

Getting started: Developing a Service

1. Questions you will need to answer

1.1. Why am I doing this and what do I hope to achieve?

Only you can answer these questions but this pack may help you to crystallise your thoughts.

1.2. Have I identified a need for the service I am considering?

Part of the answer to this question is that you are considering a service in the first place.

You may have identified patients' concerns about waiting lists, dissatisfaction with the clinical service, or their difficulty getting to the hospital where the service is provided.

You will need to find out if there are already systems in place to undertake screening and treatment programmes. You may not always be aware that these already exist or of their extent.

You will need to discuss your thoughts with other optometrists (via the LOC) and ensure that there would be sufficient practitioners prepared to undertake your proposed service.

An outline of the service then needs to be presented to your healthcare commissioner, who will probably wish to meet with the LOC/ AOC to discuss the proposal in more depth. If they agree, they will support your idea and have it included in the Health Improvement Programme (HImP) or Local Health Plan etc. They might wish to alter your original idea to see if a "better fit" with the local NHS can be achieved. For example, it may prove difficult to establish an optometric diabetic retinopathy monitoring scheme where a photographic scheme is already well established, or a low vision service where the local hospital has proven ability and short (less than a month) waiting lists for new patients. Conversely, there may be no local scheme for diabetic monitoring and the low vision service might have a waiting list of nine months. It is important to be flexible here, and remember that the commissioners have a valid agenda of their own.

LOCs/ AOCs will do well to emphasise the importance of the accessibility of services and the issue of patient choice when presenting proposals. These should be key issues for commissioners, and the flexibility of appointments and easy access to premises which community optometry-based schemes can offer are potentially crucial advantages over hospital-based services.

However in areas where local Ophthalmology services are fast and efficient, the PCT will often see improvements in ophthalmology services as low priority. In such cases, the LOC should consider starting discussions on shared care with the hospital with a view to approaching the PCT with a joint bid from LOC and HES.

1.3. What impact would the service I am considering have upon:

a. Patients?

Improving the quality and equality of patient care is of paramount importance. Healthcare commissioners will want to know how you intend to improve healthcare, that the service is patient friendly, will not put patients at increased risk and is compatible with the way healthcare is provided locally. You will have to convince healthcare purchasers that what you are advocating will:

- improve patient care, or

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- provide the same quality of care at a lower cost or
- provide the same quality of care, at a similar cost, but in a way which is beneficial to patients (e.g. more conveniently)

In particular, the proposed service development must identify and attempt to address any inequality of service or care.

Consider talking to local patient representative groups (e.g. local branch of Diabetes UK)

b. Ophthalmologists?

Some ophthalmologists may be reluctant to consider co-managed care with optometrists. You should reassure them that your objective is to ensure that their expertise is used to the best advantage. This may be to help to reduce the pressure of work that they have to sustain by reducing inappropriate referrals, or by diverting to primary care patients who do not need the level of expertise or facilities they provide, thereby freeing their time for more needy cases. Optometrists would need to show that they are willing, and able to work within protocols agreed with ophthalmologists.

It is important not to become involved in discussions over funding with hospital ophthalmologists. Funding issues should be discussed with healthcare commissioners.

Some hospitals have more problems with waiting times and overrunning clinics than others. Healthcare commissioners will be aware of local difficulties and where services are inadequately provided; it may be that some would benefit from a particular service development whereas others would not.

c. Participating optometrists?

Participating optometrists will need to consider such areas as training, accreditation, participation in audit, equipment, and patient recall and reporting systems designed for specific services. All of these aspects will have some financial implications.

Optometrists will also need to consider the “chair time” involved in seeing patients. Some services may not include refraction, resulting in fewer dispensings. That will obviously have an impact upon practice finances.

Optometrists might consider the advantages of being involved in a primary care development to include a more varied and interesting workload, practice building, professional advancement and personal satisfaction.

d. Non-participating optometrists?

Not all optometrists will be expected to participate in every development. You need to ensure that there will be no perceived threat to their practices or position. Keep all practitioners informed and be transparent about what you have in mind because you may need their support when services are further developed in the future. Poor communications may inhibit optometrists from participating in subsequent developments to which they could make a valuable contribution. This is especially true if they see a development as a way for some optometrists to build up their practices at the expense of others, rather than providing a much needed service.

Professionalism is required by both participating and non participating optometrists to ensure that shared care schemes are not viewed as “stealing” patients from non participating practices.

