Integration of Care Consultation Questions

The RCGP would like to hear your views on the following questions pertaining to integrated care. If you have experience of being part of integrated care services and models we would be especially keen to hear from you.

If you do not have the time to respond to all of the questions, we would be grateful if you could answer the four questions in bold.

Page numbers against questions relate to the sections in the consultation document where the issues are discussed.

Please return this form to paul.deponte@rcgp.org.uk or complete the online survey. The deadline for responses is *5pm on Friday 4 November*.

Joint response of the College of Optometrists, the Optical Confederation and LOCSU.

About us:

- The **College of Optometrists** is the Professional, Scientific and Examining Body for Optometry in the UK, working for the public benefit. Supporting its 13,000 members in all aspects of professional development, the College provides Pre-Registration training and assessment, continuous professional development opportunities, and advice and guidance on professional conduct and standards, enabling our Members to serve their patients well and contribute to the wellbeing of local communities.

- The **Local Optical Committee Support Unit** (LOCSU) provides quality, practical support to Local and Regional Optical Committees (LOCs/ROCs) in England and Wales to help them to develop, negotiate and implement local objectives in respect of primary ophthalmic services.

- 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 representative 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). As a Confederation, we work with others to improve eye health for the public good.

1. What in your view are the three main benefits of integrated care? (p. 3)

The three main benefits are better care for patients, better value for taxpayers and increased job satisfaction for healthcare professionals as a result. Eye care serves as a useful example to illustrate these potential gains and the scale of the challenge.

The potential benefits to patients and taxpayers are widely recognised. Integrated care should be developed with and for patients, improving their access to care, their experience of care, the quality of their care and the outcomes they achieve. A recent review noted that integrated care aims to achieve a whole host of benefits for patients and taxpayers, including: coordinated packages of services to individuals; resolving the most complex care problems; reducing the impact of organisationalfragmentation; aligning services provided byall partners with the needs of patients; making better useof resources; and influencing the behaviour of the partnersin ways that none of the partners acting alone could achieve[1].

A third and synergistic benefit is improved job satisfaction for healthcare professionals staff from being able to deliver better care for patients, more team working, fostering a shared culture, better communication, and enhanced co-operation with other agencies[2] as well as from support and training to work in a more creative culture with partners[3].

Within eye care, there is widespread agreement on the need for better integrated care and a sector-wide initiative endorsed by RCGP (commissioningforeyecare.org.uk) to produce guidance for commissioners of eye care makes clear the benefits to patients and taxpayers.

People aged 60 and over are the largest group who have problems with their sight and are also the most frequent users of NHS services. Better integrated care can make it easier for this group to access care and improve their experience of NHS services when they do.

Many eye care conditions, such as glaucoma and age-related macular degeneration are themselves serious long term conditions where integration between primary and secondary care can deliver real benefits to patients.

Moreover,sight loss alongside other chronic conditions (co-morbidity) can reduce a patient's ability to self manage their health. People with sight loss who have a stroke, for example, often have poorer outcomes than those without sight loss demonstrating the need to integrate eye care services in to care programmes for what may seem more pressing conditions[4]. Diabetes and sight loss is a more obvious example of co-mobidity. People with learning disabilities are estimated to be ten times more likely to suffer full or partial sight loss[5] but the need to integrate eye care services in to regular health checks and care plans is often overlooked to the detriment of the patient. Similarly, sight loss is associated with a higher risk of falls so sight tests and eye care should be a part of falls prevention plans[6,7].

Lastly, eye care highlights the potential benefits of an integrated approach to public health. Over 2 million people currently live with sight loss, a significant proportion of which is preventable and, without action, this is set to rise by 22% by 2020 and double to approximately 4 million people by the year 2050[8]. Substantial health inequalities are visible in eye health as people who smoke or excessively consume alcohol, certain ethnic groups and those in more socio-economically deprived areas are all more likely to lose their sight. Challenges on this scale cannot be tackled without an integrated approach across health, public health, education, social care or involvement from the public, independent and third sectors.

2. What are the risks of integrated care? (p. 3)

The risks within eye care come not from integration itself but rather from the failure to overcome the barriers that prevent integration reaching its full potential. Due to the nature of the conditions, enhanced eye care services have concentrated on integration across primary and secondary care, specifically on moving services out of hospitals and in to the community with the aim of improving access to care and value for money.

The College of Optometrists and Warwick University recently completed a systematic review of these integrated schemes[9]. That review found that the integrated schemes were safe and of good quality, and that they could deliver better value for money, better access and high patient satisfaction rates. The review also found that an important factor in the success of integrated primary and secondary eye care schemes was effective communication between eye care professionals. Without this, it is all the more difficult for

integrated care schemes to succeed. Communication can be greatly improved by better IT connections (see question 11).

