Optical Confederation response to *Enablers and Barriers to Integrated Care and Implications for Monitor*

The Optical Confederation welcomes the opportunity to comment on the Frontier Economics report, "*Enablers and Barriers to Integrated Care and Implications for Monitor".*

The Optical Confederation represents the 12,000 optometrists, 6,000 dispensing opticians, 7,000 optical businesses and 45,000 ancillary staff in the UK, who provide high quality and accessible eye care services to the whole population. The Confederation is a coalition of 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.

This is a helpful report. Monitor is to be congratulated for adopting an "evidence based" approach, for approaching its functions in such a systematic way and for providing further opportunities to comment on your plans.

Monitor as "enabler"

We are pleased that the Health & Social Care Act 2012 defines Monitor's duties in respect of "integrated health care and integrated health and social care" as "enabling" rather than directive.

We also welcome the fact that the Frontier Economics report recognises that, despite its very wide powers, Monitor's role might sometimes best be discharged by not taking any action e.g. on page 55 "These [actions Monitor could and should take] largely consist of trying to ensure that Monitor's actions do not create barriers to integrated care".

This is particularly so in the case of community eye care services where, as we have previously argued strongly

- providers are already more than adequately regulated
- to bring then within additional regulation by Monitor would be unnecessary, duplicatory and simply add to costs
- on these grounds, Ministers should exempt community optical providers from Monitor regulation under Sections 83 and 84 of the Act.

Together with the other primary care professions (community pharmacy, general dental services and hearing care) we have recently written to the Secretary of State to make this

case even more strongly. The British Medical Association also supported the general principles of this letter.

Community Eye Care Services

In the case of community eye care provision, uniquely within the NHS, patients have a very wide choice of provider in all localities. They have complete autonomy to go to the provider of their choice for a sight test or other eye care; to change that provider at will; and to go to another provider of their choice for the provision of optical appliances such as spectacles contact lenses following a sight test.

Operating in a genuinely open and highly competitive market, NHS funding directly follows each patient in the form of fees paid per service provided, and community eye care providers have, over many years, competed vigorously for each and every patient on the grounds of access, quality, choice and cost. There are no barriers to market entry or exit. This means that competition thrives in the sector with an emphasis on meeting the needs and wishes of each patient in a way that does not apply in other areas of NHS care.

Community eye care providers are already highly regulated by our own, sector specific, independent regulator, the General Optical Council (GOC), as well as normal business regulation such as the Companies Act, Office of Fair Trading, Advertising Standards Agency etc and, as noted above, we argue strongly that the imposition of further regulation through Monitor would be duplicatory, add to costs, diminish efficiency, reduce competition and ultimately reduce patient choice.

For further information please see our previous submissions to *Developing the General Licence Conditions 1 and 2*, submitted in January and March 2012, available online at http://www.opticalconfederation.org.uk/resources/consultations.

Integrated Care

Within community eye care we already have very clear arrangements for integrated care. As described above, all the care we provide is "patient-centred" and the national regulations provide very clear rules for patient handover. To illustrate:

- following a sight test, a patient is either given a prescription which they can take anywhere to have dispensed or a statement that no prescription is necessary
- if the patient is referred to another clinician, s/he is given a copy of the referral information and their GP is informed
- patients have access to their eye care records under normal NHS rules
- under the terms of their professional registration, optometrists, contact lens opticians and dispensing opticians have to make the care of the patient "their first and continuing concern"[1]
- businesses enrolled with the GOC using the protected titles of optometrist or optician are required to ensure that their clinical staff can comply with these professional duties[1].

[1] General Optical Council *Code of Conduct for Individual Registrants 2005 (as amended)*

The sector provides over 21 million sight tests per annum[2] with very few adverse outcomes or complaints about service quality, and none, as far as we can identify, about service integration.

