



Primary Care & Community Services:
Improving eye health services

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Executive Summary

The provision of high quality, patient-centred care is a key priority for the NHS. Developing primary eye health services and building on the strengths of the NHS sight testing system forms an important part of the overall strategy to ensure safe, effective, fairer and more personalised patient care. Primary eye health services have much more to offer than testing of sight and dispensing of corrective lenses. There is scope to expand provision of clinical services in primary care settings using a mix of skills and developing integrated services and for this to become a persuasive force in improving health and wellbeing.

Although the document focuses on the commissioning of primary and community eye health services, this has implications across the primary, secondary and community care sectors, and the voluntary sector. The needs of people with vision problems, and the potential development of those problems, mean that commissioners should aim to achieve integrated eye health services, across sectoral boundaries. This ensures that patients do not fall between organisational structures, and do receive increasingly high quality, personalised care. Demographics are likely to influence the development of community based eye health services and mean that increased attention will need to be given to this area. The population is ageing and this will lead to an increase in the burden of eye disease, particularly as eye disease is more prevalent amongst older people and frequently chronic in nature. Therefore the patients enter the service require lifelong follow up. Trends in public health, such as the rise in obesity, will also affect the prevalence of visual ill-health because there is a link between obesity and development of eye disease, such as diabetic retinopathy. Similarly, there are links between smoking and macular degeneration.

Whilst demographics highlight the likely increase in demand for services, commissioners can make an impact on the size and nature of that demand. Investment in identifying sight problems at early stages, and treating where possible, provides a means to reduce future demand for more complex and costly interventions from the health and social care system. In turn this can improve the independence and quality of life of people with vision problems. Therefore, commissioning primary eye health services effectively is as important as the PCT's role in commissioning other primary care services. However, this area of commissioning is complex, with a number of distinctive features that are unique. World class commissioners will need to develop and strengthen their commissioning of these services if they are to maximise the opportunities for contributing to their population's health.

This guide is intended to build awareness and capability within PCTs:

- section 1 sets the scene for the guide and emphasises the key areas for developing primary eye health services
- section 2 describes the application of world class commissioning to primary care
- section 3 provides key information about eye health services, how they are delivered and describes the distinctive features of commissioning these services
- sections 4 to 6 set out the steps of the commissioning process as they apply to primary eye health services, from establishing the baseline and developing the vision to the levers and tools available to make change happen
- section 7 contains a series of questions that are pertinent for PCT Boards in respect of their commissioning of primary eye health services
- section 8 describes what achievement at level 4 of the world class commissioning competencies might look.

Eye care and public health professionals need to have a clear voice in key commissioning decisions and a local Eye Care Forum can make a valuable contribution in determining eye care needs in relation to the broader joint strategic needs assessment (JSNA). To be world class commissioners PCTs need to have a system in place for commissioning primary eye health services based on a comprehensive, well researched and up to date targeted local needs assessment, and focus decisions on local priorities. World class commissioners need to be assured that the commissioning of eye health services is appropriately supported by public health and commissioning functions, to prevent this being disconnected from other commissioning decisions e.g. in respect of the hospital eye service and social care.

To support world class commissioning, PCTs need to make sure there is appropriate eye care input at Board level whenever decisions about commissioning primary eye health services are taken. In addition, PCTs should have a named Board member with responsibility for primary eye health services. This guide may be used alongside the stakeholder-led *UK Vision Strategy*¹.

¹ UK Vision Strategy <http://www.vision2020uk.org.uk/ukvisionstrategy>



Section 1 Introduction

Introduction

What is the purpose of this guide?

This is part of a series of supportive guides to help PCTs become world class commissioners of primary care services. They have been co-produced by NHS East of England, NHS Primary Care Commissioning (NHS PCC) and the Department of Health.

This guide focuses on improving the quality of commissioning eye care and provides practical advice on how PCTs can:

- assess their current performance
- identify their vision for the future
- commission services that meet the needs of their local communities.

This is part of a rolling programme of practical guides that also include guides on commissioning GP services, primary dental services and pharmacy services. The guides are being supported by a series of regional events to help PCTs address the strategic, leadership and operational challenges in driving up the quality of primary care commissioning.

Alongside this suite of guides, we are developing a series of practical advice and tools, including

- how to benchmark primary care services and assess how far they reflect local health needs
- how to measure quality improvement in primary care, including developing 'quality scorecards' or 'balanced scorecards'
- how to commission accessible and responsive primary care services
- how to improve primary care for social inclusion.

Who is this guide for?

This guide has been developed for senior managers responsible for commissioning eye health services.

Why change?

The final report of the NHS Next Stage Review, *'High Quality Care for All'*², sets out the strategic direction for driving improvements in the quality of care across the health service. *'Our vision for primary and community care'*³ draws together the main conclusions of the Next Stage Review for community-based NHS services, including eye care services, and sets out a strategy based around four key areas:

- shaping services around people's needs and views
- promoting healthy lives and tackling health inequalities
- continuously improving quality
- ensuring that change is led locally.

Like NHS services generally, eye care services beyond the system of NHS funded sight testing need to be developed to ensure delivery of high quality services and this will primarily be done at a local level. When commissioning eye care services, it is particularly important to consider the need for joint commissioning between health and social care to provide a service that will meet the needs of the patient.



² Lord Darzi and Next Stage Review

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825

³ Our vision for primary and community care

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085937

In January 2007, the Government announced the results of the *General Ophthalmic Services Review*⁴. The review concluded that we had a successful sight testing service, which provides patients with convenience and choice and that we should seek to build on that rather than make changes. The review recognised the potential to develop more accessible, tailored eye care services for patients by making greater use of the skills that exist among eye care professionals who work in primary and secondary care settings, to help diagnose and manage a range of eye conditions. The review also saw scope for greater collaboration between the NHS, social care and the third sector in providing integrated services for patients with low vision problems. Integration across primary, secondary and tertiary care has been the consistent aim of policy for eye care services and this guide follows the same principles whilst focusing on primary care and community services, and building on developments since the original framework and pathways were published.

The main outcome of the review was a *commissioning toolkit*⁵ that provides practical advice for PCTs and practice based commissioners on the commissioning of community based eye care services. The toolkit builds on the evaluation of the chronic eye care pilots, which tested community based pathways for glaucoma, age related macular degeneration and low vision services.

The Health Act 2006 permitted the introduction of a three-tiered framework for commissioning primary ophthalmic services, covering:

- mandatory services, which all PCTs must commission and which any eligible contractor may provide, i.e. the provision of NHS sight tests, which is specified on the face of the Act
- additional services, covering other services that all PCTs must commission and which are prescribed in regulations
- enhanced services, which PCTs may choose to commission and fund locally to meet local needs.

The intention was to create a more coherent commissioning framework than had existed previously, although PCTs had always had powers to commission primary eye care services locally in addition to the General Ophthalmic Services system, to facilitate effective commissioning of eye care services and consideration of how best to use available resources.

4 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_063984 Department of Health, 2007

5 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_063978 Department of Health, 2007

UK Vision Strategy

The World Health Organisation's (WHO) Vision 2020 programme to eliminate preventable blindness by 2020, provides strategic context for service development. In the UK, stakeholders have developed a UK Vision Strategy inspired by the WHO's initiative, and the former Secretary of State, Alan Johnson endorsed the aims of that strategy at its launch. The Department of Health is committed to supporting the aims of the UK Vision Strategy within the context of a locally commissioned service, through guidance on best practice.

The UK Vision Strategy aims to:

- improve the eye health of the people of the UK
- eliminate avoidable sight loss and deliver excellent support to those with a visual impairment
- enhance the inclusion, participation and independence of blind and partially sighted people.

Stakeholders have also developed an implementation plan for England⁶.

Commissioning community eye care services

This document seeks to deliver Secretary of State's commitment by providing PCTs and practice based commissioners with practical advice on commissioning community-based eye care services and seeks to provide support to commissioners in their decision making within the framework of world class commissioning (WCC).