Another issue with integrated care is that in some instances (e.g. if outside of core competences) professionals may feel the need for additional or refresher training before taking on new roles. Similarly, agreeing on the need for training can help build the trust required for more senior clinicians to pass over responsibility for areas of care that will in future be delivered in partnership. For example, urgent eye care schemes may require ophthalmologists to deliver some training to local optometrists and for GPs to become familiar with the scheme so they can refer patients appropriately.

Contracting is another barrier that needs to be overcome and is explored in question 7.

3. What definition of integrated care do you believe should be used to inform policy decisions? (p. 1)

While we feel comfortable with both the Nuffield Trust and RCGP definitions, the following WHO definition strikes us as the most suitable: '*the organisation and management of health services so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money*'[10].

4. How can competition and choice of provider be reconciled with integrated care services? (p. 4)

Eye care can demonstrate how tensions between integration, choice and competition have been resolved to benefit patients. The evidence on integrated primary and secondary eye care schemes demonstrates they can improve access, value and patient satisfaction while at the same time increasing choice. Mixed NHS/independent optical practices work effectively and safely with their colleagues in hospitals and general practices. These integrated schemes improve care for patients and taxpayers.

To provide some brief context, ophthalmology is the second biggest specialty in the NHS for hospital outpatient attendances. The vast majority of these patients are referred in to hospitals eye services by some 12,000 community optometrists across the UK.

Community optical practices are, in the main, mixed businesses delivering nationally commissioned NHS eye examinations and spectacles plus any locally commissioned enhanced services alongside independent services to private patients. The optical market is highly competitive by government design and funding follows the patient. Any provider can apply for an NHS sight testing (GOS) contract if they meet established national standards, which allows the market mechanism to fill any gaps in provision. The cost of sight testing to the NHS is about £250 million for over 14 million NHS sight tests, with a further 6 million self funded by patients.

There is ample evidence that these integrated schemes improve access and are popular with patients. For example, to tackle long waits for ophthalmology outpatient appointments, the well established Glasgow Integrated Eyecare Service (GIES) allows GPs to refer eye problems to an accredited optometrist for management, treatment and ongoing referral to secondary care as appropriate. All referrals to GIES are seen within two weeks, 90% within four days and all referrals to the secondary sector were considered appropriate by the receiving ophthalmologist[11]. Over 99% of patients thought they had been seen quickly enough and 97% found it easy to get to the optometrists' premises[12].

An evaluation of the Primary Eyecare Acute Referral Scheme (PEARS) and the Welsh Eye Health Examination (WEHE) schemes found they had good equity of access with

87% of patients travelling less than five miles to attend their appointment with an optometrist[13].

Patient's also expressed satisfaction with the waiting times in Bristol's large shared-care glaucoma scheme. This improved access without diminishing diagnosis accuracy or treatment outcomes for patients and without increasing consultation costs relative to HES services[14,15,16].

There is also evidence that integrated schemes improve value for money. In Bexley, savings of 62% compared to NHS tariff were achieved using an enhanced glaucoma repeat measurement scheme where referring community optometrists performed repeat tests themselves prior to referral or non-referral[17]. In Stockport, a similar intraocular pressure refinement enhanced service showed a reduction in referrals for suspect ocular hypertension of 77% in the first year, and an overall cost saving of £61,000 per annum. Carmarthenshire's Glaucoma Referral Refinement Scheme reduced the number of patients attendingHES for suspected glaucoma by 53%, reduced waiting times for new and follow-up appointments, and saved £117 per patient[18]. The Welsh PEARS scheme achieved good outcomes for patients at a lower cost per consultation than the previous, less integrated scheme[19].

In recognition of the benefits of integrated working, the College of Optometrists and the Royal College of Ophthalmologists are co-chairing a Working Group with Sir Muir Gray's Department of Health Right Care team to produce clinical guidance for commissioners on how to integrate primary and secondary care to get the best value care. We are grateful to the RCGP for joining that group, which reflects the recognition across the three professions of the benefits of better integrated eye care services.

5. Who should make decisions about what integrated care services are required in a given area? (p. 5)

There is no need to reinvent the wheel across the country. A range of established national enhanced eye care pathways have delivered benefits for patients and the public purse (see response to Q4).

