Caring for our future - Shared ambitions for care and support (Department of Health)

Introduction

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 support services and advice for Local and Regional Optical Committees across England and Wales. LOCSU has worked with a team of clinical experts over the past few years to look at models of successful enhanced services across the UK and has developed a suite of enhanced service pathways that use the core skills of optometrists to provide care in the local community for patients with particular eye problems such as low vision and glaucoma.

The Optical Confederation represents the 12,000 optometrists, 6,000 dispensing opticians, 7,000 optical businesses and 45,000 ancilliary staff in the UK who provide high quality and accessible eye care services to the whole population. As a Confederation we work with others to improve eye health for the public good.

Thank you for inviting our comments on this consultation. We are responding from the perspective of providers of eye care services (sight testing, provision of optical appliances, and low vision services) and eye care professionals, both in the High Street and the home (ie domiciliary provision).

We welcome the review of social care and the core objectives of improving choice, developing the workforce, promoting quality, early intervention and personalisation of services.

From our experience there is insufficient integration of eye care services across primary, secondary and social care. We should all work together as we believe we share the common goals of improving sight and reducing dependency, preventing avoidable sight loss and providing for the needs of individuals who suffer from sight loss.

It is important that the many health and social benefits which flow from the provision of eye care are recognised. The dispensing of spectacles may improve someone's quality of life and independence, for example by assisting with reading mail, even eating at mealtimes, which could in part reduce the need for care and support.

Visual impairment carries a substantial social and human cost which can shorten life, increase the risk of other health conditions, restrict social participation and independence, and impair physical and mental health. The total cost to society of blindness was estimated at £22 billion in 2008.[1] Sight loss is also projected to double by 2050[1], although according to RNIB half of this is estimated to be avoidable through early intervention and diagnosis. Even modest reductions in avoidable sight loss would therefore result in significant health and social functioning and well-being gains and savings in health and social care expenditure over the lifetime of this Parliament and in the future. Older people receiving social and nursing home care are often excluded from eye health and vision services. There is unfortunately widespread ignorance about the availability of NHS funded domiciliary sight testing among the public, non-optical healthcare professionals and social care, home-helps and care home staff. If a person is unable to get to a high street practice due to a physical or mental condition, they can have a domiciliary sight test in their place of residence. We would be very grateful if information about the availability of domiciliary sight tests were provided to individuals (and social care workers) as part of the proposed package of information and advice (cf Dilnot Commission Findings) to help when care needs arise.

We support the Law Commission's view that local authorities are best placed to provide this information, advice and assistance. We would welcome a recommendation that information about eye care services be supplied by local authorities and health and well-being boards.

We are also very pleased that the Law Commission has proposed that the requirement for local authorities to establish and maintain a register of blind and partially sighted people should be maintained.[2] Registration is in many cases a gateway for individuals with sight loss to receive support from social care services, and therefore a key anchor about which to integrate services.

We are also responding with some thoughts on how better to promote integration between eye care services with social care.

As not all questions are relevant to our experience, we have only responded to those questions below where we feel that we have value to add.

[1] Access Economics (2009) *Future sight loss UK (1): The economic impact of partial sight and blindness in the UK adult population*
[2] Law Commission (2011) Law Com 326 Adult Social Care

1. What are the priorities for promoting improved quality and developing the future workforce?

a. Should there be a standard definition of quality in adult social care as quality can often be interpreted differently? What do we mean by it and how should it be defined? How could we use this definition to drive improvements in quality?

Answer: We have found that in the provision of eye care services, it has been helpful to have nationally agreed quality standards, and we expect social care would benefit from the same. Clear and proportionate definitions of quality could be used to manage contracts with social care providers, who we expect would also benefit from consistent national standards.

When developing the workforce in order to join up with eye care services this could be as simple as raising awareness among the social care workforce of the benefits of regular sight testing and the availability of free NHS provision. When a social care worker encounters an individual who is struggling to read or see something, they should also be trained to check that they have the correct spectacles and ask when they had their last sight test.

b. How could the approach to quality need to change as individuals increasingly fund or take responsibility for commissioning their own care? How could users themselves play a stronger role in determining the outcomes that they experience and designing quality services that are integrated around their personal preferences?

Answer: The model in operation in primary eye care is mixed (i.e. NHS and private) provision where providers, operating to a common set of standards, compete on the basis of access, price and quality. This has the advantage that our patients, both public and private, are reassured that providers are operating to agreed standards of provision. There might be lessons from this model for social care.

c. How could we make quality the guiding principle for adult social care? Who is responsible and accountable for driving continuous quality improvement within a more integrated health and care system?