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e. General Practitioners?

GPs will be members of PCT Executive Committees, Local Health Groups (Wales), or Local Health Care Co-operatives (Scotland); or LHSCGs in Northern Ireland. Many GPs will be keen to develop primary care services which support primary care objectives and meet the needs of their patients. If your suggested development sets out to improve patient care and/ or demonstrates significant savings, GPs will be interested.

Proposals should be shared with the Local Medical Committee, but healthcare commissioners have the responsibility to consult them formally about the contents of the HimP.

In addition, proposals for direct referral or referral refinement schemes may need to be broached very sensitively; although most GPs will be supportive, some may feel their positions are being threatened.

f. Orthoptists?

Orthoptists provide a wide range of ophthalmic services. They are involved in the care of children, and may offer services such as visual field testing, tonometry, colour vision testing, electrodiagnosis, reading training for visually impaired people and, refraction in hospitals. Some hospitals have set up glaucoma clinics manned by optometrists, orthoptists and technicians, working to protocols similar to those used by community-based optometrists.

Orthoptists could be included as participants in shared or co-managed care schemes. Consideration should be given to the use of their skills.

g. Other care professionals, e.g. diabetologists, nurses, social workers?

Many services will have an input from more than one discipline, and the contributions of all professionals involved should be recognised. Excluding any professional group which is active in the care of your designated patients would probably put those professionals on the defensive.

1.4. What services could optometrists provide, and where could they be located?

Before deciding which schemes to discuss with PCTs or their equivalents, you must be certain that there are sufficient willing and able local practitioners to obtain the long-term commitment necessary for a service to be successful. LOCs/ AOCs should, therefore, regularly canvass optometrists to ascertain their willingness to participate in developments, and also find out where specialist equipment or skills (e.g. clinical or foreign language) might be located.

LOC/ AOC members who act as identified links to the individual PCTs or their equivalents, should be provided with a list of optometrists, their practice locations, level of interest in various schemes, and what special equipment or skills they might possess. Where an interested practitioner is not a practice owner, it is essential to ensure that the owner supports the practitioner participating in the scheme.

Participation in shared or co-managed care schemes is usually by individual practitioners rather than by practices, though to make administration practical, the scheme would probably only be available at the practices where that practitioner regularly works.

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1.5. How do I know which service to propose?

It is very easy to concentrate on one service only and feel it to be the only option. Ask the following questions:

- will the service development help to address an identifiable inequality in health?
- would the service be more accessible to patients if it was provided locally by optometrists?
- is it going to improve healthcare, e.g. detection of disease; or provide a service previously unavailable?
- is it likely to reduce waiting lists?
- are optometrists easily able to undertake the work (consider training, equipment, ability)?
- would patients be happier going to their optometrist rather than to a hospital clinic; if not, why not?
- what healthcare gains could be expected from a primary care or multi-disciplinary team approach?
- do you think it is likely to be less expensive than present services?
- Does the scheme contribute to a national target e.g. Action on Cataracts, a National Service Framework (NSF) on diabetes, older people?
- Having answered these questions, do you think healthcare commissioners would be interested in a primary care based scheme?

1.6. Ask these questions again for all other schemes you could consider, e.g.: screening for sight threatening diabetic eye disease or monitoring patients with known disease;

- monitoring ocular hypertension/ stable glaucoma
- low vision care and management
- paediatric eyecare
- cataract assessment and intra-ocular lens follow-up
- acute red eyes
- geriatric services
- referral prioritisation *and*
- services to people with learning disabilities

1.7. Screening or monitoring?

Screening for disease is the application of tests to identify patients likely to have a specific medical problem and for which there is a recognised treatment.

Monitoring a disease that already exists aims to identify those patients in whom a deterioration has occurred and recognises actions or routes of referral appropriate to the level of deterioration found.

It may not, therefore, be applicable to undertake refraction or other procedures of a normal eye examination if it is not indicated as part of the screening or monitoring process.

In both screening and monitoring, a protocol will need to be written and adhered to by all participants.

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1.8. Initial enquiries

Undertake some initial, low level enquiries to see if your proposals are likely to be acceptable to local optometrists, other professionals and healthcare commissioners. Always keep the welfare of patients in the forefront of your mind.