These demonstrate that within eye care, there is a clear role for patient groups, commissioners, professional bodies, and Local Optical Committees to work together, supported by national standards and pathways, to develop the right services for populations. For example, Optical Local Professional Networks are currently being set up and tested by a number of PCT clusters with a view to ensuring clinicians are linked to the NHS Commissioning Board, Clinical Commissioning Groups and Clinical Senates when they are in place.

The consultation document does not stress, as other RCGP documents do heavily, the valuable role patients should play in designing and evaluating services. We would support a leading role for patients in integrated care schemes.

Commissioners, on the back of their professional expertise, population needs assessments and Joint Strategic Needs Assessments, should have a firm foundation upon which to begin commissioning the right services for patients.

Professional bodies, such as the College of Optometrists and the Royal College of Ophthalmologists, can provide clinical guidance on service models and the outcomes and quality indicators commissioners should expect from good quality, good value services.

Local Optical Committees, which coordinate and lead optical practicesat local level, can deliver innovative, integrated care eye care services systems to agreed national standards and guidance and that meet the population's eye health needs.

The consultation document raises concerns about conflict of interest when multiple parties contribute to the commissioning process. The experience from eye care is that such conflicts of interest arise already in healthcare and can be handled appropriately and transparently.

As highlighted in question 4, the eye care market is highly competitive and so there are no concerns about monopolistic power.

6. What role should providers take in developing integrated care services? (p. 6)

See answer to question 5.

7. How can models of payments be reformed to support integrated care? (p. 6)
Optometrists in England are paid under the national General Ophthalmic Services contract to deliver NHS sight tests.GOS services, while delivered to a single national contract, are currently remunerated by PCTs, which we argue is wasteful and inefficient, and diverts NHS and provider resources from delivering frontline care. We have been making the case to the DH that GOS claims and payments should be overseen by a single centralised national authority, as has long been in place for community dentistry and pharmacy. We are also working with our colleagues in dentistry and pharmacy to deliver electronic patient signatures for NHS claims and payments which might also have a role in supporting integrated care.

Any services beyond the GOS, for example integrated shared care glaucoma schemes or urgent care for minor eye conditions, are commissioned locally by PCTs. These are underpinned by a patchwork of contracts which hinders the development of integrated care. For example, optometrists near PCT boundaries may have a contract to treat urgent minor eye conditions for patients from one PCT but not for patients from the neighbouring PCT, resulting in postcode lotteries. Different PCTs may have different payment procedures too which can increase costs to the optometrists and reduce the incentive to join integrated care schemes.

There is now sufficient evidence to warrant the establishment of two nationally commissioned enhanced eye care services for England as soon as possible:

- Glaucoma repeat measurements (now in place in 50% of PCTs after a slow process to spread innovation)[20,21]
- Primary Eyecare Acute Referral Scheme (PEARS) in the community (now in place in less than10% of PCTs despite being in place across Wales since 2003 and promoted by NHS Primary Care Commissioning)[22].

These services could be endorsed by NICE or commissioned nationally by the NHS Commissioning Board. Immediate roll out of these services nationallycould demonstrate benefits for patients, while freeing hospital capacity to focus on those facing acute sight loss.

8. What leadership and management skills are required to develop integrated care services? (p. 7)

9. What are the risks and opportunities of involving nurses, specialists and Allied Health Professionals from providers in the commissioning of integrated care? (p. 7)

Please see answer to question 5. We believe there are opportunities from involving providers in the commissioning of integrated care and these should be delivered through structured engagement with Local Representative Committees (in our case Local Optical Committees) via the Local Professional Network. For example, the fact that sight loss is associated with a much greater risk of falls illustrates just one potential benefit from integrating healthcare professionals in eye care and domiciliary care.

What risks there are can be effectively mitigated by commissioning in line with tried and tested national pathways and by involving professional bodies (such as the College of Optometrists and the Royal College of Ophthalmologists) to provide clinical expertise in the patient interest.

Where conflicts of interest do arise, then they can be handled transparently.

10. What impact will the abolition of GP practice boundaries have on the commissioning and provision of integrated care? How might these problems be resolved? (p. 8)

11. What do you need from information systems to support integrated care, and how should they be funded? (p. 9)

In common with community dentists and pharmacists, optometrists find IT connections with the NHS a significant barrier to integrating care. What is needed is a simple, secure channel to transfer information between primary and secondary care.

As noted above, integrated (enhanced) eye care schemes are currently commissioned locally by PCTs. Some PCTs however have insisted that optometry practices have a full N3 connection to share any patient data electronically. We feel that is disproportionate to the data security risks involved and our optical providers already take data protection seriously. Moreover, the expense and unsuitability of this approach has hindered the development of integrated eye care schemes. The problems of one size fits all approach were highlighted by the Public Accounts Committee[23].