Answer: As above we feel that proportionate and clear national minimum standards would make quality a guiding principle among providers, commissioners, services users and representatives of service users.

d. What is the right balance between a national and local approach to improving quality and developing the workforce? Which areas are best delivered at a national level?

Answer: From our experience we find that a national approach to developing and commissioning care and pathways can drive quality at all levels. This can then be supplemented by local flexibilities to fine-tune services to local population needs.

e. How could we equip the workforce, volunteers and carers to respond to the challenges of improving quality and responding to growth in demand? How could we develop social care leadership capable of steering and delivering this?

Answer: We would suggest that training programmes for social care staff include information about the importance of regular sight testing (to assist in preventing avoidable sight loss), and the particular needs of and challenges for individuals who have lost their sight which impact significantly on quality of life. Social carers and volunteers are well placed to pick up signs that an individual has problems with his or her sight, and to refer to an appropriate eye care professional.

f. How could we improve the mechanisms for users, carers and staff to raise concerns about the quality of care? How could we ensure that these concerns are addressed appropriately?

Answer: In primary eye care there are a number of methods by which our patients can raise concerns, depending on the nature of their concern. Nationally, we have the Optical Consumer Complaints Service (OCCS), our regulator (GOC), and national representative bodies that can assist in mediation. Many patients prefer to raise the matter with the service provider directly, or with the provider's head office. There are also local NHS officials to whom matters can be raised. We find that having a range of options for patients to pursue works well. From the patient's perspective he or she can choose the method most appropriate for their circumstances and can decide whether the concern was addressed appropriately. There should be a similar range of "concerns gateways" in social care.

2. What are the priorities for promoting increased personalisation and choice?

a. How could we change cultures, attitudes and behaviour among the social care workforce to ensure the benefits of personal budgets, including direct payments, are made available to everyone in receipt of community based social care? Are there particular client groups missing out on opportunities at the moment?

Answer: From our experience the correct ethos and behaviours should be embedded in all training, job descriptions and performance appraisals from the outset. The instillation of professionalism is core to delivering the benefits outlined above.

b. What support or information do people need to become informed users and consumers of care, including brokerage services? How could people be helped to choose the service they want, which meets their needs and is safe too? How could better information be made available for people supported by public funds as well as those funding their own care?

Answer: We feel that complementary messaging from public, private and third sector organisations is important to provide support and information to allow people to choose the service most appropriate for their needs.

c. How could the principles of greater personalisation be applied to people in residential care? Should this include, as the Law Commission recommends, direct payments being extended to people [supported by the State] living in residential accommodation? What are the opportunities, challenges and risks around this?

Answer: Not applicable to our response.

d. How could better progress be made in achieving a truly personalised approach which places outcomes that matter to people, their families and carers at its heart? What are the barriers? Who has responsibility and what needs to change (including legislative)?

Answer: Not applicable to our response.

3. How can we take advantage of the Health and Social Care modernisation programme to ensure services are better integrated around people's needs?

a. What does good look like? Where are there good practice-based examples of integrated services that support and enable better outcomes?

Answer: 'Good' care must be responsive to the individual's needs and deliver good outcomes in a timely and cost-effective manner.

In eye care, primary care and secondary care are working with the third sector to deliver and implement a series of tried and tested pathways that facilitate integrated care. We have a number of examples of this which we can make available on request.

We are also developing community-based (enhanced) eye care pathways seamlessly to join up eye care with social care and support services. Our Local Optical Committee Support Unit (LOCSU) has developed the Community Optical Pathway for an Adult Low Vision Enhanced Service precisely for this purpose which aims to signpost patients with low vision to local care services that are appropriate for their needs.[3] A further pathway for People with Learning Disabilities is in development including with social care colleagues.

b. Where should services be better integrated around patients, service users and carers – both within the NHS, and between the NHS and local government services, in particular social care (for example, better management of long term conditions, better care of older people, more effective handover of a person's care from one part of the system to another, etc)?

Answer: It is important that all aspects of health and social care work together around the individual client. One way of ensuring that eye care needs are better integrated into other health and social care services is by ensuring that the eye health needs of the local population are reflected within the Joint Strategic Needs Assessment (JSNA)

We feel that there are three specific areas within eye care could be important lead areas for change and integration between the NHS and social care.

1. The first is provision of services for people with low vision, which is at best patchy across the country. The majority of patients who suffer from sight loss are older people (and many of them are users of social care services). Low vision services can dramatically improve these individuals' quality of life and increase their independence. We would welcome the support of local government and social care to ensure that people with low vision (who are also care service users) are aware of and referred to local low vision services when appropriate.