The development of more community based eye care services complements the direction mapped out in the White Paper: *Our Health; Our Care, Our Say*⁷, which set out the intention to develop services in settings more convenient and accessible to patients. Making greater use of the primary care workforce may also help deliver the increased capacity needed in some areas to achieve the "18 weeks" target. Although this document focuses on the commissioning of primary and community eye care services, it is important to consider the whole eye care pathway across, primary, community and secondary care to ensure the most effective services.

⁶ <http://www.vision2020uk.org.uk/ukvisionstrategy/page.asp?section=72§ionTitle=All+Implemenation+Plans>

⁷ *Our Health, our care, our say*: www.dh.gov.uk/assetRoot/04/12/74/159/04127459.pdf

As eye care and vision needs can encompass social care as well as health services the JSNA is an important factor in planning the need for local vision services. Though it is not possible to cover every specific issue in this guide, commissioners need to identify inequalities and special needs, and consult people from groups affected when local plans are being developed e.g. people with learning disabilities, people with dual sensory loss, children, older people, and people from ethnic minority backgrounds all have particular needs, which commissioners should consider when planning and developing services.

Demographics are likely to influence the development of community based eye care services. The population is ageing and this will lead to an inevitable increase in the burden of eye disease in the population, particularly as eye disease is more prevalent in older people and frequently chronic in nature, so patients enter the service and then require lifelong follow up. Basic projections suggest that, even if nothing else changes, the demand for NHS sight tests will rise by 20% over the next 20 years because of the significant increase expected in the population aged 60 and over. Estimates based on official population projections and epidemiological prevalence surveys predict that the number of cases of glaucoma in England and Wales will increase by a third by 2021, and then continue to rise at a similar pace to 2031. Research continues to be produced which may inform commissioning plans. These include a project funded by the Royal National Institute of Blind People - "Future Sight Loss UK", a study on the prevalence and costs of sight loss.

It seems reasonable to assume that trends in public health, such as the rise in obesity, will also affect the prevalence of visual health because there is a link between smoking and obesity and development of eye disease such as macular degeneration and diabetic retinopathy.

As noted above, commissioners will want to think about and develop services, which prevent the development of eye disease as well as providing treatment for eye disease once it has been diagnosed or support for sight loss when treatment is no longer an option. Whilst demographics highlight the likely increase in demand for services commissioners can make an impact on the size and nature of that demand. Investment in identifying sight problems at early stages and treating where possible provides a means to reduce future demands for more complex and costly support from the health and social care system and improve quality of life for people with vision problems.



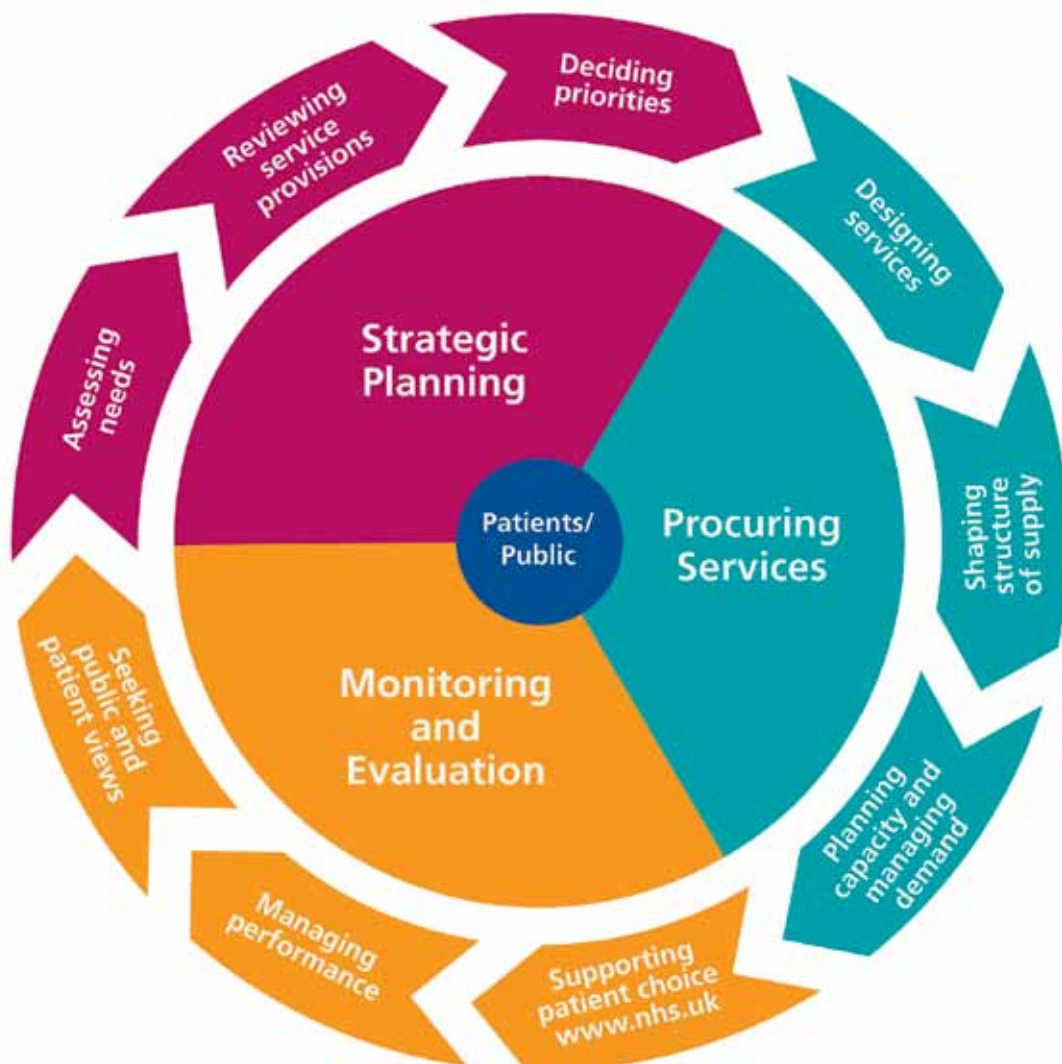
Section 2 World class commissioning

World class commissioning

The world class commissioning (WCC) programme sets out a framework to support PCTs in developing the competencies needed to commission high quality services that improve health outcomes and reduce health inequalities.

This includes strong engagement and partnership with the public, NHS staff and other healthcare professionals, and other local partners such as the voluntary sector. As world class commissioners, PCTs will be in regular dialogue with their communities about what is good with local services and what needs to change. They will have a deep understanding of local health needs and the services and interventions that will be effective in meeting these needs. They will actively manage the provider market, reward and encourage providers that continuously improve quality and bring in new providers where services are unresponsive or there is limited choice.

Information for world class commissioning



Delivering world class commissioning of primary care

The effective commissioning of primary care services is central to improving quality and implementing the regional visions for health and healthcare developed as part of the Next Stage Review. The NHS spends around £100 billion per year on health care in England. A large proportion of that sum is spent, or committed, by clinicians in primary care through either direct treatment, prescribing or onward referral.

It is essential that PCTs understand the value that can be gained by investment in primary care, and how to work with clinicians to achieve continuous improvements in patient experience, safety and the health of individuals. This requires a proactive and strategic, long-term approach to shaping the nature and range of services provided in primary care.

As part of the WCC programme, every PCT is developing a five year strategic plan, which sets out its vision, its priorities and how these will be delivered. The plan will include the high level patient offer, which sets out what the PCT is accountable for delivering to its local community. This should include its eye care commissioning intentions alongside its other commissioning intentions. Strategic plans will explain what services will be provided, where they will be available and who will provide them. In addition, each PCT will prepare an annual operating plan, outlining how it will implement its strategy in the coming year. Both the strategic plan and the operating plan should address how the PCT will improve primary care services.

The challenge is to develop a clear vision for assessing eye health needs and requirements for eye care services within the strategic plan and identify what this means in relation to the way in which eye care is commissioned as part of the operating plan.