1.9. Research other schemes

This Resource Pack contains many examples of various schemes. Read these and discuss with you colleagues to decide whether these would meet your local needs. It is wasteful of time and resources to start from an empty sheet. Commissioners will often want to know if a similar scheme has worked elsewhere.

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2. Communications & funding

By now you will have considered your ideas and have reached some preliminary conclusions. This is the time to think about how you are going to involve your colleagues.

Remember, it may be many months before a new service is accepted and a further period will elapse before it is implemented. The whole process may progress very slowly; patience and persistence are required.

2.1. Involve as many optometrists as possible that may wish to discuss, in outline, what you think you can achieve. Do not assume that anyone will want to be left out at this stage.

The Local/ Area Optometric Committee should already have surveyed optometrists. If a development is likely, a meeting should be called of all interested optometrists to discuss the idea. The LOC/ AOC should be aware of the issues surrounding the development of primary care services and should therefore play an important part in developing proposals in close proximity with local commissioners of health care.

An invitation should be extended to all optometrists to attend the first meeting, not just those who think that they might like to provide the service. This meeting would discuss the scheme in general terms. Optometrists may defer a decision to become involved at this time, yet may want to ensure that their present situation is protected. Some of them may be enthused enough to consider participating from the beginning.

2.2. Discuss your proposals, in outline, with your healthcare commissioner; then invite other interested health care professionals to attend a meeting

The local co-ordinator at this point will probably be the LOC/ AOC chairman or secretary, or a member of the LOC/ AOC who has delegated responsibility to progress shared or co-managed care schemes. The co-ordinator should consider approaching the healthcare commissioner informally at first to discuss the proposals. Through the HimP or its equivalent, commissioners determine the healthcare priorities for the populations they serve.

2.3. Identifying funding

It is vital, at an early stage, to ascertain the funding available for any proposed scheme. If there is no prospect of obtaining funding, then there is no point in proceeding to detailed discussion of protocols etc. If funding is identified, then the LOC/ AOC at this stage needs to identify how much is available, the source of funding (e.g. is it HCHS? Modernisation Fund?), and its duration (is it pump-priming? recurring?) It may not be possible to sort out all the points of detail (e.g. what will be the trigger for payment, etc), but you should proceed no further until you are satisfied that a budget can be identified.

It may be that the most a healthcare commissioner can say is that if you develop a proposal, it will be considered along with other schemes against any funds that are available. In this case, it will be a matter for local judgement to weigh the work needed to develop a proposal against the likelihood of success.

Healthcare commissioners may offer guidance about how your bid to provide services should be formulated. It may be helpful to seek guidance and an informal telephone call to the Director or Consultant in Public Health (DPH), or the Primary Care Development Manager or Commissioning Manager at the PCT or equivalent primary care organisation (PCO) might elicit it. The DPH advises the PCO on ways of meeting its healthcare objectives and may already be aware of optometric developments elsewhere in the country.

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Proposals should be sent to the DPH or Chief Executive of PCO, outlining the improvement (s) in healthcare that might be anticipated, and seeking inclusion of the proposals in the HImP. Whenever possible, the LOC's/ AOC's proposition should include statements that are "evidence based".

A wider meeting should then be considered, at which others should be invited to give a short presentation, e.g. GP, ophthalmologist, diabetologist, or public health consultant. An optometrist involved in a similar scheme in a nearby area might be worth inviting as a guest. If there is no one available locally, contact the AOP office for advice on finding a speaker.

This meeting should consider how to proceed and produce a small steering committee for the project.

2.4. With your colleagues, set objectives

This is perhaps the crucial part of the meeting. Be sure about what you want to achieve in terms of healthcare and write these down as specific objectives. Try to group these into a single overall objective which defines the whole scheme.

Getting started: Objectives

1. Possible objectives

1.1. To reduce inequalities in health

It is recognised that there is more to be gained from targeting help and services at those who are disadvantaged, rather than the whole population. Inequalities may be geographical - those living close to a hospital are able to access services more easily, the length of waiting lists; social class - poorer people tend to have lifestyles that lead to more illness; age - older people can be disadvantaged; ethnicity - racial and religious needs; language; disease - people who are unwell may not access primary care services; waiting lists may vary between specialties; disability - especially learning disability; and mental illness.

It can generally be assumed that improving access to health care will impact positively on inequalities, although care should be taken to ensure that new services are not made available only in areas where service uptake is already high.

