocols, and worked with the LOC and PCT to agree an appropriate fee. The PCT lead and the LOCSU associate presented the business case to SOTW Commissioning Executive Team in August 2008, who agreed to support the pathway and a Primary care lead was identified to facilitate implementation. A launch event was held on 13 October 2008, and the service will commence on 1st December 2008.

Appendix C:
Hampshire LOC

Appendix C: Hampshire LOC

The following is an example of the work undertaken by the LOC Support Unit in the last year.

Hampshire LOC

Hampshire LOC took the lessons they learned at the joint LOCSU/NHS Alliance PBC workshop and put these into practice. Turning theory into reality, they wrote a commissioning business case for a community-based Glaucoma monitoring scheme and submitted it to the PCT and PBC groups. In addition, they met Clinical Directors from NHS Trusts and other stakeholders to share their vision and gain support.

The business case included prevalence data from the epidemiological toolkit and referenced existing schemes. These were particularly welcomed by the PCT. As advised at the workshop, the commissioning case clearly set out the benefits for the commissioner, i.e. the PCT.

Setting out the benefits for the commissioner is often overlooked, but they are the 'carrot' for the PCT. We offer them high standards, and a safe, prompt, uniform and shared glaucoma care scheme that would enable them to meet their national and local targets, including:

- 18-week target
- Care closer to home
- Choice for patients
- Improved patient/user experience
- Improving the health of the population
- Pro-active management of people with long-term conditions
- Improved access to service
- Implementing reform.

The proposal has been accepted. The PCT, lead PBC group, LOC and hospital eye service are currently working together on the detailed service specification.

Appendix D:
Kent LOC

Appendix D: Kent LOC

The following is an example of the work undertaken by the LOC Support Unit in the last year.

Proposed Kent wide community based cataract service

Introduction

The demand for ophthalmic services in the UK is increasing due, in part, to the increasing number of elderly people who place an above average demand upon the service. Cataract related appointments within the HES account for up to 30% of all appointments, and cataract surgery is known to be highly effective and cost-effective. In "Action on Cataracts" (2000) the Government suggested a target for Health Authorities of 3,200 cataract operations per 100,000 of the population. At that time, in East Kent, the number of cataract operations was somewhere in the region of 2,200 per 100,000. The concept of co-management of cataracts is that the burden of patient management is divided between community based optometrists and hospital based clinicians. It is well-known that co-managed schemes can bring benefits to patients, practitioners and to commissioners of ophthalmic services, providing integrated and multidisciplinary patient care.

Benefits to patients include:

- Easier access. Most optometric practices are situated in convenient locations that are readily accessible to public or private transport.
- Continuity of care. The patient will usually be consulting the same practitioner in familiar and generally more comfortable surroundings, which may be less stressful for the patient and lead to improved communications.
- Flexibility of appointments. Usually optometrists can offer appointments at shorter notice and at more convenient times than in secondary care.

Benefits to secondary care include:

- Better utilisation of resources. Transfers of workload from the overstretched HES to relatively underutilised optometric primary care.
- Reduced hospital waiting lists.
- Improved quality of referrals with patients sent directly to secondary care.
- Improved inter-professional communications. Ophthalmologists may feel more inclined to request advice on optometric matters e.g. refraction, contact lenses.

Benefits to commissioners:

- Optometrists are graduate professionals specialised in primary eye care and already have many of the skills necessary to manage eye conditions efficiently and economically.
- Clinical governance. Optometrists, like other practitioners within the NHS, are

committed to clinical governance, including continuing education, training and professional development (CET/CPD), quality assurance, peer review and clinical audit.
- Optometric services are well-established. Recall systems and support staff are already in place.
- Minimal need for further capital expenditure. Optometrists already work in well-equipped practices.
- Access to optometrists is better due to their greater numbers and more convenient setting.