World class commissioning competencies and assurance process

To commission primary care effectively, PCTs will need to develop and display each of the eleven competencies defined by the WCC programme. Section 8 sets out the specific criteria and performance indicators for each competency.

The annual cycle of the WCC assurance process will hold PCTs to account as they move towards world class levels. The Department is exploring with SHAs how best to reflect commissioning of primary care services in the development of the assurance process.



Section 3 About eye health services



About eye health services

Many people take their vision for granted but losing your eye sight can have a huge impact on your life. It is expected that due to demographic changes and wider trends in public health, for example obesity which is linked to eye diseases such as diabetic retinopathy, the demand for eye care services will grow considerably over the next ten years. PCTs will need to commission services that not only treat vision problems but support patients with chronic vision related illness. Links across health, social care and the third sector are important for planning of vision services and the local JSNA should consider these needs, including issues relating to emotional and psychological matters.

Key facts

One of the features that distinguishes eye health services from other areas of primary care is the range of providers and professions who are potentially able to deliver services and support to patients and the fact that a patient with vision problems may need support from across different sectors (sometimes in combination) – primary and secondary care, social care and the voluntary sector – at different times in order to best meet their needs. People’s needs may range from vision correction through glasses or contact lenses, screening for eye disease, management of a chronic condition in primary care, preparation for surgery and support for people with permanent vision loss. Services may be provided from a range of locations including optical practices, health centres, GP practices, social services, voluntary sector premises etc.

Appendix A to the commissioning toolkit issued in 2007 provides background facts about major eye conditions⁸

Who provides eye health services?

Eye health services are provided by a number of different professionals including:

- ophthalmologists
- optometrists
- dispensing opticians
- orthoptists
- ophthalmic medical practitioners (OMPs)

⁸ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_063984 Department of Health, 2007

- ophthalmic nurses
- ophthalmic technicians/Ophthalmic Science practitioners
- general practitioners with a specialist interest in ophthalmology.

Eye health professionals work in a range of different settings including national optical chains, health centres, GP practices etc and this is something which commissioners should consider in developing services.

Appendix B to the commissioning toolkit issued in 2007 provides information about eye care professionals⁹

What services are provided?

Mandatory Services – NHS funded sight testing

Mandatory services are the traditional 'high street' sight testing services offered by optical businesses with a General Ophthalmic Services (GOS) contract with their local PCT, and are available to specific eligible population groups. All PCTs must contract for these services and any eligible contractor may provide them subject to local decision on matters such as quality of service e.g. inspection of premises and equipment etc. The NHS funded sight test is subject to the same regulations as privately funded sight tests and the same clinical and legal responsibilities apply. NHS funded sight tests may only be carried out by an ophthalmic practitioner on a PCT performers list.

Where glasses or contact lenses are needed to correct vision, the sight tester is required to prescribe them and to give the patient a copy of their optical prescription. The sight tester is also required to issue an NHS optical voucher to all eligible patients at the time that the sight test is carried out unless a patient's circumstances change in which case a voucher can be issued later. If signs of injury, disease or abnormality are identified then the practitioner will refer the patient to a GP, through a GP to hospital or directly to hospital as appropriate.

Patients may take their prescriptions and their NHS optical vouchers to any supplier of optical appliances who will accept them although patients who are aged under 16, blind or partially sighted must take them to be dispensed by an optometrist, a dispensing optician or a registered medical practitioner.

⁹ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_063984

Additional Services

Additional services are those prescribed in regulations which PCTs must contract to provide. At present, the only such service is the NHS sight testing service, but provided:

- **at home:** the patient must be eligible and must be unable to leave home unaccompanied because of physical or mental illness or disability
- **at a residential or care home:** the patient must be eligible and must normally live there and be unable to leave the home unaccompanied because of physical or mental illness or disability
- **at a day centre:** the patient must be eligible and must have difficulty in obtaining sight testing services from practice premises because of physical or mental illness or disability or because of difficulties in communicating health needs unaided.

All PCTs must contract for these services but not all contractors are obliged to provide them. Optical providers may have a mandatory services contract, an additional services contract or both.

Supply of optical appliances – usage of NHS optical vouchers

The supply of optical appliances in primary care is not strictly speaking part of GOS. Such supply is always a private transaction even if an NHS optical voucher is used in full or part payment. NHS glasses have not been available since 1986. Suppliers of optical appliances do not hold a contract with the PCT for this function. They may also be GOS contractors but do not have to be. Dispensing has been deregulated and non-registered suppliers are able to dispense to some people. However, dispensing to children under 16 and people who are registered as blind or partially sighted is restricted under the Opticians Act to registered opticians.

Enhanced Services

Beyond the NHS sight testing service, whether provided through mandatory or additional services, and the supply of glasses, there is a wide range of eye care services available to patients, which span different sectors of the NHS as well as social care. Whereas sight testing is restricted under the Opticians Act to registered optometrists or medical practitioners these restrictions do not apply to enhanced services if the service is for something other than a sight test as defined in law.

Hospital eye services deal with acute and chronic eye conditions and long-term follow up of patients is mostly also 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 community eye centres, GP or optical practices and other primary care locations, with optometry having provided most additional services including a primary eye care acute referral scheme which has been supported by the Welsh Assembly. However, these approaches are not universal and many PCTs and Practice Based Commissioning (PBC) groups are looking for alternative primary care provision of services for patients.

The Department of Health's *Transforming Community Services*¹⁰ programme aims to improve community services so that they can provide modern personalised and responsive care of a consistently high standard. The programme provides support for moving diagnostic and therapeutic services into the community.

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 older people and children.

One example is low vision services, where need is increasing steadily. This service should be available to all patients with reduced vision, whether or not they are registered as sight impaired. Commissioning of low vision services involves planning across sectors.

Commissioning enhanced primary eye health services provides scope to develop services which are integrated across sectors and professions. They are delivered outside hospitals, possibly including medical ophthalmic care i.e. above and beyond the sight testing service, in people's homes, which meet patient need and may free up capacity in secondary care to deal with more complex work.

What are the distinctive features of commissioning eye care services?

The commissioning of eye care services is complex. Some factors are broadly common to all primary care contractors (i.e. GP practices, dental practices, community pharmacies and optical practices); others are unique to eye care services.

A key feature of eye health services that does make it different is the number of different professionals who potentially might be involved in service delivery and the importance of working across sectors i.e. health (primary and secondary care), social care and the voluntary sector, to best meet patient need. This can make commissioning eye care services more challenging, but can also provide greater opportunities to make sure that services meet people's needs. A good example of this is services for people with low vision which is a complex commissioning activity as it sits across both health and social care. Specific support is needed both at the point of diagnosis and ongoing follow up. This is also an area where the third sector has a crucial role to play. All of which make this area of commissioning particularly complex and place patient service at risk of breaking down unless careful and comprehensive planning is applied.

