GOVERNMENT CONSULTATION
LIBERATING THE NHS – COMMISSIONING FOR PATIENTS

Overview

Together the Optical Confederation represents the 12,000 optometrists, the 6,000 dispensing opticians and 7,000 optical businesses in the UK who provide high quality and accessible eye care services to the whole population. The Confederation is a coalition of the five optical bodies: the Association of British Dispensing Opticians (ABDO); The Association of Contact Lens Manufacturers (ACLM); the Association of Optometrists (AOP); the Federation of Manufacturing Opticians (FMO) and the Federation of Ophthalmic and Dispensing Opticians (FODO).

We are pleased to have the opportunity to comment on this consultation. We do so from the perspectives of our eye care patients and as providers of community eye care services.

Much of the detail is for others to comment on but we wish to make the following observations/submissions.

We very much welcome the Government’s commitments

- that the NHS Commissioning Board should continue to commission the national primary ophthalmic service on a national basis (paragraph 3.30) – the UK system is currently the most cost-effective in the developed world and this will preserve that efficiency going forward.
- to design locally commissioned services around patients and offer “choice for patients wherever practicable” (paragraph 1.7) - community eye care already delivers this in spades!
- to engage “the full range of other health and care professionals” as well as GP consortia in the commissioning process (paragraphs 1.7, 1.8 and passim).

We also welcome the fact that this is one of the first government papers in our experience specifically to include references to commissioning community eye care services from optical practices (paragraphs 3.3 and 3.4). We hope this is a long overdue recognition of the effective role the community optical sector can play in delivering eye care services and in significantly reducing costs for the NHS and social services.
We support the direction of travel and look forward very much to being part of the process and success of the new arrangements. We therefore welcome the Government’s commitment to “work with the NHS and the health and care professions to promote multi-professional involvement in commissioning”. This is an invitation the Optical Confederation and College of Optometrists are delighted to accept. We look forward to engaging

- with Government and NHS Commissioning Board at national level, and
- with GP consortia through Local Optical Committees at local level.

**Managing the Transition**

We also welcome the Government’s specific commitment “to work with the NHS and professional bodies in the transition to the new arrangements to promote multi-professional involvement” (paragraph 6.13) and, as noted, are keen to be part of this process and to help in any way we can.

**Partnerships**

We welcome the replacement of local authority Overview & Scrutiny Committees with stronger local authority Health and Wellbeing Boards and would urge the Government to ensure effective input to these new Boards from health professions such as our own.

The prevention of blindness and support for people with visual impairment to prevent loss of independence and downstream costs to the health and social care sectors is a major concern and has been neglected by both health and social care commissioners in the past – leading to significant expenditure for public authorities which could have been avoided.

We would argue for a community eye health professional (who commands the confidence of the profession) to be either

- a member of the local Health and Wellbeing Board or
- a member of a professional stakeholder group supporting the Board.

**Multidisciplinary Working**

We agree that it is only by “enabling GP practices to work alongside other health and care professionals through commissioning consortia [that] will enhance their ability to fulfil [their responsibility to use public resources responsibly and in the public interest]” (paragraph 5.20).

Our hope is that, to achieve this, GP Commissioning Consortia may opt to be supported by multi-professional stakeholder group possibly analogous to the old multi-disciplinary PECs.
We have found to be these effective models of engagement and service improvement where community optometric expertise has direct input through membership of such boards or committees.

If GP Consortia are developing such stakeholder groups to inform their commissioning we would argue strongly that optometrists or dispensing opticians nominated by the Local Optical Committee should be included.

**GP Consortia - Staffing**

We fully agree that GP Consortia will need effective management and administrative support to fulfil their functions. However our major concern is that, given the necessary urgency of the Government’s plans, this might lead to PCT staff simply being transferred from one arm of the service to another carrying with them the “muddled and over-bureaucratised approach” (paragraph 5.12) which has made locality commissioning fail in the past.

The Commissioning Board should have reserve powers to ensure that this is avoided as one of the “other activities could be undertaken to support efficient and effective local commissioning” (question at paragraph 3.33).

**Input to the NHS Commissioning Board**

We welcome the fact that the NHS Commissioning Board is to be “lean” and perform its functions “in a streamlined way” (paragraph 3.23). This should avoid the bloating and bureaucratising that bedevilled SHAs and PCTs. We also welcome the commitment to ensure that the NHS Commissioning Board will involve professional representative bodies in carrying out its work (paragraph 3.28) and are keen to help in any way we can.

**Consultation Questions**

We also have the following responses to the consultation questions.

1. **What features should be considered essential for the governance of GP Consortia?**
   
   As described above, we believe there should be some professional stakeholder group (possibly akin to the old PECs) to ensure other professional groups feed directly into the clinical and commissioning processes.

2. **How far should GP Consortia have flexibility to include some practices that are not part of a geographically discrete area?**
   
   Although this would clearly drive patient power and patient choice i.e. introducing patient voice and choice in a very direct way into commissioning, it would make it more difficult to operate community-based optical and other schemes taking on routine care as part of the re-shaping of hospital services. We believe this public health priority might override the contestability
arguments in this case. From the perspective of our professions therefore, we would prefer the GP consortia to have relatively discrete geographical boundaries.

3. How can GP Consortia best be supported in developing their own capacity and capability in commissioning?

We are concerned that, in seeking support, some GP Consortia could inadvertently reinvent failed NHS management practices. There will be many management consultancies (including ex-NHS staff) marketing themselves to possibly inexperienced GP Consortia and promising a range of support. This is fine provided it is clear that this should not be a recipe for reinventing the old bureaucratic approaches which have made GP Commissioning fail in the past. Perhaps guidance should be issued on consultancy use including advice about specifying deliverables and timescales, and payment only against delivery of acceptable results.

4. What safeguards are likely to be most effective in demonstrating transparency and fairness in investment decisions and in promoting choice and competition?

Simple, but transparent, tendering and bidding processes.

The GP Consortia should

- be very clear to potential bidders about the health needs they are aiming to meet and any constraints that they foresee in the delivery of services
- ensure particular groups are not disqualified from bidding by the blanket imposition of unnecessarily complex rules designed for more complex services
- flexible in enabling local bidders to work in new and innovative ways to deliver new care models to meet the needs the Consortium has identified.

An example here would be simply transferring (without thinking and because it is the easiest route) the requirements for hospital services onto community optical practices where these are neither necessary or desirable eg full N3 IT requirements when secure email provides perfectly secure data transfer.

5. How can GP consortia best work alongside community partners (including seldom heard groups) to ensure that commissioning decisions are acceptable and reflect public voice and local priorities?
As we have suggested above by the use of local professional and other stakeholder groups which can feed their expertise and experience directly into the commissioning process.

This would also be a means of enhancing local democratic legitimacy in health (paragraph 6.6).

6. **Where can we learn from current best practice in relation to joint working and partnership for instance in relation to care trusts, etc?**

Throughout the country there are examples of excellent practice of joint working between the NHS and Local Optical Committees representing local NHS eye care contractors and practitioners.

The Optical Confederation and College of Optometrists would happy to prepare some best practice guidance based on this evidence for

- GP consortia on how to engage with Local Optical Committees
- Local Optical Committees on how best to engage with GP consortia.

**Optical Confederation**  
**11 October 2010**