As a consequence of 'Action on Cataracts' and in response to the increased demand for cataract surgery, a care pathway was established in East Kent in 2001. The development of this pathway was facilitated by a group representing all the key stakeholders (the integrated primary and secondary ophthalmic services committee) including optometrists, ophthalmologists, orthoptists, ophthalmic nurses, general practitioners, hospital trust managers and Health Authority and Primary Care Trust managers. The pathway enabled direct referral of appropriate patients by optometrists to a dedicated secondary care cataract clinic. A specific referral form was developed for the optometrist to complete to facilitate the subsequent assessment of the patient in secondary care. In the optometric assessment of the patient several specific issues were highlighted including: the affect of the cataract on the patient's quality of life; the presence of any co-morbidity; the desire of the patient to undergo cataract surgery; and the degree of urgency of the referral. More recently the introduction of Patient Choice has added another dimension to optometric assessment of the cataract patient.

In addition to the initial assessment of the patient with cataract, the optometrists' role in the care pathway in East Kent was extended to include the post-operative management of the patient. Again a specific form was developed for the optometrist to complete including various clinical details and a patient satisfaction section enabling audit of clinical outcomes.

Optometrists wishing to participate in the East Kent cataract care pathway were required to undertake additional training and accreditation. Several study days and refresher courses were subsequently organised and now almost all optometrists practising in East Kent are accredited to participate in the care pathway.

Shortly after the cataract care pathway was established in East Kent a similar pathway was developed for West Kent though this only involved the initial assessment of cataract patients in the primary care setting. Following the experience gained from East Kent, several enhancements were made to the referral forms and clinical procedure, notably the inclusion of a dilated assessment of the patient.

Strategic Context

The Government White Paper 'Our Health, Our Care, Our Say in January 2006 set out the future strategy for the development of primary and community-based health and social care services. This set out a vision of high quality services which met people's aspirations for independence and greater control over their lives, making services flexible and responsive to individual needs. This vision was based on a set of principles:

- Patient Choice
- Resources following these choices
- Greater autonomy where it matters for local professionals

This cataract service addresses some of the main goals set out in Our Health, Our Care, Our Say, in particular:

- Earlier intervention
- More responsive and innovative models of care with more local services
- More care undertaken outside hospitals
- People are given more choice and a louder voice
- Inequalities tackled and access to community services improved

Centrally mandated National priorities are set out in the 2008/9 Operating Framework, December 2007. These include:

- Improving access through achievement of the 18-week referral to treatment pledge
- Improving patient experience, staff satisfaction and engagement

South East Coast wide priorities include:

- Ensure equality of access to healthcare for disadvantaged groups

This service addresses all the above priorities.

Current context

It is extremely helpful that the three PCTs' shared optometric adviser has now put forward proposals for harmonisation of cataract schemes in East and West Kent and Medway because this will further ensure consistent and equal access to care for all patients requiring this service across Kent, regardless of where they live or work and where they chose to receive their primary eye care.

Health need and access

The population aged over 65 is predicted to increase, bringing with it increased demands on health services. By 2011 it is predicted that almost 18% of the population of Kent as a whole will be over 65, with the greatest rise in the population aged over 75. The Overall Index of Multiple Deprivation (2007) shows that while deprivation is more marked in East Kent, there are pockets of deprivation in the West, most noticeably in Dartford and Gravesham. Appropriate detection, referral and management of cataracts is a key health need for this group of the population and is incredibly important in order to strengthen their ability to maintain independence.

The West Kent PCT Strategic Services Development Plan 2008 states that the standard of practice premises (79) used for the provision of General Ophthalmic Services (GOS) is very good. This provides an opportunity for local access for the population to cataract referral and follow up services. The West Kent Plan also states the need for investment to facilitate the introduction of new models of care as assumed in the Maidstone and Tunbridge Wells PFI development and the Fit for the Future consultation.

Service need

Optometrists are responsible for the majority of referrals of patients for cataract surgery in the UK and have the necessary skills to investigate the clinical and functional needs of these patients, both before and after surgery. In most cases there is very little advantage by the patient being seen by the GP before referral to the hospital, and so direct referral is a straightforward option acceptable to the majority of ophthalmologists and GPs.

Under the General Ophthalmic Service patients with any defect of sight not correctable by optical means are referred to their GP. The optometrist's responsibility ends there. There is no requirement to make a differential diagnosis or refine the referral in any way. Undifferentiated referrals for cataract surgery result in substantial numbers of patients attending for Ophthalmic Outpatient appointments who are either unsuitable for or unwilling to undergo surgery.

The Kent Cataract Referral Scheme will address the problems of unnecessary referrals, deliver better care for patients close to their homes and reduce referral to treatment times.

