Your LOC needs you

Continuing our series on finding inspiration in and out of the consulting room, **Chris Bennett** looks at how to get involved in local eye care schemes

In a little over a year the structure of the NHS in England will change beyond all recognition, opening up a mass of opportunities for optometrists to get involved in primary care schemes.

The NHS reforms are being driven by a desire to deliver the right services to the right people at the right price, and optometrists are well placed to offer primary eye care services in the high street at a vastly reduced cost to some services in hospitals. Local optical committees will be at the forefront of negotiating and setting up these enhanced schemes and now is the time for optometrists to get involved.

Katrina Venerus, an associate for the Local Optometric Support Unit (LOCSU), stresses that the reforms will only apply to England and will be organised around a new NHS Commissioning Board (NHSCB) which will take over responsibility for GOS contracts from April 2013.

The Optical Confederation will continue to negotiate eye examination fees on a national level, but local services and enhanced schemes will be handled by new, local structures. Diabetes will still be managed under the national screening committee and

Rex Features

Retinopathy screening: LOCs provide the opportunity to become involved in enhanced services

come under the public health arena.

The NHSCB will have local outposts likely to be based around the 50 or so primary care trust (PCT) clusters that were formed from the 153 PCTs for the transition period. 'As far as where an LOC and individual contractors can have influence, then we have to look at the other bodies,' says Venerus.

'Locally we are almost assured that enhanced services will be handled by the clinical commissioning groups (CCGs), which will be responsible for looking at local eye care services and the primary/secondary needs.'

All of the glaucoma, PEARS, ACES-type services (see panel opposite)

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BEYOND THE CONSULTING ROOM WILL COVER:

- How to promote eye care and eye health outside the consulting room
- How to get involved in local eye care and eye health schemes
- How to run a staff training session on clinical and technical topics
- How to gain additional qualifications
- How to become an examiner or supervisor
- How to access and evaluate eye care resources
- How to be a clinical investigator
- How to prepare a presentation
- How to run a clinical workshop or peer review session
- How to put pen to paper to communicate with your peers
- How to write patient communications

In this series, *Optician* will talk to practitioners around the country about their experiences in and out of practice. If you have an interesting story to share, or are involved in any of the areas the series will cover, contact alison.ewbank@rbi.co.uk

HOWARD'S WAY

Fred Howard, chair of Wirral LOC, has been involved in local optics for six years. He joined the profession in his 40s as a second career and now owns three practices in the area. His enhanced services include being lead optometrist for a diabetic screening service, plus schemes for pre-cataract, red eye, flashes/floaters, glaucoma referral refinement of fields and intraocular pressure. The LOC has recently launched a low vision service too.

Howard has also managed to encourage more optometrists and DOs to take part in enhanced services and join the LOC. He got involved in his local committee after voicing concerns at meetings and was invited to join; he soon became secretary. Having attended the National Optometric Conference and become more aware of threats to the clinical role of optometrists he stood as chair to push things

SERVING ACES

Someone not short of enthusiasm is Sarah Farrant who practises at Earlam and Christopher in Taunton and East Quay Vision in Bridgwater. Farrant qualified in 2003 and quickly got involved with her LOC as well as achieving additional AS and IP qualifications and Part A of the College's glaucoma diploma.

'In Somerset we set up the Acute Community Eyecare Services (ACES) scheme which is a Primary Eyecare Acute Referral Scheme (PEARS) equivalent.' This covers a range of eye problems and operates at the East Quay health centre like an outpatient department.

'We see about six or seven ACES per day. The receptionist at the medical centre signposts the patients through to us and we treat them. Because both my husband and I have IP we can manage most things that aren't surgical. This is a PCT scheme for all optometrists in the county. You don't have to be an IP but because we are we use it to the next level.

'It's one of those schemes where you can treat within your confidence level; because we're comfortable prescribing steroids for uveitis we'll manage the sort of conditions others might refer on.'

So how did that scheme come about? 'I set it up,' says Farrant, who got involved with her LOC and after three years or so decided to set up a referral scheme. She contacted Ted Arbuthnot, who was pivotal in setting up PEARS, and asked him to do a talk to the PCT, LOC and key stakeholders such as ophthalmologists and GPs. 'That set the ball rolling because we could demonstrate that it was working in Wales. Being reasonably rural in Somerset, why didn't we have something equivalent?'