1.2. Improvements in care

Improvements might include:

- reduced hospital waiting lists and better managed clinics
- more timely referrals to reduce unnecessary appointments so that urgent cases are seen more quickly
- assisting purchasers to meet Government targets such as those detailed in “Action on Cataracts”
- less worry and inconvenience for patients because they are only referred to hospital when necessary
- most patients find an optometric practice less intimidating than a hospital clinic
- prompt feedback of information to other health professionals and clear explanations to patients
- continued care by a named person, in this case, an optometrist
- improved access for patients

Optometric practices are likely to be:

- nearer and more accessible to public transport or parking, in many hospitals it can be a long walk from the car park to the clinic
- able to offer appointment times and days that are more suitable to patients and their carers
- offer an appointment within a short time scale
- in some cases, able to offer services in languages other than English
- convenient to attend when patients doing other tasks, e.g. shopping
- good timekeeping by practitioners, without long waits for different tests

Patients may want to consider that they would:

- be able to take less time off work (applies to their carers also)
- not have to travel so far
- possibly have a shorter wait than in a hospital
- be able to get an opinion quickly if they felt they needed one, possibly before their next scheduled appointment
- be seen in a more personal environment by named professionals.

1.3. Greater integration of primary and secondary care

The NHS Plan maps out a future of services operating across traditional boundaries, such as ‘primary’ and ‘secondary’ care. The services should no longer be seen as distinctly “those in hospital” and “those at the doctors” and may include services provided by optometrists,

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chiropractors, dieticians (diabetes), social workers, mobility officers and rehabilitation officers (low vision). Communication, in particular the passing of clinical findings to patients and other team members, will be of major importance, as will the knowledge that each patient has been successfully transferred to another member of the team when their skills are required.

1.4. Reduced costs

Healthcare commissioners should be reminded that:

- optometrists' salaries are lower than those paid to ophthalmologists
- overheads in a hospital are high because of the need to provide back-up services such as nursing and medical records
- many hospitals charge the same amount for all ophthalmic out-patient appointments, irrespective of complexity, and then cross-subsidise services. Many of the services optometrists are offering do not warrant a fee as large as the average fee charged by the hospital.

Hospitals often argue that the cost of seeing extra patients is only a small marginal sum. If there is spare capacity this may be the case, but often to meet the extra need more staff, equipment and extensions to existing premises are required. New staff, especially medical staff, may take many years to train. Consideration also needs to be given about how a doctor's time (especially consultants) can be used to the greatest effect considering the public investment made in their education and training. Thought also needs to be given about whether optometrists, orthoptists or technical staff are the most cost-effective deliverers of some parts of the service.

1.5. Better use of personnel, premises and equipment

Reducing unnecessary referrals should be a high priority. Likewise, monitoring a condition thought to be stable can be a poor use of medical time unless the only person who can undertake that monitoring is medically qualified. It is worth considering that glaucoma patients account for about 25-30% of all ophthalmic out-patient attendances; many of these patients will be "stable" and it might, therefore, be appropriate to consider whether or not their care could be provided by optometrists.

Many hospitals would like to increase the number of ophthalmic appointments they provide but cannot because of staff numbers and the physical space available for clinics. Optometrists developing services in primary care settings may be able to offer both of these without the need for commissioners to consider major capital investments in new instruments and rooms. Equipping a GP surgery suitable for an occasional ophthalmic clinic is a very expensive option and having ophthalmologists work in GP clinics without the back-up provided by other personnel may make poor use of their time and skills, although the government has made a general commitment to increasing the number of "outreach" clinics.

1.6. Go through all of the issues with your colleagues and obtain a consensus of opinion

Allow any perceived difficulties to come to the surface for discussion. **Do not** discuss anything in detail at this stage, leave this to the steering committee.

Elect or appoint a small working party to see the project through and produce a timetable for them to work to

The working party should contain representatives of the professions involved in caring for the patient group under consideration. A patients' representative and a member of the

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commissioning team might also be invited to participate. Involving a member of the PCT or its equivalent is useful because it would probably give you access to their skill in arranging meetings and some secretarial support.

The working party's timetable should be realistic but should not be allowed to stretch too far into the future. If a regular day and time for meetings can be agreed, this is helpful. Some medical staff prefer meetings at lunch time rather than in the daytime or evening because this interferes less with their professional and personal commitments. Be prepared, therefore, to take some time off work to attend meetings. Consider if and how the LOC is going to fund this time.