¹⁰ <http://www.dh.gov.uk/en/Healthcare/Primarycare/TCS/index.htm>

Feature	Challenge	WCC response
Contracting with a number of providers outside hospital	<p>Assessing service need and potential providers of services outside hospital and commissioning services, which meet need and work effectively with secondary care.</p> <p>The local knowledge held by providers can result in a diversity of service provision, which is sensitive to population needs. This could contribute to reducing inequalities in health, but can also place extra demands on commissioning services.</p>	<p>Commissioning from a number of providers can help PCTs to commission a broad and individualised range of services that meet the local community's needs and provide patient choice.</p> <p>Be sure to invest appropriate resources in managing contracts and relationships with this range of providers.</p> <p>Plan for services, which work effectively with secondary care and social care so that patients are referred on as necessary.</p>
Contracting with large organisations who operate in many PCTs	Large 'multiple' community optometrists operate within a set of corporate policies, procedures and standards. Business decisions are more likely to be made through a corporate management structure than at local level.	PCTs need to understand their providers' business processes for decision making and may need to work with regional and area managers, as well as the manager of individual branches, to affect change.
Potential providers may be legally independent entities	Services provided by independent contractors are supplied by businesses over which the NHS has less direct influence than some other NHS services.	<p>PCTs need to understand the range of commissioning levers available to manage and develop performance and promote improvement.</p> <p>Encourage and stimulate independent providers to develop their own business models for responding to patient wishes and PCT commissioning.</p>
Pattern and mix of services can be outdated	In some areas, the location, size and make-up of primary eye care services may not adequately meet current needs for services outside hospital.	<p>By comparing local needs with current services, you can identify any changes required for services to meet local need.</p> <p>Practice-based commissioning is an additional mechanism for achieving service redesign.</p> <p>Commissioning services in particular locations if there are areas of the PCT where service is needed.</p>

Feature	Challenge	WCC response
IM&T infrastructure	<p>Primary eye care services have had little or no investment by PCTs in their IM&T infrastructure and many submit manual claims for payment and have difficulties with communications with secondary care.</p> <p>Record keeping will vary from practice to practice and analysis of outcomes will be difficult.</p>	<p>PCTs should consider working with their primary eye care providers to update IT systems and facilitate electronic record keeping and build this into planning for potential providers.</p> <p>PCTs should seek to improve communications between primary and secondary care.</p>
Variability in primary care capacity and interest in developing services	<p>PCTs need to assess service need in their areas and commission in line with that assessment.</p> <p>For primary eye care providers to be willing to provide enhanced services they need confidence about the stability, security and viability of providing those services.</p>	<p>PCTs need to understand the drivers from the providers' perspective and try to address these concerns in their approach to commissioning.</p> <p>PCTs have a legitimate role in developing providers and will want to consider how to best deliver services in their areas.</p>
Clinical governance	<p>There are specific requirements in relation to matters such as health and safety and infection control in contracts for NHS funded sight testing but no general clinical governance requirement.</p> <p>Clinical governance should be considered when contracts for enhanced services are being developed.</p>	<p>For services over and above the NHS funded sight test clinical governance requirements should be built into the contract and funded as part of the contract value.</p>
Increase in demand for treatment	<p>As diagnostic tests become more sophisticated and easier to apply, patients are being referred earlier.</p>	<p>To make best use of capacity in hospital ophthalmology outpatient departments PCTs should consider commissioning community based local enhanced services, especially referral assessment services.</p> <p>PCTs will need to ensure that these services effectively link with secondary care. This is in line with the principles of Transforming Community Services.</p>

Feature	Challenge	WCC response
Approval of new treatments for AMD and glaucoma	NICE has recently released guidance on the use of Lucentis within the NHS and has also published a detailed guideline on diagnosis and management of chronic open angle glaucoma (COAG). NICE will be issuing further detailed commissioning guidance for services for COAG in Summer 2009.	PCTs 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. Further consideration by NICE of this clinical and cost-effectiveness appraisal is necessary, so access to expert advice is critical for PCTs.
Making valid comparisons	It may be difficult to compare the costs of in-house and other providers as organisational overheads may be differently accounted for in each situation.	Investment decisions should be based on local needs, but in assessing the affordability of different systems, you need to have good analysis of the actual costs. Comparison of outcomes and quality measures also need to be consistent across providers.



Section 4 Mapping the baseline

Alannah Thompson
Student

Year 2000

Mapping the baseline

Before you can begin to make improvements to eye health services, you first need to establish the baseline of where you are now.

There are three key stages to this:

- assess needs
- map existing services, including NHS funded sight testing
- identify what needs to change.

This will enable the PCT to take a rational approach to commissioning eye care services through identifying:

- service gaps
- the potential for redesigning services
- the level of resources needed.

Stage 1 Assess local needs

The first stage in the commissioning cycle is assessing the health needs of the local population. This should be done using a combination of the JNSA carried out with the local authority and the PCT's own up-to-date eye health needs assessment.

Together these should:

- give a complete picture of the populations involved and how their needs differ, including:
 - the specific needs of children in support of the implementation of the National Service Framework for Young People, Children and Maternity
 - identifying specific communities with particularly poor health, such as people with learning disabilities, people from ethnic groups with high rates of diabetes, glaucoma, travellers, migrant workers, those living in disadvantaged areas or demographic groups such as older people, particularly those living alone or in care, who may not access available services or be reached by screening programmes.
- enable comprehensive benchmarking against comparable populations
- give a clear view of unmet needs
- support the eye health awareness of the local population.

Obtaining patient feedback and evaluating levels of patient satisfaction is an essential part of the commissioning process.

In determining the eye health needs of the local population, a variety of key assessment processes should be 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 and/or Information Analysts connected to the PCT or PBC 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) has published the five step process of a health needs assessment¹¹. In order to undertake an effective health needs assessment it is important that the PCT has the required resources to carry it out properly. These 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 i.e. 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.

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 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.

¹¹ http://www.nice.org.uk/aboutnice/howweare/aboutthehdalhdpublications/health_needs_assessment_a_practical_guide.jsp NICE, June 2005

PCTs should gather information about inequalities in access to eye care services particularly for those from deprived areas and ethnic minority groups as well as greater incidence of certain eye diseases in particular communities. For example, commissioners might consider evidence about increased incidence of eye disease among African-Caribbean young males (Glaucoma); Asian populations (diabetic retinopathy) particularly in those communities where cousin to cousin marriages are common. In addition, they might consider evidence, which suggests there is higher incidence of refractive error and cataract amongst the learning-disabled population.

Local assessment of needs by PCTs and JSNA should encompass the visual health needs of different population groups. Annual Public Health Reports and Inequalities Strategies should also consider eye health alongside other core business.

*The Department of Health Diabetes Commissioning Toolkit*¹² outlines how a commissioner would determine the magnitude and burden of eye health locally. This will 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.

Stage 2 Map existing services

Next, you need to understand how services are currently being provided and identify any gaps that can be addressed by commissioning new or different services.

You will want to consider how you benchmark current service provision, both by comparing localities within your area and comparing yourself with similar PCTs.

*The commissioning toolkit for community based eye care services*¹³ contains information on how to build a complete picture. The table opposite expands on this to include possible sources of the information:

12 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4140284, Department of Health, November 2006

13 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_063978, Department of Health, January 2007

Topic	Question	Data/ Information Source
Resources and Capacity	<p>How are eye care services organised?</p> <p>What services are provided by primary care?</p> <p>What services are provided in a community setting?</p> <p>What services are provided in secondary care?</p> <p>Is there any duplication of services?</p> <p>What choice of providers exist, if any?</p> <p>What is the distribution of optical practices within the PCTs area?</p>	<p>Local PCT audit. Consider mapping them using IT software to help identify gaps.</p> <p>e.g. child vision screening in schools.</p>
	<p>Are services for certain eye care problems effectively integrated across health (primary and secondary care) and social care and the voluntary sector?</p>	<p>Mapping of the patient journey (see chapter 3 of the toolkit)</p>
	<p>What do patients, carers and the local community think about eye care services?</p> <p>Analysis of complaints.</p> <p>e.g. what are their views on accessibility</p> <p>Is there any evidence that some groups are not accessing services?</p>	<p>Patient questionnaire</p> <p>Local audit – working with Local Authority, local voluntary sector, Local involvement Networks (LINKs)</p>
	<p>Are there any specific gaps in services provided against identified need, including necessary adjustments to be made to ensure equity of access and counselling for people experiencing sight loss?</p>	<p>Comparison of service provision to identified need</p>
	<p>Are there any capacity deficits in secondary care that will impact on the achievement of 18 weeks referral to treatment target</p>	<p>Local audit</p> <p>Waiting times data – stage of treatment and Referral To Treatment return</p>

