Department of Health Consultation on

Liberating the NHS: Greater Choice and Control

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.

Summary

1. As a sector, we have been pleased to welcome

   - the Government's White Paper *Equity & Excellence: Liberating the NHS*
   - the current consultation paper, particularly the statement that "we expect choice of treatment and provider to become the reality for patients in the vast majority of NHS-funded services by no later than 2013/14".[1] This is precisely the model of care that the optical sector has always provided
   - the proposal "that choice and shared decision-making ought to be the rule, not the exception, and should be built into health professions' everyday practice – no decision about me, without me". This is absolutely the norm in community optical practice
   - and the Government's decision to maintain a national sight testing service commissioned by the NHS Commissioning Board.

2. This decision has been wise since the national sight testing service already operates on a standard tariff and 'any willing provider' basis, with a market that is genuinely open to any provider who meets standard quality criteria (effectively a simple national licensing system). Moreover, with a national tariff, money genuinely follows the

[1] Department of Health White Paper, *Equity and Excellence: Liberating the NHS,* 2010

patient, so that all providers compete vigorously for each and every patient on the issues of quality, access and choice.

3. As a result, this genuine market-based system has delivered standards of quality, access and choice unparalleled and envied in other parts of the NHS, and funded primarily by the private sector through competitive investment.

4. In this way, as Professor Nick Bosanquet of Imperial College[2] has recently reported, community optical practice is an "exemplar" service for the *Liberating the NHS* reforms by already providing excellence in care and having a firm foundation for further rapid expansion of enhanced ophthalmic services in the community, based on the same model and infrastructure.

5. It is against this background of support that we welcome the further proposals in the consultation document *Liberating the NHS: greater choice and control* but with two significant exceptions.

Additional Licensing Regime

6. As a genuinely market-driven system, we would be opposed to the application of pseudo-market mechanisms to our sector, such as a new duplicatory licensing regime operated by the Care Quality Commission (CQC) and the economic regulator, Monitor, where none is necessary. These would in our view simply add to frontline costs without benefit to patients or the NHS.

7. In optics, any willing provider can already enter the market provided he meets minimum entry standards (on premises, equipment and record keeping) and, once in, competes vigorously with all other providers for market share through quality of service to both NHS and private patients. As a genuine market system, our sector does not therefore need market substitute mechanisms such as regulation and licensing which seek simply to replicate the operation of the market in a non-market environment. There is no evidence that this is necessary for the optical sector and would simply add to costs on front-line care without benefit.

Locally Commissioned Enhanced Services

8. We further feel - and for the same reasons - that the proposed new joint licensing regime should not apply to community optical practices which opt to provide locally commissioned enhanced services, e.g. for glaucoma, cataract and age-related macular degeneration (AMD). Again this would simply result in duplication, additional costs and administrative burdens, as well as discouraging many practices from providing these services in the community, because of the additional bureaucracy. We would also like to stress that licensing optical practices would not fit with government policy of ensuring proportionate regulation.

[2] Professor Nick Bosanquet, Liberating the NHS: Eye Care – Making a Reality of Equity and Excellence, December 2010 http://www.epolitix.com/fileadmin/epolitix/stakeholders/liberating_NHS.pdf

9. Instead, if the NHS Commissioning Board and GP consortia wish enhanced services to be subject to a common set of quality standards, we propose that these should be agreed, ideally nationally, as part of the standard terms for locally commissioned enhanced services and then replicated within local NHS enhanced services contracts. This would achieve precisely the same ends at lower cost and without inhibiting the genuine operation of the market for enhanced local services or putting up barriers to market entry for small local providers. Provision by small providers is very important to ensure a wide geographic spread of services for patients. It would also keep a significant additional bureaucratic burden away from front line services.

Additional Information Requirements

10. Since the restrictions on advertising community optical practices were lifted under the Conservative Government in the 1980s, providers have been able to compete vigorously for patients on the basis of information (including about clinical and service quality). Given that this works extremely well (there are very few complaints in community optical practice through either the NHS or the Optical Consumer Complaints Service for private patients), we would also be opposed to additional information requirements being imposed on community optical practices, where they are not necessary or proportionate, simply to make all services fit within a model developed for providers where in the past, competition has not operated.

National Pathways

11. What is genuinely required in our sector to encourage more enhanced local services to be commissioned outside hospital is the endorsement by the Department of Health and ultimately NHS Commissioning Board of single agreed national pathways for the most common conditions such as cataract, glaucoma, age-related macular generation (AMD), and urgent care. These, of course, should be updated from time to time in line with emerging clinical practice and new technologies, but the more pathways there are at local level, the more boundaries there are to patients moving between one system and another, and the greater the risk to patients and the cost to providers.

12. The advantage of having single national pathways in these areas is that clinical standards would be clearly set out – and ultimately approved as national standards by NICE such as the national quality standard being developed for glaucoma – enabling providers to compete on access, service quality and choice.

Urgent Care: 111

13. We welcome the Government's proposal to "develop a coherent 24/7 urgent care service in every area of England" and would urge the Government/NHS

Commissioning Board to require that this includes emergency eye care in the community.