The working party should perhaps consider its plans as follows:

- define the procedures involved
- ask why these procedures need to be undertaken
- decide how they should be done
- decide who should do them
- and finally, where should they be done

Getting started: Protocols

1. The protocol

The protocol is very important. It should detail precisely how a service will operate, who will be involved, the qualifications and level of expertise that they will need and what actions they will be expected to take. The protocol must be agreed and accepted by all of those involved. Optometrists must feel completely comfortable with all it contains. Sample protocols from other schemes are available in this pack; others may be available from the AOP office.

A protocol needs to:

1.1. be clear, precise, comprehensive and unambiguous.

Protocols need to define accurately what is expected at each stage in the process and how contact is to be maintained with patients. Protocols should be written in clear English, avoid jargon, with technical phrases defined if necessary. They must not be open to misinterpretation by any of the parties.

1.2. be, where possible, 'evidence based'.

In many areas of care there is no definitive evidence of the superiority of one form of health provision over another. However, papers detailing the effectiveness of different modalities of care may be available from the local Director of Public Health and local ophthalmologists. The AOP will also be able to advise you.

1.3. be within the training and capability of the personnel involved.

Optometrists involved in shared or co-managed care schemes will need to recognise that they will normally be expected to undertake further training. In general terms, optometrists have been taught to recognise pathology and, if disease is found, to refer patients - this is a statutory duty (although modified by the GOC rules on referral). In many shared or co-managed care schemes, patients already have recognised eye disease and optometrists are being asked to check whether progression or deterioration to a defined level has occurred before referring patients for an ophthalmological opinion. Decision making in a shared or co-managed care scheme may well depart from the traditional optometric role in patient management, and all involved need to be confident in the abilities of the other members of the team.

1.4. be followed by all concerned.

This means everyone specified in the protocol. If people depart from the protocol confusion and mistrust can occur.

1.5. be breached only in very exceptional circumstances.

If a protocol has to be breached it must be made clear why this has been done. For instance, it may have been necessary in a patient's best interest, or a patient may have objected to a particular procedure. If there are any departures from the protocol, the nature and reason should be clearly stated, and any resulting action recorded.

It may be worth recording these separately for audit purposes and to consider if changes are needed to the protocol in the light of such breaches.

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1.6. Accurately define the patient group to which it applies

Protocols might be generalist, e.g. all patients within a defined catchment area with diagnosed diabetes; but then contain specific exclusions, e.g. except those aged under 11 years, who are pregnant, or who are already under continuing ophthalmological care.

For example in glaucoma schemes it may be necessary to confine services to only those patients within defined ranges of:

- age
- time since diagnosis
- time since stability reached
- treatment regimes
- visual acuity
- visual field defect (extent)
- intra ocular pressures (absolute and variation from target)

This also effectively defines those who should not be on the scheme either because they do not exhibit characteristics of the disease, or because the disease is more advanced than the protocol is designed for.

1.7. State who has clinical responsibility at each stage of the process

There should be no ambiguity about this. Words such as 'refer' and 'responsibility' should be used whenever a patient is transferred from the care of one professional to another. If a professional, or a manager, has a responsibility for a particular action, it should be made absolutely clear.

1.8. Set out the procedures for optometrists' involvement in a scheme

Individual optometrists, not practices, should be contracted to provide specified primary care services outside the GOS. A statement should be made about how optometrists will retain registration to provide a service.

Participation should be limited to those optometrists who have been adequately trained and subsequently accredited, have suitable equipment and indemnity, and agree to abide by the protocol.

All shared or co-managed care schemes should include provision for audit of the scheme, and for the review (at suitable intervals) of the optometrist's continued participation. The procedure for individual optometrists to be registered to participate will have to be agreed with the commissioner of the services.

Payment for work undertaken will depend upon being registered and working to the agreed protocol.

A list of accredited practitioners, their practice addresses, and times of attendance will need to be kept centrally, most probably by the purchaser. The way in which the list, or part of it, is released to people other than the professionals involved, especially patients, also needs to be agreed, and should have due regard to the patient's right to choose his/ her practitioner. The layout and the wording of such a list should be factual and should not imply that a named optometrist has any superiority over those not on the list.

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1.9. Explain how patients should

a. be introduced into the scheme.