[3] http://www.locsu.co.uk/enhanced-services-pathways/low-vision/

Good low vision services include elements of health care, social care and third sector support. Each professional delivering part of the service must know what the others do and how their services can join up to benefit the user. As stated above the Local Optical Committee Support Unit (LOCSU) has developed a pathway designed to join up the provision of low vision aids with rehabilitation assessments and local support (e.g. emotional or mobility support) as appropriate for the patient's needs. Given that one of the biggest barriers for low vision patients is access to information, the LOCSU Community Optical Pathway for an Adult Low Vision Enhanced Service has been designed so that professionals providing the service act as 'signposts' for service users telling them what services are available in the area and how to access them. We would be willing to work with all parties to ensure that this joined-up approach can be delivered for low vision services.

2. The second area is in respect of falls. Evidence shows that the provision of sight correction needs to be an integral part of a falls prevention service among the elderly. Studies have shown that falls can be reduced by as much as 14% by treating visual impairment including uncorrected vision as part of a falls reduction plan.

   In 1999, 189,000 falls requiring hospital treatment occurred in individuals with visual impairment of which 89,000 were attributed to the visual impairment itself at an estimated cost to the NHS of £128 million.[4] Reducing the number of falls attributable to visual impairment will also help more people to stay active, independent and less reliant on social services.

   As many who access social care services will be in the higher risk category for falls, we would welcome the inclusion of training about the risks of uncorrected (and indeed poor) vision where appropriate in (national and local) training and awareness initiatives that aim to prevent falls among the elderly population.

3. Another area that would benefit from a more joined up approach is sight testing for people with learning disabilities (PwLD). LOCSU is currently developing a national pathway which takes the best elements from those areas where an enhanced service for PwLD is currently available. This national pathway also aims to signpost to other local services (modelled on the approach taken by the Community Optical Pathway for an Adult Low Vision Enhanced Service). PwLD have very specific eye care needs, they are more at risk of sight loss and have often significant levels of uncorrected refractive error. It would be very helpful if social care workers who support people with PwLD also had a general awareness of the benefits of regular sight testing. The dedicated charity SeeAbility has developed some very

[4] Scuffham, PA, et al. The incidence and cost of injurious falls associated with visual impairment in the UK. Visual Impairment Research 2002; 4 (I) 1-14.

useful information and tools for people with learning difficulties and their carers for these purposes available from its website.[5]

c. How can integrated services achieve better health, better care and better value for money?

Answer: As above provision of low vision services can significantly improve the quality of life for individuals that suffer from sight loss, for example with reading, watching television and other social functioning and participation.

Including vision as a core element within a falls prevention service would obviously improve the quality of life for those for whom a fall is avoided. Moreover where falls have been prevented, this delivers significant downstream cost savings.

d. What, if any, barriers to integration should be removed, and how can we incentivise better integration of services at all levels?

Answer: In our experience, the main barriers to integration are lack of awareness of the benefits of integration, and that policy, pathways and the professions themselves have traditionally been developed in 'silos'.

We can all do a lot more to promote integration between health and social care, and we would be happy to support this nationally via the Optical Confederation and LOCSU, and regionally/locally through our Local Optical Committees which have a presence across the whole of England and are available to liaise with and support local government.

We would be very grateful if one output of this consultation is to promote the benefits of integration with eye care services to our colleagues in local government, communities and social enterprises.

PCTs and local authorities have powers to pool funding for areas for which they have joint responsibility. There is a disappointing lack of use of pooled (NHS and local authority) budgets to support individuals with visual impairment, for example to deliver targeted and joined-up support. We would suggest that a lead area for joined up commissioning should be low vision services (please refer to our response to Q3(b) for further details).

e. Who needs to do what next to enable integration to be progressed in a pragmatic and achievable way?

[5] http://www.seeability.org/our_services/

Answer: We expect the first steps need to be taken by national and local government, and as above we are ready to support and assist at national and local level with the integration of eye care services in any way we can.

f. How can innovation in integrated care be identified and nurtured?

Answer: From our experience in eye care we have found that the spread of innovation has been hindered by the lack of endorsement of national pathways, overly bureaucratic requirements e.g. IT, and lack of understanding on all sides of the benefits of and possibilities for innovation and integration.

Please refer to the examples we have identified above on integration between eye care and social care. As above we feel training and awareness (among local government, commissioners and social care workers) including how best to engage with health care professionals and vice versa is key to nurturing and spreading these innovations.