The intractability of IT problems requires a joined up solution and we have called on the Department of Health, the National Commissioning Board and NHS Connecting for Health to work with IT leads from community dentistry, optics and pharmacy to find one. Such a solution would make integrating primary and secondary eye care much simpler and more effective.

Another example of how better communication can help integrate care is that optometrists rarely get feedback from ophthalmologists on the outcomes of the referrals they make to hospital eye services. That is despite guidance from both professional bodies that feedback can improve quality of care in integrated schemes and reduce the number of unnecessary referrals for patients and commissioners[24,25]. Anecdotally, ophthalmologists usually report that this is due to IT problems or the fact that feedback cannot be sent electronically, with postal feedback being prohibitively time consuming and expensive. Simple electronic solutions would also enable images to be sent between care providers, as already happens in some areas (e.g. Fife).

Electronic referrals can improve communication between primary and secondary care services and may reduce hospital admissions. An evaluation of the use of electronic referrals in Fife, found that only 63% patients who were referred electronically required

admission to hospital eye services compared to 85% of patients who were referred through the traditional route[26]. This may be because of the extra detail that can be sent electronically.

12. How might outcomes measures be used to support integrated care? (p. 11)

The College of Optometrists and Royal College of Ophthalmologists are working together with the Department of Health Right Care team and the RCGP to develop the outcome measures and quality indicators commissioners should expect from good eye care services for the major eye conditions.

As detailed in answer 5, we believe there is a role for professional bodies, patient groups, and providers through Local Optical Committees to support commissioners to help shape and deliver integrated services which can best contribute to those outcome measures.

The UK Vision Strategy and the Optical Confederation,together with the two Colleges,have been working with the Department of Health to explore how an eye health indicator could be included in the Public Health Outcomes Framework due to be published this autumn. The proposed indicator would measure the number of people registering as blind or partially sighted as a result of: age-related macular degeneration, glaucoma, cataracts and diabetic retinopathy. This is an excellent example of how an outcome measure could align services across primary care, secondary care and public health to encourage a population approach to tackling health inequalities.

13. How can integrated care help to reduce health inequalities? (p. 11)

As noted in answer 1, eye care is a major public health challenge. Without action, the number of people with sight loss will double to 4 million by 2050[27]. Most of this sight loss is preventable, particularly amongst older people[28]. There are also significant health inequalities in ophthalmic public health. Smokers have triple the incidence of AMD (the biggest cause of blindness in the UK) compared with non-smokers[29] and smoking is strongly associated with cataracts[30]. People in poorer socio-economic groups are more likely to suffer from poor ophthalmic health and less likely to access services[31,32].

Public health could also be significantly improved by integrating health and domiciliary care for populations of older people with sight loss, in particular those who are also frail or suffer from dementia. This population has been much overlooked. Research from the Thomas Pocklington Trust have found that a lack of domiciliary means there is unmet need to enable people to leave their homes or carry out even small tasks like changing light bulbs. This leaves older people with sight loss isolated and undermines their ability to live independently in their own homes and, in some cases, their will to live [33 34 35]. Visually impaired older people are more likely to experience poorer physical health, less economic well-being and engage in less social and civic participation leading to low quality of life and poor psychological well-being[36]. Visual impairment is associated with a significant increased risk of falls and as well a reduced ability to live independently[37].

Some of these health inequalities can be tackled by nationally commissioned public health campaigns, to reduce smoking for example. Others, those rooted in socio-economic deprivation, require integrated solutions that go beyond health and social care.

CCGs can more easily take real leadership in tackling ophthalmic health inequalitieslinked to ethnic and older populations. The key to uncovering avoidable sight loss is regular sight testing, and there is a health promotion role for CCGs in areas with significant numbers at risk of sight loss (as above older people, ethnic minorities, and lower socio-economic groups).

CCGs also have a role in ensuring adequate eye care services to meet the population's needs, for example those with a large African-Caribbean population may find there is significant unmet need for glaucoma services. The CCG could take leadership to develop targeted prevention and early detection programmes and at the same time bring optometrists and ophthalmologists together to develop more accessible, better value schemes for monitoring and treating at risk patients. There could also be benefits to integrating glaucoma patients' health care with social care via the Joint Health and Well-Being Board. A population with a large number of elderly patients with sight loss from glaucoma could have a high number of fractures from falls and integrating low vision services in to falls prevention would be particularly rewarding.

14. **How can integrated care services prevent silo working? (p. 12)**

15. **Are there any other important issues not identified above?**

16. **How can the RCGP help to ensure that integrated care services are developed in the future?**

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