Patients may be recruited from many sources - GPs, hospitals, nurses, social services, rehabilitation workers, or by self referral to an advertised service. Careful consideration needs to be given to the target population; do you wish to inform and include all patients with a recognised problem, e.g. diabetes? It will be necessary to identify patients who are already being cared for by other professionals, e.g. ophthalmologists and diabetologists. The size of target population must be able to be seen by the available practitioners within the agreed budget.

Patient information campaigns and leafleting appropriate patient contact points, e.g. GP surgeries, pharmacies, optometric practices, local disease or disability groups, newspaper reports of the development, etc., may bring patients forward. An active campaign by GPs and practice nurses to recruit patients can be very effective. You should however recognise that some potential recruits will be missed. Very often they are the ones most at risk because they attend appointments less frequently, or because they do not fully appreciate the nature of their medical problem - they may need further encouragement to attend. You will need to discuss how to recruit such people with the other professionals involved. A centrally held directory of patients who need to be screened or followed up is a great asset.

Protocols should describe a method for the feedback of clinical information to the referring optometrist. The information should be provided in such a way that the optometrist could ascertain if the referral had been correct and, if it was not correct, to indicate in what respect it had been flawed.

b. have their participation recorded and examination results communicated.

Once a patient has received a service there must be some way of verifying, without recourse to the patient's notes, that:

- the patient has attended
- referral (and to whom) was indicated or not
- any other action required has been undertaken
- a recall date for a further examination was set if no referral was made

This information could be held at GP practices, GPs would expect to be informed of findings; centrally by the PCT or its equivalent, who have to be informed for payments to be made; by optometrists themselves, may be desirable in cases where continuous follow-up is required, e.g. glaucoma; in a hospital, e.g. medical records department; or in another suitable location. No participating clinician should be expected to have to take photo copies of forms in order to share information.

NB Optometrists must always keep their own records of examinations undertaken.

The information should be easily accessible and kept in a common format, e.g. same computer program for all practitioners, and its ownership needs to be established in the protocol. The collection and processing of information is vital to the success of any scheme.

c. if they do not attend, be recognised. It should be agreed what action then needs to be taken.

Non attending patients are possibly at higher risk than those who do attend. In some schemes, e.g. diabetes, glaucoma, an active policy to 'chase' these patients needs to be considered. It is recommended that before a further appointment is sent by an optometrist, the GP is contacted to find out if the patient has moved, is in hospital, or has died.

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d. have their clinical findings communicated.

Most schemes will demand paper-based communications rather than a linked computer or e-mail. A form to state what has been found and what actions are required will need to be drafted. For clinical protocols a “check box” system is desirable, a tick or number indicating a finding, a blank box indicating no finding.

The boxes can be grouped into areas which may require similar responses, e.g. no action, follow-up in one year, refer for GP opinion, non-urgent ophthalmology referral, etc., through to a casualty referral.

Agreed urgency of communication might also be specified, e.g. no action reports to be sent weekly or monthly, action reports or a referral, to be faxed or sent by first class post within one working day.

Information may be required by a number of people, e.g. GP, diabetologist, services commissioner, ophthalmologist, and the information they hope to derive from your reports needs to be ascertained. Multicopy non-carbonised reporting forms then need to be printed. These are quite expensive to produce and a commitment to meeting initial and ongoing costs needs to be obtained from the commissioners. A pilot using forms produced may be advisable before printing large numbers.

1.10. Agree referral criteria, the routes and urgency of referral

Referral criteria will differ according to local circumstances and will need to be agreed with clinicians. They must be adhered to even if they do not correspond with the views of individual practitioners.

1.11. Detail equipment and techniques to be used

The reporting of results might rely on the use of specific equipment, especially as electronic transfer of information within the NHS becomes more popular. Equipment and software may have to be purchased and will therefore be reflected in the charges made to commissioners. Similar equipment in each practice may be insisted upon so that direct comparisons between practices, or interfaces with other services and providers, e.g. hospitals, can be made.

Techniques, especially if new to practitioners, may need to be taught and time allowed to master them.

1.12. Be auditable

Auditing can take three general forms - structure, process and clinical outcomes.

Structural audits deal with ‘the hardware’ of the scheme, for instance, equipment and training; process audits consider whether patients have been seen, data properly collected, findings acted upon and arrangements for follow-up care made. These audits are relatively straight forward and can be undertaken soon after a scheme has started to ascertain that it is working properly.