Topic	Question	Data/ Information Source
	Are the specific needs of children considered in planning services?	Local audit
	Are vision services for people with learning disabilities commissioned to support Valuing People Now?	Local audit
	<p>Are vision services commissioned in line with relevant recommendations of the National Service Framework for Children, Young People and Maternity, Child Health Strategy and the National Screening Committee?</p> <p>Are low vision services commissioned for all patients with reduced vision, whether or not they are registered as sight impaired?</p> <p>Are low vision services accessible to those in need and in line with NHS low vision recommendations¹⁴.</p>	Local audit
Hospital eye services	<p>What is the degree of specialisation in the local hospital?</p> <p>Does specialisation occur at a clinic or clinician level?</p> <p>Do consultants have special interests?</p> <p>Are clinics organised on a generic basis or eye care specific basis?</p> <p>Are consultants working to develop ophthalmic primary care?</p> <p>How well does the hospital service integrate with primary care? E.g. existing services such as cataract post-operative care.</p> <p>Are counselling services available to people experiencing sight loss?</p>	Local audit – working with secondary care

14 <http://www.eyecare.nhs.uk/evaluationdoc.aspx>

Topic	Question	Data/ Information Source
	How good are communications between the hospital service and primary care e.g. feedback on referrals, discharge communications	Local audit – working with secondary care
	<p>What is the local provider's aim with respect to choice – are they looking to specialise in some areas?</p> <p>Is the provider looking to cease some areas of provision to concentrate on others?</p>	
Current patterns of utilisation	<p>What is the current local demand for sight tests?</p> <p>(NHS and non-NHS)</p>	<p>NHS statistics:</p> <p>General ophthalmic services: Activity Statistics – www.ic.nhs.uk/statistics-and-data-collections/primary-care/eye-care</p> <p>Local Audit for non-NHS services</p>
	What proportion of sight tests result in referral?	Local audit – working with Optometrists
	<p>How many GP consultations relate to eye problems?</p> <p>How many of these end up with a referral to secondary care?</p> <p>How many are managed in primary care?</p>	Local audit – working with GPs
	What data is available on the quality of referrals from primary care?	Local audit – sample referrals
	<p>What is the pattern of outpatient utilisation in Ophthalmology?</p> <p>How many referrals?</p> <p>Who do referrals come from?</p> <p>How many first appointments?</p> <p>How many follow-up appointments?</p>	<p>National data return (QM08)</p> <p>Contract monitoring/SUS</p> <p>Local audit</p> <p>Outpatient Minimum Data Sets looking at source of referral</p>

Topic	Question	Data/ Information Source
	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?	Local audit – working with secondary care
	What is the pattern of utilisation for acute and urgent eye services? – how many via referral, how many via eye casualty?	Local audit –working with secondary care Outpatient Minimum Data Sets looking at source of referral
	What measures are available about how well these services are meeting identified need? Are there any quality measures?	Local audit Secondary care contract with PCT

Workforce

Commissioners need to determine the current and future eye health workforce that will be able to deliver services if changes are required. Workforce planning of staff can be onerous but is essential if appropriately skilled practitioners are to be positioned throughout community based services and available at the right time. 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.

Topic	Question	Data/ Information Source
Workforce profiles and skills	<p>Which provider organisations are involved?</p> <p>What is the profile of the local eye care workforce? e.g. Community Optometrists, Orthoptists, dispensing Opticians, GPwSI, Ophthalmic Nurses, Ophthalmologists, Ophthalmic Medical Practitioners, Ophthalmic technicians/ Ophthalmic Science practitioners; other Practitioners with a Special Interest, rehabilitation officers, social care workers, counsellors?</p> <p>Who are the clinical 'leaders'?</p>	<p>Current PCT commissioned services</p> <p>Local audit of Optometrist practices</p> <p>Local audit of GP or medically-led eye care services</p> <p>Local audit of hospital eye service</p> <p>Local Authority Social Services</p> <p>How many staff in each staff group? Full descriptions of specific eye care professionals are available in Appendix B of the Department of Health Commissioning toolkit for community based eye care services⁹.</p> <p>Local Optical Committee (LOC)</p>
	<p>What competencies currently exist within this workforce?</p> <p>Is there an identifiable workforce who could provide or are providing a community based eye care service?</p> <p>Is there full cooperation of local practitioners to be involved in new service plans?</p>	<p>Local audit of Optometrist practices</p> <p>Local audit of GP or medically-led eye care services</p> <p>Local audit of hospital eye service</p> <p>Clinical stakeholder meetings</p>
	<p>What are the likely future workforce trends?</p> <p>What are the current or future special interests of local practitioners?</p> <p>What workforce training needs are there?</p> <p>Are specific competency assessment procedures in place?</p>	<p>Local surveys</p> <p>Reports from Deaneries</p> <p>Local Optical Committee (LOC)</p> <p>Workforce lead at the SHA</p> <p>Links to workforce plans</p>

Access

- opening times
- wheelchair access
- consultation facilities
- languages spoken
- needs of those with sight loss
- needs of those with dual sensory impairment.

Patient experience

- analysis of complaints received
- feedback from site visits by Local Involvement Networks (LINKs).

Premises

- these should be pleasant, accessible, and meet the relevant national standards. Often the poorest premises are in the areas with the highest health needs
- good clinical equipment present and properly maintained that will enable the service to be provided
- feedback from site visits by Local Involvement Networks (LINKs).

Quality

- where services are required to be covered by registration with the Care Quality Commission (CQC), compliance with essential levels of safety and quality as set out in registration requirements.

You may need to gather some of this information locally by offering your contractors a suitable, locally negotiated and funded remuneration package.

Stage 3 Identify what needs to change

Comparing your eye care needs assessment with an analysis of current provision will highlight what needs to change.

Every PCT will be different, but this may include:

- areas where there are gaps in existing service provision
- areas with specific health needs that could benefit from additional investment in eye services

- communities that have limited choice, either in terms of providers or in the nature of services available
- practices/providers that are falling short on quality standards
- investment in services not targeted on areas of greatest need.

Mapping software will enable you to overlay existing service provision or patient satisfaction results with demographic data, making it easier to identify hotspots.



Section 5 Developing the vision

Developing the vision

PTCs should have a clear vision of what eye care services should look like in the future. This will be informed by your five-year strategic plan, known national priorities, the baseline mapping exercise (see Section 4) and the ongoing involvement with patients, clinicians and other local partners.

There should be two parts to this vision:

- patient offer
- strategic service model.

The patient offer

Your 'patient offer' should be outlined in your strategic plan and described in the PCT prospectus. It should clearly set out the range of services available to patients and could include the PCT's expectations around essential requirements for:

- access to an optical practice (opening hours, travel times, etc) for NHS funded sight testing
- services to promote health and wellbeing
- enhanced services
- integration with social care and other support services
- clinical quality
- patient experience (complaints, patient surveys)
- premises.

The strategic service model

The strategic service model should describe how you intend to make the patient offer real. It will include:

- future plans for the structure of eye care services in your area, taking into account identified unmet need, population growth, and changes in the pattern of services needed

- the range and type of services you need to commission to best meet the needs of your populations and make best use of available skills and capacity across primary and secondary care
- commissioning more integrated delivery of services across primary, secondary and tertiary care; greater co-ordination of community health services; greater integration between health services, social care and wider local government services
- commissioning services in line with relevant programmes for specific user groups – e.g. annual health checks for people with learning disabilities under the strategy *Valuing People Now*¹⁵. Commissioners should consider follow-up and referral for people who have identified vision needs as part of service planning
- consideration of targeting for particular groups where eye disease is a greater risk or where take-up of services is low
- consideration of targeted eye health and eye care messages at groups where take-up of services is low in order to reduce current inequalities. PCTs should include population groups at greater risk of eye disease and where take-up is low is consultations to inform development of service plans to effectively address inequalities. An option might be to work through/with providers to deliver these targeted messages
- as well as considering inequalities in access to services and eye health, commissioners may need to consider the potential wider role of eye health professionals in holistic promotion of good health and tackling health inequalities. Primary care professionals are well placed to deliver important messages about smoking, alcohol intake and diet. Some PCTs are already working this way
- assessing demographic changes which are likely to influence the development of community based eye care services. The population is ageing and this will lead to an inevitable increase in the burden of eye disease in the population, particularly as eye disease is frequently chronic in nature, so patients enter the service and then require lifelong follow up.