Stakeholder support and commitment

The results of the audit undertaken in East Kent show a very high patient satisfaction with the service and the clinical outcomes are excellent. Waiting times for surgery have been reduced significantly and chair-time freed-up for busy GPs and secondary care practitioners. The conversion rate i.e., referred patients undergoing surgery, is very high. Personal communication with the ophthalmology team indicates satisfaction with the role of the optometrist in the care pathway.

Development of existing and new services

The East and West Kent Cataract referral schemes have been in operation since 2001 and both have demonstrated clear benefits to patients in delivering easily accessible and appropriate care. The proposed Kent wide Cataract Referral Scheme combines the best elements of the existing two schemes and addresses the confusion to both patients and practitioners arising from cross boundary issues. (It is important to remember here that patients have the freedom to attend any optometrist in the U.K. for their sight test).

In both East and West Kent, following a sight test, patients with suspected cataract are fully assessed by their optometrist to determine the exact nature and extent of their visual problem and ascertain whether there are any other ocular co-morbidities. Patients who will benefit from surgery are counselled about the process of, the risks, benefits and options for surgery. Those who are either unsuitable for or unwilling to undergo surgery are retained in primary care for continuing management.

Referrals outside the scheme require an additional GP appointment and at the very least one additional out-patient appointment. Both incur considerable extra costs. If the schemes were to be discontinued the numbers of inappropriate referrals would substantially increase with an inevitable effect on the demand for outpatient appointments and referral to treatment times.

Optometrists generally care for their patients over very many years and the LOC takes the view that the optometrist is not only the most appropriate professional to initiate a referral but also the best person to undertake patients' long term eye care after surgery. In East Kent patients are returned to their optometrist for post-operative follow up and refraction six weeks after surgery. Under the new harmonised scheme patients in West Kent will also benefit from follow up with their local optometrist. Again there are clear benefits both in the cost of a follow up appointment in outpatients as well as cost and inconvenience for patients.

The LOC suggests the Quality in Optometry (Q in O) initiative is regarded as the basis for ensuring an appropriate standard of quality assurance for this scheme. Q in O was devised by the profession, for the profession, and was published in 2007. It includes a checklist for Core and Development standards (based on Standards for Better Health). It is recommended that Core Standards, both level 1 (Legal and Mandatory requirements) and level 2 (Good Clinical Practice), be used in this instance. The LOC would be happy to discuss Q in O in more detail with individual PCTs.

Consequences/risks if the service does not proceed

If this service does not proceed successfully then the achievement of the 18 week referral to treatment target could be jeopardised. The workload for GPs would be increased because optometrists would not be in a position to accurately assess patients and develop appropriate referrals to secondary care resulting in a potentially poorer service for patients. Patients' access to local services would be diminished and the quality and number of appropriate referrals may be reduced. If the scheme does not proceed patients would lose the current benefits of eye care education, counselling to ensure the patient understands and really wants to go ahead with the treatment and information provided by optometrists on patient choice.

Fees

The present cataract schemes were set up as part of the Action On Cataracts initiative in 2001/02. The fees are £25 for pre-referral with dilation in West Kent and Medway and £10 for pre-referral without dilation in East Kent. In East Kent the fee for post-op check is £20. Optometrists have received no cost of living uplift on their fees for this work for 7 years. If 2% inflation, per year was added to the West Kent fee, it would be £28.70. If 2% per year inflation was added to the East Kent post op fee it would be £22.95.

Not surprisingly, fees around the country vary. The most recently agreed scheme is the Liverpool scheme where optometrists receive £40 for assessment with dilation. The vast majority of schemes pay fees higher than the PCT proposal of £10 for post op review.

The cataract referral scheme saves some first consultant outpatient referrals (saving £106 per avoided referral) by making sure that referral is really necessary – for example ensuring that cataracts are present and need treatment rather than other pathology such as age related macular degeneration and also by ensuring that even if the patient has cataracts, the patient is willing to undergo treatment. The scheme also saves a GP consultation. A follow up appointment is also saved (£48).

The LOC proposes a fee of £40 per patient for pre-referral if dilation is requested and £30 if no dilation is requested and that the fee for post-operative follow up checks remains at £20.