New Mechanism – Local Eye Health Networks

As a sector, we have very much welcomed the announcements by the Department of Health & the NHS Commissioning Board Authority that

- Local Eye Health Networks will be established in all areas in England
- Local Eye Health Networks will be an integral part of the NHS Commissioning Board (NHS CB) structures at local level.

The aim is that Local Eye Health Networks will engage the active involvement of all local partners including Local Optical Committees, community optical practices, hospital colleagues, patient groups, Health and Wellbeing Boards, commissioners and the voluntary sector. The specific aims of these networks will be to improve eye health, streamline and integrate eye care pathways, reduce costs, improve outcomes and deliver the national eye health indicator. In line with Goodwin's and Kodner's terminology[3] (quoted page 15) we fully support the view that Local Eye Health Networks should be "both 'patient-centred' and 'population-orientated'.

Local Eye Health Networks are thus explicitly designed to be towards the "Informal networks and working arrangements" end of the spectrum (page 6) and to be consistent with the key messages on page 52 viz

- "Monitor is just one actor in the system
- commissioners are likely to play a lead role in achieving integrated care
- to remove any of the barriers …….will require the involvement of multiple stakeholders working in parallel."

They are thus the very embodiment of the solution to barriers to integration identified in the case studies on page 42 ie "a combination of local commissioners and providers [which] have come together in order to try to overcome some of the barriers identified" and as exemplified by Productive Nottinghamshire "collaborative working between commissioners, providers and Local Authorities" (page 42).

Crucially from our perspective the report goes on to note at page 42 that "none of the cases [reviewed] required an intervention of a *sector regulator*, the definition of new currencies or other central measures" (our italics).

We would also strongly support the conclusion of the King's Fund - Nuffield Trust report to the Department of Health (quoted page 31) that

> "Integrated care is a process that needs time to embed locally."

[2] Optics at a Glance 2011
[3] Goodwin N Kodner D *Passing the Inkblot test: towards a standard definition of integrated care,* International Journal of Integrated Care (forthcoming)

It follows from both these pieces of evidence that we believe that no new regulatory intervention is required by Monitor (or any other agency) in respect of integration in community eye care until Local Eye Health Networks - this new part of the NHS architecture - have been given time to become established, bed down and deliver results.

As providers we stand ready to work through Local Eye Health Networks to break down any silos where they exist, standardise practices, improve coordination, develop clarity over clinical responsibilities and champion successes in integrated eye care.

Patient Choice

Inevitably, many of the studies cited in the Frontier Economics review had been designed for or from a management rather than the patient perspective, e.g. to reduce bed days, facilitate early discharge, etc.

We were pleased therefore to see explicit recognition in the study that:

- "more integrated care is not always the right answer to improving the patient's experience and the system efficiency" (page 15)
- patient freedom of choice "can create deviations from the planned pathway of care and may cut across attempts to provide integrated care" (page 29)
- "one factor complicating integrated care is **patient choice** itself. While it is desirable...their choice may go out of the integrated pathway that has been created" (page 34).

We have already addressed these issues within the community eye care sector and, on balance, believe that the benefits of patient choice – even where this provides some interruption in continuity of care – outweigh the rigid confinement of patients to pre-established pathways in that this enhances patient autonomy, offers choice of provider and encourage patients to take responsibility for managing their own care.

In such circumstances, it is the system which needs to respond to patient choice, not the patient to the system (as long as there are no gaps in the system for patients inadvertently to fall through). The solutions here of course lie in information for individuals and good record keeping.

In our sector, under the existing regulatory system, community eye care providers (including providers of private sight care) already meet these standards. Under national regulations they are required both to

- issue patients with a copy of their prescription at the end of their sight test (or a statement that they do not require vision correction)
- keep appropriate records.

Patients can then choose any other provider of their choice for their provision of contact lenses, spectacles, low vision aids etc.

We do not believe that any further regulation is required in this regard in our sector.