Clinical outcome audits generally take place at a later stage, and can be more complex and time consuming. However, if outcomes capable of being measured are incorporated into the protocol at the outset this will make audit easier. The data required for the audit can be collected in the report form.

Getting started: Training and accreditation

1. Training and accreditation

Optometrists will require training appropriate to the protocol's needs, complexity and the level of responsibility expected of them. The protocol should clarify this.

An initial accreditation system will be needed to set up to get the scheme under way but consideration must be given to adding new practitioners to the scheme regularly on a long term basis. This may need an urgent mode to avoid problems when a practitioner leaves a practice and his/her replacement needs accreditation to provide continuity of care.

Accreditation is very important. It would be best to have a written statement attesting to each optometrist's ability and the responsibilities they are able to assume. The original accreditation document should be held by the purchaser with copies being provided for each named optometrist. Patients would be informed, when introduced to any service development, of those optometrists who are accredited to undertake the clinical work involved.

Training, accreditation and continuing education (when specified) will have financial implications and should be funded by the purchaser either directly, paying for courses, locums, etc., or indirectly through the fees optometrists receive. The direct funding is perhaps the fairer of the two because some optometrists may be seeing fewer patients than others, e.g. because of location, yet their services are valued just as highly.

A source of administration funds from the commissioner should be established to provide expenses for LOC officer's time in managing the scheme and office expenses (e.g. mail shots to participating practitioners). There should also be a funding stream to pay for ongoing re-accreditation of existing participants and accreditation of new practitioners.

Consideration needs to be given as to who will manage the accreditation/re-accreditation system.

Getting started: Audit

1. Clinical audit

One aspect of shared or co-managed care, which appears to concern many optometrists, is clinical audit. Clinical audit should be regarded as a way of identifying where improvements might be made within the structure of a clinical service. Clinical audit should therefore be seen as one way towards improving patient care. It is also an important part of clinical governance.

Clinical audit was first proposed in 'Working for Patients' (1987) and was regarded with some suspicion by many doctors who thought it would challenge their individual way of treating patients. Clinical audit therefore got off to a very shaky start, but was later regarded as a way of identifying different clinical practises and seeing if one delivered more effective or efficient treatment than another. From the patients' viewpoint, this should be seen to be highly desirable because they have to have faith in the treatment and advice they are given by health care professionals; rarely do they have the necessary knowledge to question any advice they have been given. Patients desire good quality, consistent advice and treatment that makes the best use of information available to doctors.

In hospitals clinical audit has now, for the most part, been accepted as part of the working arrangements. It has taken longer to establish a foot-hold in the GP-led primary care services, but it is now also recognised by many GPs as an important clinical tool to help them to improve the care of their patients. Purchasers of health care services usually insist upon audits forming part of the contract to provide services. This allows them to assess that the service they are purchasing is of the high quality they and their patients, expect.

It is all too easy to concentrate upon the clinical outcomes only, and although these are important they only form part of the picture. Patients expect to be treated as human beings, to be seen in clean and comfortable surroundings, to have information about their condition to be communicated to them in a form they understand and for that information to be appropriately and promptly transmitted to others. The best clinical service can be unappreciated by patients if other aspects do not meet their perceptions of quality. Optometrists should ensure that audit looks at the larger rather than the narrower, clinical, picture.

1.1. The aspects of clinical audit

The objective of clinical audit is to identify areas of weakness, institute changes aimed to rectify the weakness and then to audit again to ascertain that the changes made have been a positive influence upon care. The process of setting of targets to be audited - audit - implement change - reassess targets, may be referred to as the audit loop or audit cycle. (See section on Clinical Governance and Audit)

The main areas for clinical audit are based upon:

1. Structure
2. Process
3. Outcomes (quality aspects of the service)
 - effectiveness
 - efficiency
 - equality
 - patient friendly

Structure considers whether or not the basic requirements of the scheme have been met, e.g. that the personnel are properly qualified and that any equipment is used correctly and is properly calibrated. The target figure for acceptable performance in this area should be 100% because the structure is the base upon which the service rests.

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Process does not deal with clinical outcome but aspects such as how effectively patients have been contacted, what happened to them on their visit to the clinic, and what arrangements have been made to see them again. The correct filling in of forms and sending of letters would also be covered by process auditor. High levels of performance (over 95%) would be expected in this area.