There was a lot of ground work to do and developing the detail of the scheme was a team effort, she says. The exercise was

definitely worthwhile if a little protracted. 'It was long-winded. From me wanting to set something up to actually realising it was probably 18 months to two years. So you have to be dedicated.'

Farrant says there weren't really any pitfalls to avoid; the length of time taken is just the nature of the process.

'It had to go through all of the hoops – that's why it took so long. We originally tried to get the ophthalmologists on board, for obvious reasons, and that delayed it a bit because we were trying to get their support but not really getting anywhere. I guess that didn't help us.'

Her advice to anyone thinking of setting up a scheme is to work with the LOC. The first task is get on to the committee, develop links with the commissioning managers within the PCT and instigate a meeting to explain the sort of things you want to achieve in the community and why.

From a community optometry point of view there are also great benefits. Offering clinical services is an integral part of practice; it makes the practice the 'go to' place for a range of eye health issues and provides another income stream.

Farrant explains: 'For ACES we get funded £45. If the patient has a subconjunctival haemorrhage and is worried then it's great because it only takes us two minutes to look at them, whereas if you have full flashes and floaters you have got to dilate them.

'It's swings and roundabouts, but the true benefits for me are the diversity in my clinic and the interest in my day because it isn't just churning out sight tests.'

For the future Farrant hopes ACES will be embraced by the new NHS structure. 'From Somerset's point of view we have been quite forward thinking and quite successful so I would hate to see the reforms drive us backwards,' she says. 'I would love to be optimistic but I can't see it being a good thing.'

For others looking to set up similar schemes the starting point has to be the LOC. 'I got involved with the LOC not long after qualifying because it seemed like a sensible thing to do if for nothing more than keeping in tune with what was going on in the local community.'

Farrant says she would encourage all optometrists to work with their local colleagues. 'The work of the LOC impacts everything that you do in your local area and if you want to be an opinion leader in terms of arguing your corner or getting schemes up and running then the LOC is really the only way you can do that.'

forward. Howard encourages other optometrists to get involved in their local area and the first port of call, he says, is the LOC. 'Find out if they have a full complement and how often they meet.

'As individual practice owners you can't just sit around and wait. In some areas, such as West Cheshire there is no structure or organisation so practices don't get to hear about what is going on.'

In the beginning that was Howard's experience too. 'We had an LOC but they used to just wait until the optometric adviser came and told them what they were going to be doing. They [the LOC] didn't shape anything or decide on fees.'

Once involved in running the LOC he looked around for best practice. 'The very first thing I did was go to Eastern Cheshire [LOC] to their meeting, I saw what they were doing and started restructuring ours.'

Howard recently shared his experience, along with David McGowan at the NOC, on how to set up enhanced services. He told delegates that under the new structures it would be the clinical commissioning groups that LOCs would need to work with.

He warned that there were many conflicts of interests and different ways of working. 'People have got different agendas but you have to educate and make them understand that they don't need to go anywhere else to get the services done.'

Howard already has an eye on the future to ensure that established schemes carry on when the NHS reforms take effect. 'We are going to be audited so when these new groups start up we can show them how effective our schemes are and there is no need for anyone to change it.

'Don't sit back and wait. If you have some enthusiasm offer your services to the LOC,' he concludes.

will sit with the CCGs, while contracts management may be delegated back to local commissioning boards. Other organisations, called health and wellbeing boards, will have the job of looking at who they have in the local population and their needs, and part of that will be eye health, says Venerus.

'The LOC will have opportunities to build relationships, influence the people doing the needs assessment to say: "Hang on, is eye care even in there, and this bit is important and that bit is important".'

Local professional networks are also beginning to take shape, but it is not yet clear exactly how they will work. 'These should have representation from the local committees so for us that should be the LOC. In a way, the LOC has a greater opportunity to have official representation. That's why we have to make sure that energetic proactive people are involved in these things as they get off the ground.'

Venerus believes there is an opportunity to push enhanced services with the changes to the NHS. 'The opportunity is much greater than it's been before because the agenda is to have as much done in primary care as you possibly can and not in hospitals.

'Obviously opticians aren't the only group that can provide eye care services in the community, but they have got the premises, they have got the equipment and, as long as they are organised, are an easy bunch to deal with because they have already got the GOS contract.'