4. What are the priorities for supporting greater prevention and early intervention?

Answer: The costs of avoidable sight loss are very substantial and the majority impact heavily on social care budgets. We would argue that the key to reducing visual impairment is early detection and every effort should be made to publicise the benefits of regular sight testing, as a core part of any prevention strategy.

a. What do good outcomes look like? Where is there practice-based evidence of interventions that support/enable these outcomes?

Answer: Please see our response to Q3(a) and Q3(b).

b. How could organisations across the NHS and Local Government, communities, social enterprises and other providers be encouraged and incentivised to work together and invest in prevention and early intervention including promoting health and wellbeing?

Answer: In order to work together effectively, there needs to be a greater awareness of the key players locally and where to go for advice on integrating care. Across England there is a range of local representative committees which can assist local government, communities and social enterprises to invest in prevention and early intervention, as appropriate for that local population's needs.

The provision of information about this local clinical support is an important first step to working together. To facilitate joint-working across the boundaries of health and social care, we have developed a guide to engaging with local healthcare contractors and practitioners (in partnership with our colleagues in dentistry, general practice, and pharmacy with the support of the Local Government Association).[6]

It would be very welcome if one outcome of this consultation were to be to make this guide widely available to colleagues in local government, communities and social enterprises through official channels.

c. How could we change cultures and behaviour so that investment in prevention and early intervention is mainstream practice rather than relying on intervention at the point of crisis? How could we create mechanisms that pay by results/outcomes?

Answer: In eye care, regular sight testing is key to early detection and prevention of avoidable sight loss. According to RNIB estimates, 50% of sight loss is avoidable if detected early. It would be very helpful if this were more widely understood. We work in association with our colleagues in the eye care sector to get this message across through awareness campaigns. Our efforts can only go so far, so we would

[6] http://www.epolitix.com/fileadmin/epolitix/stakeholders/Engaging_with_primary_healthcare_professionals_to_improve_the_health_of_the_local_population.pdf

be very grateful if this message were also delivered via local government, social care and health and wellbeing boards.

We would be happy to assist if you would like further information about the importance of regular sight testing.

d. How could individuals, families and communities be encouraged to take more responsibility for their health and wellbeing and to take action earlier in their lives to prevent or delay illness and loss of independence? How could we promote better health and wellbeing in society?

Answer: Individuals, families and communities have a key role to play. With respect to eye care, it would be very helpful if these groups were also aware of the benefits of regular sight testing and the eligibility of free NHS sight testing for those on low incomes and in higher risk groups eg people with diabetes, people with a relative with glaucoma etc. As above, we would recommend that these messages be included in the package of information and advice to help when care needs arise.

LOCSU will be hosting a virtual Ophthalmic Public Health Network soon to bring together the small but growing number of people working on or interested in ophthalmic public health across the UK in order to enhance the position of ophthalmic public health in the context of reforms to the NHS. This network provides an opportunity for organisations across the NHS and Local Government, communities, social enterprises and other providers to share ideas and evidence of eye health prevention and early intervention initiatives, including promoting health and wellbeing.

e. How could innovation in prevention be encouraged, identified and nurtured?

Answer: As above for eye health and visual independence the key is regular sight testing and access to interventions and treatment (when required).

5. What are the priorities for creating a more diverse and responsive care market?

Answer: We do not feel we have anything to add to this section.

6. What role could the financial services market play in supporting users, carers and their families?

Answer: We do not feel we have anything to add to this section.

7. Do you have any other comments on social care reform, including the recommendations of the Commission on Funding of Care and Support?

Answer: In our view, the recommendations made with respect to funding social care seem fair.

a. What are the strengths and weaknesses of the Commission's proposals in addressing the problems of the current system? What are the priorities for action coming out of the Commission's report, including in relation to other priorities for improvement in the system?

Answer: As stated above we fully support the recommendation for a major information and advice strategy to help when care needs arise. There are important messages about prevention of avoidable sight loss and where those who have suffered sight loss can go to for support that we would like to see included in the information packs. We are available to assist with any of this work, e.g. to suggest appropriate wording and sign-posting initiatives.

We also welcome the recommendations about integration with other (health) services, and we would be pleased to assist in making this a reality, both nationally and locally.

b. What are the implications of the Commission's proposals on other areas of care and support reform?

Answer: We believe that we and other parts of the NHS have a key role to play to ensure seamless integration of services and we are open to suggestions about what we might also improve eye care services across the board and in both sectors.

c. The Commission presented a range of options in relation to some of their recommendations, which would affect the balance between the financial cost to the individual and the taxpayer. These include:
• the level of the cap
• the contribution that people make to their living costs in residential care

What would be the implications of different options on the outcomes that the Commission hoped to achieve?

Answer: Not applicable to our response.