14. The various Primary Eye-care Assessment and Referral Services (PEARS) which have operated in Wales and in some areas in England have shown high levels of patient satisfaction and the ability to provide a simple, accessible location for patients suffering from, for example, red eye, foreign object in the eye, sudden onset infections of the eye, to attend a community optical practice for their first line care.

15. If such services were required to be commissioned as part of every 111 local area network (from accredited local optical practices either on sessional or case by case basis) this would provide an extremely cost effective service for the NHS whilst at the same time reducing pressure on GPs, A & E departments and hospital ophthalmology departments.

16. We hope the Government finds all of the above comments helpful. The Optical Confederation is willing to work with the Government and Department of Health to develop these proposals further and deliver efficiency savings for the NHS.

17. In the meantime, our responses to those specific consultation questions which affect our sector are below.

Q1. How should people have greater choice and control over their care? How can we make this as personalised as possible?

A1. Provide patients with as much information about their choices as possible. This is already the norm in community optical practice.

Q3. How can we offer greater choice of provider in unplanned care?

A.3. We would suggest that community optical practices have an important role to play in minor ocular emergencies. When patients have an eye care emergency e.g. sudden onset red eye, conjunctivitis or dust or grit in the eye, they should be directed or encouraged to attend an appropriate community optical practice in their locality where first line care can be provided in the majority of cases. Where the relevant schemes for minor ocular emergencies are in place (e.g. ACES in Somerset which is reviewed in recent report by Professor Nick Bosanquet – Liberating the NHS: Eye care – Making a Reality of Equity and Excellence), this high quality care can be provided conveniently and cost-effectively for the NHS.

Local Optical Committees should be involved in the discussions to commission these local services, although using national pathways as a baseline, for dealing with minor ocular emergencies, so that patients can receive the most appropriate, convenient and timely care.

Q4. What would help more people to have more choice over where they are referred?

A4. Market transparency is key here and there is much scope in an NHS which has not traditionally worked in an open market system to fall into a number of probity traps. It is particularly important to ensure that the new system of patient choice is operated genuinely and that there are no hidden conflicts of interest within the system.

Tendered services should be genuinely open to 'any willing provider' and contracts awarded transparently; triage, referral refinement systems and centres should be entirely independent of both referrers and recipients of referral.

There should be a clear duty on all professionals involved in commissioning (irrespective of discipline) to reveal any personal pecuniary or other interest, in any company tendering for either direct care services or indirect care services, e.g. triage. This should be binding and enshrined in NHS codes of commissioning practice and codes of professional conduct established by the nine health regulators.

Q7. When people are referred for healthcare, there are a number of stages when they might be offered a choice of where they want to have their diagnostic tests, measurements or samples taken. At the following stages, and provided it is clinically appropriate, should people be given a choice about where to go to have their tests or measurements and samples taken:

- **At their initial appointment – for example with a GP, dentist, optometrist or practice nurse?**
- **Following an outpatient appointment with a hospital consultant?**
- **Whilst in hospital receiving treatment?**
- **After being discharged from hospital but whilst still under the care of a hospital consultant?**

A7. In our view, it is at their initial appointment with their optometrist or ophthalmic medical practitioner that patients should always be given a choice about where to go for their diagnostic or other eye treatment. This is not the case currently and in order to facilitate decision making at the initial primary care appointment in optical practice, there should be an enhanced fee to cover the knowledge and time required to assist patients in considering their options and choosing. The current General Ophthalmic Services (GOS) contract does not provide for this; however it would be sensible if, in future, an enhanced fee were specifically provided for this. In return for this investment in optometric care, the NHS would have a downstream saving of time and resource by allowing the patient to make this choice prior to referring the patient on to their GP or hospital eye department.

Q18 How do we make sure that everyone can have a say in their health care?

A18 Within the optical sector, we still come across groups who are not having regular sight tests, leading to undiagnosed pathology, permanent visual impairment and blindness. This is particularly true of patients in residential and care homes, people with learning disabilities and children.

In children, lazy eye and squint can normally be corrected in children up to about age 8; however, in many parts of the country, screening services do not operate or have been discontinued.

Equally, when optometrists visit patients in care homes they often find high levels of uncorrected refractive error and often, in the case of dementia patients, undiagnosed cataracts and other visual problems which can exacerbate the patient's condition and behaviour.

The solution, we would suggest, is that residential and long term care homes should be encouraged to keep an 'eye care record' in all care plans (particularly for service users with dementia).

These should set out clearly the date of the patient's most recent sight test, what the results were and what, if any, referral action was taken as a result. It should also set out what their prescribed visual correction is so that care staff can ensure that patients are wearing their spectacles appropriately and for appropriate activities.

Q19 How can we make sure that people's choices can reflect their different backgrounds – whether ethnic, religious or any other background that could affect their health care preferences?

A19. In the optical sector, patients already have a very wide choice of optical practice, including for example practices which open on Sundays and practices which include minority ethnic language speakers.

We also support the recent changes to regulations that offer patients a choice of practitioner (e.g. a female practitioner) if there is one available.