Not all optometrists get involved in the organisation of their LOC, but a big proportion take part in LOC schemes. However, it could and should be higher, says Venerus. In most areas there are upwards of 70 per cent of local practices involved in schemes such as IOP services. For enhanced services, take-up is generally lower but it needs to grow.

'The appetite for more community practices to get into primary eye care services is definitely there.' It might not be for all practices but the goal is pushing that forward. The result may not only be an expanded role for practitioners and greater job satisfaction but also enhanced patient care.

Useful resources

Local Optical Committee Support Unit (LOCSU) www.locsu.co.uk
info@locsu.co.uk or 0207 549 2051
LOCSU can put you in touch with the relevant committee in your area.

WORKING WITH HOSPITALS

Wendy Newsom graduated from Aston in 1983 and started her working life in a small independent partnership in Gloucester. During that time she sat on Gloucestershire LOC and chaired the Three Counties Optometric Society, organising educational lectures and meetings.
Newsom first got involved with screening for diabetic retinopathy in a local GP practice in Gloucester with a slit lamp and Volk lens, and in 1998 was invited to represent the LOC on the steering committee setting up the Gloucestershire Diabetic Retinopathy Screening Service. She was also involved in the Action on Cataract initiative to reduce waiting times for cataract surgery.

Following a move to Cambridgeshire in 1999, Newsom joined Cambridgeshire LOC. 'I became accredited to the, then, new Direct Cataract Referral Scheme set up in conjunction with the LOC, Huntingdonshire PCT and Hinchingbrooke Hospital in Huntingdon. In early 2002 I took up a post to coordinate this scheme at Hinchingbrooke and since then I've been predominantly a hospital-based optometrist.'

This scheme saw the creation of ophthalmologist and PCT supported schemes for community optometry-based management of pre and post hospital patients, then a move for her into triage, optometrist-run acute eye clinics and later the development of a paperless referral system.

'In 2008 an optometrist took over the running of the acute eye clinics within the hospital and this team has expanded to three, two of whom have the IP qualification. The team is now involved in trying to set up community-based GP and optometrist referral triage and a pilot is soon to be undertaken.'

Newsom has now taken a post at Moorfields to help set up further enhanced services with community optometrists in Bedford.
Her advice for optometrists looking to offer enhanced service is to work with hospitals and ophthalmologists. 'The hospital has to be the hub of an enhanced service. I know that's not the case some places in the country but I think if you have got ophthalmologists on board your schemes will be successful.'

Ophthalmology in general will welcome the moving of services from secondary to primary care. They will also welcome an improvement in the quality of referrals from optometrists, says Newsom, describing the referral letter as 'the face of that community optometrist'. GP commissioners like to know that ophthalmologists are involved. This generally reassures them that evidence-based practice is being performed and that clinical governance is in place.

'Avoid leaving out ophthalmology when you develop services, even if you think it makes it easier to get things off the ground. It damages relationships between primary and secondary eye care and is not good for the patient in the longer term.'

Other tips from Newsom include lots of networking and communication, such as getting to know GPs by going to their meetings, offering to give talks on eye services and getting to know the chair on the local medical committee. 'Here in Bedfordshire there is a clinical governance lead who is very active in optometry and she's been a key person.'

She agrees that the LOC is crucial. 'I think membership of the LOC is essential. It enables colleagues to work together, pool their knowledge, use the fantastic support from LOCSU and engage in peer review. Meeting the PCT commissioners and getting to know them well has also helped us so much in Cambridgeshire. We took on an LOC administrator with both an optometric and business consultancy background and this helped us present a professional well organised front at meetings.'

Newsom is also optimistic about the

changes to the NHS and believes they will give LOCs more say. LOCs should be on their local professional network and this will give optometry a forum to air its ideas and be actively involved when commissioners are making decisions. Some areas have eye networks which will become the LPN, she says. 'The expansion in ophthalmic public health is also a fantastic opportunity for evidence-base population involvement.'

She would encourage other optometrists to get involved but concedes this is often influenced by employment factors. In the past one supermarket banned their professional staff from involvement in LOCs. Others take a different view. 'With Specsavers they are very keen and encourage their managers to be on an LOC. It's part of their franchise role.'

Newsom says at first she didn't know anything about being active in local health care commissioning but as she mixed with more colleagues she soon became aware of the benefits. 'I think that all of this extra involvement has helped me to still have the drive and enthusiasm to try and develop and improve myself and our optometric services, even after nearly 30 years in optometry.'