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Reference:

Ms Kim Read BSc (Hons)  
Secretary  
North Yorkshire Local Optical  
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21 February 2011

Dear Ms Read

Thank you for your letter dated 1<sup>st</sup> February 2011 in which you highlight a number of concerns regarding the referral pathway for patients with cataracts requiring secondary care intervention. I know that these concerns were discussed at the optometry commissioning group on 18 February, but it will be useful to respond to the concerns you have raised in your letter and share with optometry colleagues across North Yorkshire.

The Service Level Agreement which was distributed to optometrists was a revision to the existing scheme with a sign up sheet attached.

The existing scheme was revised following the outcome of a regional clinical network that highlighted variability in the threshold for cataract extraction across Yorkshire and Humber. I understand that Lisa Barker attended a meeting on the 12<sup>th</sup> October at which the Sheffield scoring tool was discussed where optometrists present highlighted concerns that they felt that the lifestyle score on the form could potentially result in an increase in referrals. My colleagues in the clinical effectiveness team had discussed the implications of adopting the new referral threshold with GP commissioners and both LOC and LMC, and whilst recognising the potential risk of increased referrals the decision to proceed with the revised threshold was ratified by the Integrated Commissioning Executive last year.

Patient choice is a key NHS policy, but as you rightly state, optometrists cannot refer patients via choose and book. The referral pathway therefore provides patients with choice either through referral to the PCT's choice office, or where appropriate, for patients outside of the pathway criteria, through the patients GP.



You have highlighted in your letter concerns regarding section 2, regarding to action that may be taken following 'failure to achieve a 90% conversion rate'

The wording in this paragraph deliberately states that the contract may lead to the withdrawal of the contract. This target has been set in discussion with secondary care colleagues, and would be subject to audit. If this target proves unrealistic we would revise this in subsequent years, however the principle behind this target is to avoid inappropriate referrals being made into secondary care incurring a cost to the NHS and tax payer. A fundamental part of any new pathway is audit and education and NYYPCT would seek to support any colleague where audit identified a significant number of referrals which did not proceed to a surgical outcome.

You have highlighted the inappropriate use of the term counselling which we have used in section 3 of the contract. I apologise for this, the term counselling is overused and inappropriate and I agree that the term "discussion" would have been a more appropriate term. We will issue an SLA variation to reflect this.

Whilst I acknowledge the LOC's concerns regarding the funding of this scheme, the payment schedule has not been arrived at arbitrarily. The payment is based on outcomes (hence it is linked to the patient being listed for surgery) It was calculated by our primary care finance lead and the principles agreed by the PCT Optometric Adviser. It is comparable with how services have been calculated for the Pharmacy colleagues which was agreed with the LPC.

The fee is based upon an assumed salary of £50,000 plus employers' on costs, approximately £8 and 50% of this charge, £4, has been added as a contribution to the over heads and profit of the practice. The time assumed for the consultation plus pre and post consultation work has been 15 minutes.

I believe the pathway was discussed at an optometry commissioning group meeting on 11<sup>th</sup> October where Darryl Taylor was in attendance, minutes of that meeting evidence the discussion around the tariff price and an opinion that the paperwork could be completed in 10 minutes or less. Following the LOC's concerns, the pricing of the pathway was discussed again at the optometry commissioning group on 18 February and the decision of the group was that we should continue with the £12 tariff as previously agreed.

I note your comments regarding prime and sole pathology. The distinction on the referral form had been intended to ensure that where a patient's health problems are more complex, a ophthalmic referral may be better coming from the patient's GPs so that full details of past and current medical and treatment history can be included with the referral. Your feedback is useful and if there remains too much ambiguity, then we will certainly revise the form in light of feedback.

The intention is anyway to audit this pathway on 31 March and we will share the feedback and plans to revise the pathway or forms at this time. Introducing such a change is inevitably going to create teething problems and I am keen to work with the LOC to ensure this pathway works for everyone, particularly the patient.

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I would really welcome the opportunity to come and discuss further and to meet with the local Optical committee, please in the interim, feel free to get back to me if there are outstanding points needing clarification

Best wishes

Yours sincerely



**Dr David Geddes**  
**Medical Director and Director of Primary Care**  
**GMC Number: 3253722**

Cc; North Yorkshire Optometrists  
Kate Malyn, Optometric Adviser NHS North Yorkshire and York  
Dr John Crompton, Chair, YorLMC  
Lisa Barker, pathway Implementation manager, NHS North Yorkshire and York



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