Q20 How can we make sure that carers or families of patients and service users can have a say in decisions about the health care of the people they support, where appropriate?

A20. As in our answer to Q18 above, the 'eye care record' in a care plan for residential and long term care homes, and where necessary, for children and people with learning difficulties, would also enable carers and families to access that information and take any necessary action where appropriate.

Q21. How can we support the changing relationship between health care professionals and patients, service users, their families and carers?

A21. In the optical sector, we have a genuinely market-driven system where patients are equal partners in their care. Patients choose where to go for a sight test and where to purchase their glasses or contact lenses, whether they are an NHS patient or private patient. They are not required to be registered with a particular optometrist, in the way patients need to be registered with a local GP and are therefore able to choose freely where to access community eye care services.

It is unsurprising, therefore that, in our sector, the quality of relationship between practitioner and patient is very high and there are very few formal complaints [(>3000)] against the background of 20 million sight tests per annum.

It follows therefore that, any further regulation in our sector in this regard would be unnecessary, disproportionate and would impose an unnecessary additional burden on the optical front line in return for no patient benefit.

Q37. How can we encourage more health care professionals to use Choose and Book when they make a referral?

A37. In our sector, by ensuring the roll-out of NHS Mail to all optical practice so that practices can make referrals electronically.

In order to facilitate direct referrals by optometrists into secondary care the fee structure should be re-examined so that it can support referral. We would support the introduction of Choose and Book in optical practices in the future. We are aware of a number of teething problems with Choose and Book and we would like to see these resolved before it could be introduced in optical practices. It should be possible to move ahead with direct referrals from optical practices to secondary care without requiring Choose and Book.

Q41. Do you agree with the proposed approach to establishing a provider's fitness to provide NHS services?

A41. No, as described above, while this may be appropriate for secondary care providers, we feel very strongly that such a system would be unnecessary and duplicatory in the community optical sector which is genuinely market-driven, with fitness to practice of eye care professionals regulated by the General Optical Council. Adopting the same system would impose an unnecessary and costly burden on frontline care which would ultimately have to be passed on to patients or the NHS.

Q42. Should this approach apply uniformly to all providers no matter what size sector in health care services that they provide?

A42. No, please see answer to Q41 and above.

Q43. Do you agree that "any willing provider" directory should be established to make it easier for commissioners to identify providers that are licensed and an agreed to the NHS standard contract terms and conditions?

A43. Not for the community optical sector. As suggested above, we propose that standard inspection and 'joined-up' terms and conditions should be included in any local contracts for enhanced optical services that are commissioned from optical practices to provide services outside hospital. This would enable inspection as appropriate but would not impose a new bureaucratic cost on the system.

We would also be particularly opposed to nationally set fees for enhanced eye care services in the community. In a genuine market system such as that in which we operate, this would stifle competition and remove the drive for efficiency. In our view, providers should continue to be able to compete to deliver services on quality and price, subject to meeting the terms and conditions in an enhanced service contract. Another list of 'willing providers' would simply re-introduce PCT bureaucracy.

Q46. What do you consider to be the main challenges to ensuring that people receive joined-up services, whichever choices they make, and how should we tackle these challenges?

A46. In our sector, the challenge is to ensure proportionate cost effective but secure IT links between all community optical practices and other NHS providers. In our view, the full burden of N3 connection, and NHS Connecting for Health Information Governance requirements, are unnecessary in our sector and that a far simpler system based on secure internet or NHS Mail should be developed in partnership with the Optical Confederation.

Q47. What do you consider to be the main risks to the affordability of choice and how should we mitigate these risks?

A47. The community optical sector is a genuinely market-driven system which copes well with market exits as well as entries. This is not so for the traditional NHS. For the 'NHS sector' of health care, the NHS Commissioning Board, Monitor, and the Care Quality Commission will have to ensure and manage appropriate market exits.

As noted above under paragraphs 6-9, unnecessary bureaucracy would put up barriers to market entry for small local providers. Provision by small providers is very important to ensure a wide geographic spread, and therefore choice, of services for patients. Unnecessary bureaucracy would be mitigated against by avoiding, for

example, unnecessary oversight mechanisms that simply replicate existing structures or functioning market mechanisms.

Q50. What is the right mix of measures to encourage GP Consortia to offer appropriate choices to their populations?

A50. Three elements are essential to the proper working of choice and local commissioning

- transparency of commissioning with full disclosure of any conflicts of interest
- right of patients and alternative providers to challenge commissioning decisions
- a right to appeal to the NHS Commissioning Board if the challenger is not satisfied.

We would also welcome an underlying principle that GP Consortia commissioned services should ensure that, where possible, the patient is able to be seen without delay in an easily accessible location in the community.

Q53. If you do not get a choice you are entitled to, what should you be able to do about it?

A53. Complain to your GP practice in the first instance, then the GP Commissioning Consortium and finally the NHS Commissioning Board or Ombudsman.

For further information please contact:
Mark Nevin
Head of Policy and Regulation
Optical Confederation
Email: mark@fodo.com
Telephone: 020 7298 5151

January 2011