Entitlements to care

We would also support the patient plea (cited by National Voices on page 17) that patients should not lose entitlements to care if they cross geographical boundaries.

It is for this reason that we are arguing strongly that certain Primary Ophthalmic Services enhanced services (which are part of normal community optical care such as glaucoma referral refinement and minor emergencies) should be designated by the NHS Commissioning Board as Primary Ophthalmic Service "additional services" for all CCGs to commission in their areas according to local needs.

Service user reported experience measures

As a sector we have previously welcomed the recommendation of the NHS Future Forum report (quoted p 30) that "a new generation of service user reported experience measures that evaluate service users' experiences across whole journeys of care, and within and between services is needed".

To this end, we would support the adoption of outcome measures defined by blind and partially sighted service users themselves *Seeing it My Way*[4] launched at the UK Vision UK 2012 Conference on 12 June 2012.

Again these 'service user reported outcome measures' should be implemented through Local Eye Health Networks by incorporation into local service specifications adapted to their own circumstances rather than by further regulation.

Information is key

We agree with the finding of almost every study cited that information is key, particularly at patient handover.

Like the GPs involved in diabetes care (quoted on page 61), optometrists and opticians "are rarely given sufficient information about ... patients once they have been treated in secondary care even [where they will then] play a crucial role in co-ordinating the ongoing care of those patients."

This is not the fault of secondary care clinicians who are under extreme pressure in acute care settings but rather a system defect and in particular the absence of simple electronic referral and feedback links between the hospital eye service, optical practices and the patient's GP.

Patients do of course sometimes bring copies of their discharge letters back to their optical practice (copies of which can be taken for community optical records for future care) but this is far from universal and, as noted above, patients have complete choice of which optical provider they return to for any necessary continuing care, so they may not return to the original referring practice.

It is vital therefore that, in order to improve integration and ensure high quality referrals, clinical referral and feedback is provided for in a simplified electronic way so that community

[4] http://www.vision2020uk.org.uk/ukvisionstrategy/ (last accessed July 2012)

and hospital eye care information can be joined up, rapidly transferred, and used to deliver more efficient services and better patient outcomes.

We welcome the recognition that legal rules on information governance and data protection have created a constraint on effective integration. In our view, while such information governance rules have a role, they should be set proportionate to the degree of risk involved while facilitating simple but secure IT connectivity across a variety of formats, which we believe can be resolved through adequate funding and effective joint working.

The Scottish Government has already invested in such links and Wales, we understand, is gearing up to follow suit. Systems are already therefore in place to be copied and implemented. The Optical Confederation is already working with NHS Mail to see how that can provide the necessary links in England. Urgent progress in this area however is needed if the anticipated benefits of the Government's NHS reforms are to be realised. This is however a simple IT connectivity, not a regulatory, issue.

Summary

In summary, we welcome Monitor's systematic and evidence-based approach to developing regulation.

We reiterate our case that regulation by Monitor is not required in the community eye care sector which is already heavily regulated under existing regimes:

- regulation of registered professionals and enrolled bodies corporate by the sector-specific independent regulator, the GOC
- NHS contract and performer listing regulations and compliance frameworks
- the operation of eye care in a genuinely open and highly competitive provider market - unique in the NHS – where money directly follows the patient and practices have to compete for each and every NHS patient on grounds of access, quality, choice and price
- business regulation under the Companies Act and related legislation.

We describe the new NHS system of Local Eye Health Networks and argue strongly that these should be allowed to develop and deliver more integrated care, greater efficiency and improved outcomes before any further regulation is imposed. Such additional and duplicatory regulation would risk jeopardising the very objectives that Monitor and the NHS reforms are seeking to achieve.

Finally, we would be pleased to be involved in any further work on the integration agenda and would be happy to participate in workshops and seminars as well as further consultations to bring our experience of open market regulation to the system Monitor is seeking to develop.

We are happy for this response to be made public.

Submitted by

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