15 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093377



Section 6 Making it happen

Making it happen

PCTs have a range of powerful commissioning levers and tools at your disposal. Knowing how each of them works will enable you to combine them in the most effective way possible to deliver the changes you want.

We have grouped these levers and tools under nine broad headings:

- transparent use of performance information
- a comprehensive approach to managing performance
- supporting performance and quality improvement
- information for patients and the public
- essential levels of care
- promoting patient choice
- developing the market
- commissioning additional capacity
- practice-based commissioning.

The precise combination of tools and levers used will vary according to your PCT's unique circumstances and the changes you want to make, but we would expect every PCT to implement a comprehensive approach to assessing and managing performance. Otherwise, you will not know how each primary eye care provider is performing or be able to support improvement.

All of these commissioning levers and processes need to be underpinned by:

- board-level oversight and leadership
- senior accountability to the PCT Board for the commissioning of primary care, including eye care services
- expert clinical advice and clinical leadership through access to a well supported optometric advisor
- regular engagement with providers of eye care services and wider clinical engagement
- regular engagement with other service providers such as social care and the voluntary sector
- regular engagement with the public and representatives of patients and carers.

To take the comprehensive approach described in this guide requires capacity and capability. Where PCTs need to invest more resources in their eye care commissioning teams, this could be achieved by:

- pooling resources across PCTs or collaborating on particular topics
- increasing the size and capability of the core team
- buying in additional support, for example through the use of the framework for procuring external support for commissioners (FESC) or NHS PCC Building Foundations programme.

As a world class commissioner, you will need to ensure that you have access to expertise in all aspects of eye care services, including those services and developments in the community, at the interface with secondary care, public health and practice support.

Transparent use of performance information

Without good comparative information on the quality of services provided, PCTs cannot effectively manage performance, support quality improvements or provide information for their patients and the public.

In line with the principles of '*Measuring for Quality Improvement*'¹⁶, you should make sure that you have a robust and balanced set of quality measures in place for enhanced services commissioned in primary care. These should be developed in collaboration with local clinicians and patient groups.

A quality framework or 'scorecard' can draw together and triangulate data from a variety of sources, including national data (e.g. reports published by the NHS Information Centre) and local data (e.g. information from optical practice visits, data on premises, patient feedback). Together, this balanced set of data:

- enables PCTs and providers of eye care services to reach an objective and rounded view of performance
- suggests the key metrics to be used in structured performance reviews
- encourages self-assessment and peer review
- helps to keep the public informed about quality and performance.

Criterion-referenced indicators (i.e. 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

¹⁶ http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_090444

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:

- where services are required to be covered by registration with the CQC, compliance with registration requirements
- 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.

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 providing guarantees within the contract or reducing the capital investment required by the provider.

The process of developing a quality scorecard is itself extremely valuable. It stimulates focused discussion with providers about current performance, existing strengths and weaknesses, and priorities for the future. It also helps commissioners to ascertain any service development areas or support required by providers. To help you with this, NHS PCC has developed a step-by-step guide, which you could adapt for eye care services¹⁶.

A comprehensive approach to managing performance

As world class commissioners, PCTs will need to invest considerable time and effort in developing close working relationships with their eye care and eye health providers and may find it helpful to establish a local Eye Care Forum with representation across primary and

secondary care and social care and the voluntary sector if one does not already exist. These relationships are vital to effective management of the system.

Transparent, documented approach to contract management

In respect of primary eye care services you should work with providers to develop and agree a policy for performance managing contracts. It needs to be transparent and clearly documented and should enable providers to answer the following questions:

- what standards are we expected to meet under the contract?
- when and how will our performance be reviewed?
- what will happen if our performance is below the agreed standards?
- what support will you offer to help us improve?
- what action will you take if we fail to improve?
- how will good performance be incentivised?

Standards you expect providers of eye care services to meet fall into two areas:

- essential requirements that must be met including, those services required to be covered by registration with the CQC, registration requirements, many of which will be contractual standards. Failure to meet them will usually trigger a formal intervention
- aspirational standards that set out what you would like primary eye care providers to deliver or work towards. These will often be accompanied by development support.

NHS funded sight testing

NHS PCC has published a toolkit - the *GOS Contract Compliance Framework*¹⁷ - to help PCTs monitor providers' compliance with the contractual framework for the provision of the NHS funded sight testing service.

Eye Care Services other than NHS funded sight testing

Enhanced services over and above sight testing are the main focus of this document. A model contract is planned for use in relation to services over and above the NHS funded sight test and, as is normal with a locally negotiated contract, standards and clinical governance requirements should be written in and funded as part of the contract. As enhanced services are not restricted to optical providers you should ensure that full consideration is given to all interested potential providers of eye care services over and above the sight test.

¹⁷ <http://www.pcc.nhs.uk/326>, NHS Primary Care Contracting, April 2009

Performance cycle

PCTs should develop a performance cycle, which clearly sets out what will happen and when. Try to make this the same for everyone. As a world class commissioner, you will be expected to work just as intensively with your best providers as you do with your weakest to help them develop further as outstanding providers of eye care services.

Escalation, local resolution and disputes

You should also have a formal escalation process which sets out what you will do if performance slips below agreed standards. This should clarify:

- how you will respond to different kinds of challenges, such as:
 - clinical issues
 - organisational problems
 - breach of minimum standards.
- what support you will provide.

For non-compliance of a minor or technical nature, which does not pose a significant risk to patient care, PCTs are encouraged to develop an action plan to resolve the problem with the contractor. If the issue is not resolved within the agreed timescale the GOS contracts for the NHS funded sight testing service make provision for the PCT to issue either a breach notice or a remedial notice (clauses 162 – 166 of the model GOS contracts¹⁸).

Alternatively PCTs may consider exercising their powers under the NHS (Performers lists) Regulations 2004¹⁹, which were amended in 2008 to include optometrists²⁰.

Guidance is available on managing fitness to practice in respect of applicants to ophthalmic performers lists²¹ and PCTs should develop robust processes for dealing with concerns about practitioners poor performance.

In instances where other providers of eye care services continually breach contractual standards, delivering poor or unresponsive services to patients, PCTs should use relevant contractual levers, which could include:

- decommissioning enhanced services
- issuing breach or remedial notices

18 http://www.pcc.nhs.uk/uploads/Optomtry/june_08/gos_model_contract_-_mandatory_services.doc or http://www.pcc.nhs.uk/uploads/Optomtry/june_08/gos_model_contract_-_additional_services.doc, NHS PCC

19 <http://www.opsi.gov.uk/si/si2004/20040585.htm>

20 http://www.opsi.gov.uk/si/si2008/pdf/luksi_20081185_en.pdf

21 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084744, Department of Health, May 2008

- contract sanctions
- termination where this is permitted by the terms of the contract or service level agreement.

You may need to seek legal advice before invoking any of these formal contractual levers.

Supporting performance and quality improvement

You should also make clear what you will do to help providers improve service quality. As a world class commissioner, you should do everything you can to help providers recover and meet the required standards as quickly as possible

The Principles and rules for co-operation and competition²² make it clear that commissioners have a legitimate role in directly supporting providers, provided the approach is transparent and non-discriminatory. Support should be linked to the overall approach to managing performance and PCTs should clearly define the circumstances in which they will provide support.

PCTs can offer a number of different kinds of support. These may address a specific issue or be part of a broader package of support to help providers develop as organisations. Examples include:

- sharing best practice examples from other providers
- establishing local learning networks across eye care contractors
- brokering support from agencies such as NHS PCC
- commissioning external consultancy support.

You may wish to incentivise providers to improve quality. This could be in a certain area or over a set period to help embed a particular change.

When developing local incentives, you should make sure that:

- you are considering the range of potential providers
- you are not paying twice for sight testing activity that should be provided as part of the mandatory or current additional services contract.

Non-monetary support is another way of encouraging quality. You might want to provide training, equipment or back-fill of staff time to enable completion of a specific task or initiative.