Outcomes measure clinical performance and service quality and can be classified into four categories:

- effectiveness - did the service meet its objectives?
- efficiency - did the service provided represent good value for money?
An audit of the service before a scheme is implemented is required, otherwise comparisons involving value for money can only be made upon subsequent changes
- equity - is the service available to all of those people who might benefit from it? The take up of a service can be adversely influenced by barriers such as language, culture and distance to travel
- patient friendly - was the service provided in a way agreeable to patients?
Aspects such as availability of appointments, advice, reassurance, kindness and communication of information to patients should all be considered.

Expected performance level for outcomes are much more difficult to estimate and should be set at levels regarded as realistic by all concerned. If performance levels are not attained it might indeed be due to poor performance but it could also be due to factors such as unrealistic expectations or a mismatch of referral to treatment criteria. If poor performance is identified as a problem then appropriate training should remedy this.

The audit process:

Before you can audit any aspect of a service you should ask yourself:

1. What am I trying to find out (what is the objective I am seeking)?
2. Does the objective form part of the structure, process or outcome of the procedure under consideration?
3. Will the questions I ask, or the data I collect, help me to achieve my objective?
4. Is the information I seek going to be easily available?
5. What would be considered to be an acceptable level of achievement?

The best time to consider audit is when writing the protocol within which you are required to work. The information you require can be identified and arrangements made for it to be collected as part of the routine procedures written into the protocol.

An example of an audit in each category is outlined. The numbers relate to the answer to the questions outlined above.

An example of a structural audit:

A glaucoma monitoring scheme might insist that each practitioner uses a Goldmann tonometer.

1. The objective might therefore be to ascertain that each practitioner has a calibrated Goldmann tonometer, an appropriate method for sterilisation and appropriate eye drops.
2. This objective would form part of structure of the glaucoma protocol, but not others, e.g. low vision.
3. The question I need to ask is 'Can I visit your practice to check your tonometer?'
The check would cover not only the tonometer but also sterilisation procedures, that anaesthetic drops and fluorescein are available, and in date, and the calibration of the tonometer may be checked.

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4. The information may be obtained by visiting the practice, or possibly via a written statement made by the optometrist - perhaps by filling in a form with searching questions like asking how things are done, what drops are used and their expiry date and batch number of the current drops you are using.
5. In a structural audit such as this it would not be appropriate to set an achievement target of 100% in all areas.

An example of an audit relating to process:

All schemes will require some way of reporting findings.

1. An objective might be to check that reports are received on time.
2. The objective would form part of the process of all schemes.
3. Questions to be asked:
 - a. on what date was the patient seen?
 - b. on what date was the letter sent?
 - c. on what date was the letter received?
4. The information would be sought by:
 - a. checking the report from the date the patient was seen
 - b. checking the date of postmark
 - c. recording date the report was received. [Checking the postmark may indicate that delayed reports might be due to a clinician not completing and sending reports promptly (a delay between dates a and b), or a delay in the postal service (between dates b and c)]
5. An achievement level, depending upon the importance of the information, might be 98% within two working days for referrals, 98% within one week for reports not indicating referral.

An audit relating to effectiveness:

Did the service achieve the projected standard of effective recognition of the problem?

1. The objective might be to ascertain if too many patients are being referred inappropriately.
2. This is an important objective in most clinical services.
3. Consultants are asked to make a note on the referral form if they agreed, or disagreed, with the findings of the optometrists.
4. Examine patients' notes.
5. Achievement level might be set at x% of inappropriate referral. If x% is exceeded it may be necessary to examine the incorrect referrals made and identify if any specific training is required to reduce their number. Suspected over-referral might be due to those clinicians assessing the referrals 'moving the goal-posts'; e.g. stating a criteria for referral on the report form but then classifying the referral as 'inappropriate' because treatment is not required.

Optometrists should expect to be involved in clinical audit schemes. The results of audits should be confidential, should consider aspects that can be assessed from the information available and should not be carried out without the complete agreement of all practitioners as to audit's nature and the performance standard to be considered acceptable. Audit should be seen as an open process aimed at identifying ways to improve patient care by addressing problems found to exist.

Access to information:

For successful audit optometrists must have access to clinical data relating to patients, which may be held by the GP or secondary trust. Such access should not be blocked on the grounds of patient confidentiality. The local Caldicott Guardian should be consulted when such an audit is to be undertaken.