²² http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081098, Department of Health, December 2007

Information for patients and the public

You should work with patient groups to determine what information is most useful to local people. This might include:

- basic details on location, car parking and transport
- opening hours and contact details
- languages spoken (including support for people with dual sensory loss)
- ease of access and facilities for disabled people
- detailed description of services offered, including any areas of special expertise
- details of any services that are only available at certain times
- patient satisfaction scores, including by group and trends over time
- national performance indicators.

You will need to present this information in an accessible way and keep it up to date. NHS Choices already provides some of this data and will be developed nationally to provide an increasing amount of information on individual optical practices, but it is up to you to supplement this with information on wider primary eye care services and other details the public have highlighted as wanting or needing.

You also need to make sure the public are aware that this information is available. You can do this:

- through links in the PCT prospectus
- by making sure that public bodies, such as libraries display the information
- by developing innovative ways of distributing the information, for example through links on house moving and utility switching websites or mail shots to new additions to the electoral roll.

Care Quality Commission

Under the Health and Social Care Act 2008, many health and adult social care services will be required to be covered by registration with the Care Quality Commission (CQC).

(see - Response to consultation on the framework for the registration of health and adult social care providers and consultation on draft Regulations²³)

23 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_097141

The requirement to register with the new Commission will be based on the kind of activity being provided, rather than the organisation or setting that it is provided in. That will mean that patients and people using services will have the same level of assurance of the quality and safety of their care and treatment, whether it is being provided by the NHS, Local Government or the independent sector.

The scope of registration will be set in secondary legislation through a set of regulations under the new framework, regulated activities will include:

- healthcare provided for the treatment of disease, disorder or injury, by, or under the direction of a medical practitioner or a nurse, or in a multi-disciplinary team that includes a medical practitioner or a nurse, and
- surgery carried out by a healthcare professional (including cosmetic surgery).

All providers of these activities will need to be registered with the new Commission and meet the registration requirements.

Where services are required to be covered by registration with the CQC, the registered providers of those services will need to demonstrate that they are meeting and are continuing to meet on an ongoing basis, the essential levels and safety and quality that users of those services are entitled to expect, as set out in statutory registration requirements. The CQC has a range of independent enforcement powers intended to bring providers back into compliance when they are not meeting these legal requirements.

Although it is proposed that primary care services provided by GPs and dentists should be registered with the CQC it is not proposed that there should be any requirement for providers of primary ophthalmic services to be routinely registered. This is because the current legislative systems for primary ophthalmic services i.e. the NHS funded sight test, are felt to be sufficient to protect patients. However, in the future providers of enhanced primary eye care services (i.e. services over and above the NHS funded sight test, which may include optical practices who are commissioned to expand their activities) are likely to need to be registered.

When commissioning enhanced services from local eye care providers, you must ensure that the services are only provided by suitably trained staff and that appropriate standards are established. NICE guidelines may stipulate requirements to carry out certain activities and PCTs should work towards commissioning in line with these where they exist. Where NICE guidelines do not exist, although there is not a requirement for those providing locally commissioned enhanced services to be accredited, it is good practice. At present requirements for accreditation can vary from one PCT to another, causing problems for staff moving between PCTs.

A review of community eye care services in 2007 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 schemes²⁴. Many were fully integrated services with demand management used as their primary objective.

In April 2007, the Department of Health published new guidance²⁵ on the professional accreditation process for all new and existing GPs and Pharmacists with Special Interest. This process emphasises a 3-yearly cycle of accreditation but with annual appraisal at the appropriate clinical level.

Developing the market

As described in Section 4, you will want to analyse the capacity and quality of eye care services provision, and the extent to which they match local patient needs, including the degree of patient choice and competition. You will also want to consider how far both existing providers and other providers would potentially seize opportunities to develop new services.

Together with neighbouring PCTs and the SHA, you should have a quantitative and qualitative understanding of the provider market. Your analysis should include the viability of infrastructure, especially premises that can be used to support service provision. You should consider:

- volume of potential users for any new services
- analysis of skill set needs
- sufficiency of the current and future workforce – including the extent to which incumbent and potential providers will contribute to the training and development of the current and future workforce
- the viability of infrastructure, especially premises, that the PCT can utilise either directly or through the potential providers market to support service provision
- sustainability of the services required. Do the identified needs and the proposed service models provide enough opportunity to sustain the range of providers for at least the length of the contract, ensuring an appropriate degree of competition remains?

²⁴ http://www.pcc.nhs.uk/uploads/Optomety/Jan_07/community_eye_care_services_review_core_final.doc, NHS PCC, January 2007

²⁵ www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074430, Department of Health, April 2007

- mechanisms for contracting, which may include the GOS contractual framework, a separate contract for local enhanced services and other routes
- the provider's viability – at least for the duration of the potential service contract.

You will need to develop a strategy for ensuring that the provider market can meet identified needs, both now and in the future. This strategy should not be limited to the current models of service provision or levels of integration. As a world class commissioner, you should also ensure that all potential providers are considered.

Practice-based commissioning

The primary and community care strategy made a commitment to ensure the engagement of a broader range of clinicians in a redefined and reinvigorated PBC.

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, 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.



Section 7 Questions for the PCT Board

Questions for the PCT Board

- Is there a named Board member with responsibility for eye care services?
- Do non-executive Board members have a good understanding of the relationship between the PCT and its providers of eye care services?
- What is the PCT's vision for eye health?
- Are Board members aware of the aims of the UK Vision Strategy?
- What is the PCT's approach to the support and development of individual providers of eye care services?
- Does the PCT have clear ways of engaging with the public and local population to understand needs and demand and to help shape services?
- Does the PCT know the local pattern of inequalities in eye health and have plans to address these?
- Do services provided include emotional support at the time of sight loss and integration to other services, such as rehabilitation?
- Can the PCT demonstrate that it is working jointly with social care and third sector and that it is involving service users?
- Does the PCT have a good picture of how current investment in eye care services is deployed and the levels of access and quality that this provides?
- Does the PCT have a clear assessment of the impact of demographics on future service need?
- Does the Board receive regular reports on primary eye care performance?
- Does the primary care commissioning team have appropriate capacity, skills and support from Directors?
- Does the team have good access to expert independent ophthalmic advice, public health advice and financial expertise?
- Does the PCT have a clear strategy and policy on procurement of eye care services?
- Does the PCT have systems in place for managing contract compliance effectively?
- What is the PCT's strategy for communications and stakeholder engagement on eye care issues?



Section 8 Moving to world class commissioning of eye health services

Moving to world class commissioning of eye health services

The previous chapters have described the steps that all PCTs will want to follow to become competent strategic commissioners of eye care services. Through the systematic use of these commissioning skills, you will be able to achieve significant improvements in the quality and availability of services, as well as improvements to health and a reduction in health inequalities.

The aspiration to become a world class commissioner will apply to the commissioning of eye health services as to other aspects of a PCT's strategic commissioning. This section describes, under each of the world class commissioning competencies, what level 4 might look like in relation to eye health services. As you progress towards the highest competency levels, you are likely to use more wide-ranging and innovative techniques. WCC competencies are due to be revised and commissioners will want to read this guidance alongside the new competencies when they are available.

Competency 1 – Local leadership

Reputation as the 'local leader of the NHS'

- Key stakeholders strongly agree that the PCT is the local leader of the NHS.
- The PCT actively participates in and leads the local eye health agenda, effectively participating in multi-agency and NHS-wide agendas.
- The local population strongly agree that the local NHS is improving services.

Reputation as a change leader for local organisations

- Key stakeholders strongly agree that the PCT significantly influences their decisions and actions.

Position as an employer of choice

- The PCT is able to source and recruit high calibre staff for all positions in commissioning.
- PCT staff are motivated and satisfied with the roles that they adopt.

Competency 2 – Collaborative working with community partners

Creation of Local Area Agreement based on joint needs

- The PCT creates joint accountability and clearly delegates roles with local partners for all key targets.

- The PCT has developed a partnership way of working with active participation.
- There is clear clinical and PBC leadership and engagement in the Local Area Agreement

Ability to conduct constructive partnerships

- Key stakeholders, including service users, strongly agree that the PCT proactively engage their organisation to inform and drive strategic planning and service design.
- Multiple partnerships are in place across a broad range of settings to support health and wellbeing agenda.

Reputation as an active and effective partner

- Key stakeholders, including service users, strongly agree that the PCT is an effective partner in delivering health objectives.

Competency 3 – Continuous and meaningful engagement with the public and patients

Influence on local health opinions and aspirations

- Key stakeholders strongly agree that the PCT has proactively shaped the health opinions and aspirations of the local population.

Public and patient engagement

- The PCT demonstrates that they know the impact of their involvement and engagement and know how effective it is through evaluation that demonstrates improvements in people's health experience of services.
- The PCTs successfully deployed innovative approaches to engagement, which:
 - have been shared with other PCTs
 - have led to high levels of engagement with hard-to-reach groups
 - accessed non-traditional partners e.g., criminal justice system.
- The PCT can demonstrate how proactive engagement and partnership arrangements with the local community including service users and LINKs, is embedded in all commissioning processes and drives decision-making.
- The local population strongly agree that the local NHS listens to the views of local people and acts in their interest.

Improvement of patient experience

- The PCT demonstrates how ongoing integrated patient experience data systematically drives commissioning decisions.

Competency 4 – Lead continuous and meaningful engagement of all clinicians

Clinical engagement

- All engagement groups actively drive PCT planning and service development and support the setting of the strategic direction for the PCT.
- Clinical engagement supports the ongoing improvement of patient outcomes.

Dissemination of information to support clinical decision making

- Quality reports include recent clinical evidence, benchmarks and changes in clinical practice.
- The PCT can calculate PBC return on investment.

Reputation as leader of clinical engagement

- Key stakeholders strongly agree that the PCT pro-actively engage clinicians to inform and drive both strategic planning and the service design.

Competency 5 – Manage knowledge and undertake robust and regular needs assessment

Analytical skills and insights

- The PCT analyses the effectiveness of past interventions to drive tangible change for health needs.
- The PCT analyses progress and any gaps, identifies the key drivers of variance from expectations and develops solutions.
- The PCT has proactive population risk stratification in order to identify populations at risk and to intervene promptly at the earliest possible point.

Understanding of health needs trends

- The PCT has a view of unmet needs for disadvantaged subgroups, and identifies gaps in care and opportunities to improve services for these populations on an ongoing basis.
- The PCT uses predictive modelling and analytical tools to discuss and describe trends in eye care needs, create future projects and identify variants from expectations.
- The PCT can articulate the levels of preventable blindness and eye disease for its population.

Use of health needs benchmarks

- The PCT benchmark itself continuously against similar populations, national and international targets on local health needs status, to create ambitious improvement trajectories.
- The PCT has developed plans to match the top performers on each benchmark and identifies the key capabilities it will need to develop to match their performance.
- The PCT has identified key health needs gaps.

Competency 6 – Prioritise investment according to local needs

Predictive modelling skills and insights

- PCT staff can lead knowledgeable discussion and defence of all predictive models, including evidence to support modelling techniques, assumptions used, and links to clinical expertise.
- The PCT has, and effectively uses, predictive modelling to support its ability to target required interventions with precision.
- PCT forecasting is based on full understanding of all relevant root causes and is linked with other public forecasts.

Prioritisation of investment to improve population's health

- The PCT understands the return on investment of past interventions and investments and compares this to best practice. This is used to inform future investment.
- The PCT Board works with local clinicians, key stakeholders and the public to develop, implement and evaluate strategy.

Incorporation of priorities into strategic investment plan

- Projects and initiatives are evaluated against prioritisation with effective targeting of resources toward projects that offered the highest value for money.
- Planning and budgeting cycles are aligned to facilitate coordination and joint financing arrangements.
- Mature programme budgets for all key priority care pathways/disease groups with integrated investment plans of up to ~10 years are in place.
- The PCT invests for longer-term health gain and can quantify impact.

Competency 7– Effectively stimulate the market to meet demand and secure required clinical and health and wellbeing outcomes

Knowledge of current and future provider capacity and capability

- The PCT has identified cost and quality for each procedure in each area of care and in each setting of care.
- The PCT has developed a clear specification for each setting of care including quality, access and cost.
- The PCT has dedicated resource containing expertise and experience to support provider capability development.
- The PCT can demonstrate that it has established strategic relationships with providers that include the expertise and experience to support provider capability development.

Alignment of provider capacity with health needs projections

- The PCT takes demand projections and incorporates demand management assumptions from strategic plan (e.g. pathway redesign) to identify the required capacity both by provider type, by specialty and by care/patient pathway
- The PCT implements specific changes to provider capacity driven by needs modelling, including long-term structural changes and forecasts based on actual risk analysis.

Creation of effective choices for patients

- The PCT has clear investment and disinvestment processes which lead to a mix of providers based on clinically defined cost/quality trade-off.
- The PCT explicitly tests the acceptability of the choice available with patients, on a regular basis.
- The PCT has a coherent strategy for increasing personalisation of care, including choice, addressing joint health and care needs

Competency 8 – Promote and specify continuous improvements in quality and outcomes through clinical and provider innovation and configuration

Identification of improvement opportunities

- Together with eye care providers, you regularly review and agree clinical pathways and engage on opportunities for improvement and innovation.

- For each pathway initiative, the PCT should outline:
 - a 'process map' listing the specific interventions required at each point in the pathway, as well as clear criteria for moving patients along the pathway
 - clinical guidelines sourced from international best practice
 - plans to ensure a smooth patient journey along the pathway and between different levels of care.

Implementation of improvement initiatives

- Milestones of clinical pathway change programmes are actively tracked.
- The PCT actively demonstrates on the basis of monitoring findings, e.g. prescribing choices and failures to collect alerted to GPs.

Collection of quality and outcome information

- The PCT has developed strategies for monitoring the impacts of specific eye care initiatives on clinical quality/outcomes.
- Reporting arrangements process and transmit data directly to key decision makers.
- The PCT actively seeks out clinical evidence for comparison with international best practice.

Competency 9 – Secure procurement skills that ensure robust and viable contracts

Understanding of providers' economics

- The PCT can use its database to sort and extract a variety of metrics and benchmarks by providers and by disease group – e.g. capacity, average and marginal cost, and financial results.
- The PCT uses target costing, i.e., forecasts service costs before providers supplies estimate.
- The PCT demonstrates that for all services the PCT has secured the best placed providers (Principles and Rules for Co-operation and Competition, principle 1)

Negotiation of contracts around defined variables

- Negotiation has successfully delivered changes to variables and significant improvements in eye care service quality and value for money.
- Negotiation of contracts delivers a positive position for both the PCT and providers, that reinforces strong strategic relationship with providers.

Creation of robust contracts based on outcomes

- All contracts include clearly specified, measurable, practical outcomes, quality metrics, and a transparent arbitration process.
- Specific, measurable performance improvement targets are jointly agreed.
- Contract incentives drive desired optical provider performance, leading to health improvements.

Competency 10 – Effectively manage systems and work in partnership with providers to ensure contract compliance

Use of performance information

- The PCT obtain real time feedback from users on services.
- The PCT maintains a 'live' dashboard of information on key performance indicators, and ensures it is readily available to support performance management.
- Data is proactively discussed with providers to drive fact-based continuous improvement in quality and outcomes.
- Performance information is available for and accessible to the public.

Implementation of regular provider performance discussions

- Continuous performance improvement discussions occur, leading to demonstrable change.
- There is ongoing provider capability building through sharing of international best practice.
- The PCT clearly defines responsibility for the performance management interface for each provider.

Resolution of ongoing contractual issues

- Required improvements are always delivered.
- There is a track record of innovative and effective resolution of conflict.
- The PCT has clear track record of not tolerating poor performance from providers, particularly in patient care, and act swiftly to ensure change.



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