THE COLLEGE OF OPTOMETRISTS

Optical Confederation
The voice of UK optics

Our NHS care objectives:
A draft mandate to the NHS Commissioning Board

Thank you for inviting the Optical Confederation and the College of Optometrists to comment on the draft mandate to the NHS Commissioning Board.

Our responses to the consultation questions and some wider points are below.

Question 1.) Will the mandate drive a culture which puts patients at the heart of everything the NHS does?

Yes.

Community optical providers of course already do this. Like community pharmacies and, in future, NHS community based hearing care providers, we already operate in a genuinely open and highly competitive commercial market. Patients can go to any practice they like for sight testing and then, if they wish, somewhere completely different to obtain spectacles, contact lenses or other services. Each practice's income and survival depends on competing to satisfy each and every patient in terms of quality, access, choice and cost.

In addition all clinicians already have a duty to make the care of the patient their first and continuing priority.

What the Government's reforms - and this mandate therefore - are seeking to challenge and change are the institutional inertia and insensitivity of bureaucracy-driven commissioning.
We agree that putting clinicians together with public and patients at the heart of commissioning – and by this we mean all clinicians with CCGs drawing on the skills and experience of other professionals in their community, as well as patients and public - should begin to move commissioning (and therefore services) in this direction.

Q2.) Do you agree with the overall approach to the draft mandate in the way the mandate is structured?
Yes. This builds on existing frameworks and should therefore enable a smooth transition.

Q3.) Are the objectives right?
In the main, yes but we would like to make some additional comments.

<u>Mental Health, dementia and learning disabilities</u>

We particularly welcome putting mental health on a par with physical health and the particular emphasis on the growing public health burden of dementia (Objective 9). It is our experience that eye health issues such as uncorrected refractive error, incorrect spectacle

wear, undiagnosed cataract and the adverse effects these may have on the comfort, health and well-being of individuals with dementia, are often not taken into account by either carers or fellow health professionals working with dementia patients. This is particularly true of people living in some care homes and may also be true of other impairments such as poor hearing.

We would be keen to work with the Government to ensure that patients with dementia have their eye health and hearing needs assessed and professionally met in the same way as all other groups in society.

Within community eye care, we have been slightly ahead of the Government in tackling inequalities in access to care for disadvantaged groups. We have already published a community based eye health pathway for adults with learning disabilities developed with third sector partners[1] and are working on a similar pathway for local commissioning for people with autism (Paragraph 2.22).

We are also, through the UK Vision Strategy, working with Professor Steve Field and his team within the Department of Health to begin to address eye health and access issues for homeless people.

We look forward to continuing to work with the Department and the NHS Commissioning Board through the new Local Eye Health Networks (LENs) to ensure that eye health needs are properly assessed and services appropriately planned and delivered to meet those needs.

We are particularly concerned there is no mention in Objective 18 of the new Local Professional Networks (LPNs) and in our case LENs. We agree that the NHS Commissioning Board should support clinical networks and senates as a "highly-valued source of advice and insight to commissioners" (paragraph 5.7). We strongly suggest that the mandate should also include another indent in respect of the three LPNs for NHS dentistry, community pharmacy and eye health such as:

> "local professional networks for dentistry, community pharmacy and eye health practice are supported and developed to become a key resource to commissioners in assessing health needs and designing services to meet those needs at local level;"

Level Playing Field

We welcome the requirement (paragraph 5.15) that "re-configuration processes should reflect the principle of a fair playing field, ensuring that all potential providers have the opportunity to contribute to proposals for providing care to the local population." We hope this will apply to community eye health and eye care providers as this has not always been the case in the past.

It follows that we also support the principles that

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

- "pricing must support a fair playing field between providers and that improved payment systems " (paragraph 5.10)
- "improved payment systems should not be undermined by non-tariff payments, loans or subsidies" (paragraph 5.10)
- "money follows patients in a fair and transparent way that enables commissioners to secure improved outcomes" (Objective 19) although we would suggest amending this objective to say "that enables commissioners and providers to secure improved outcomes".

We do however feel that further guidance is necessary to the NHS on the meaning of a "fair and level playing field".

As hinted in the references to "non-tariff payments, loans and subsidies", the traditional NHS commissioning approach has often been to hamper competition so that inefficient providers are bolstered up and given an unfair advantage in order to compete with efficient providers. This cannot be in the public interest.

Q4.) What is the best way of assessing progress against the mandate, and how can other people or organisations best contribute to this?

The measurable outcomes should help, but it would also be worthwhile asking patient groups outside the system (in addition to Healthwatch, the third sector and professions working within the NHS) to what extent they believe the mandate objectives have been delivered. This could be in the form of a simple annual questionnaire to the major stakeholder representative bodies, e.g. patient interest, charities, medical Royal Colleges and other professional associations – with much of this consultation carried out by email.

Q5.)Do you have views now about how the mandate should develop in future years?
Yes ambitiously, but incrementally. As we have seen in the past, rapid changes of direction do no-one any good – least of all patients and the public. They simply send everyone scurrying off after a new set of objectives without delivering on the previous ones.

One area where we would like to see more progress is on clearer linkages between the three outcomes frameworks for the NHS, public health and social care.

Q6.) Do you agree that the mandate should be based around the NHS outcomes framework, and therefore avoid setting separate objectives for individual clinical conditions?

Yes. Clinical condition-specific objectives are more appropriate to the Public Health Outcomes Framework. However, as in our response to Q5, we believe there should be clearer synergy between the three outcomes frameworks (NHS, public health and social care) which still look as though they were developed at different times, by different people, for different purposes rather than as a coherent set of interlocking frameworks.

Q7.) Is this the right way to set objectives for improving outcomes and tackling inequalities?
Yes. We must use the system we have and the new duties in this respect on all parts of the system should help.

When health minister Earl Howe, addressed the All Party Parliamentary Group on Eye Health and Vision Impairment in December 2011 he made the point that if the Government were to include an eye health indicator in its forthcoming public health framework (which it did), this should be taken as shorthand for improving the eye health of all groups in the country. We welcome this.

Q8.) How could this approach develop in future mandates?
It is too early to say at this stage without seeing how the current mandate plays out in implementation.

Q9.) Is this the right way for the mandate to support shared decision-making, integrated care and support for carers?
Yes. However leaving the issue of carers aside and on the issue of integration more widely (paragraphs 3.5-3.18) there is no mention in the mandate of the important role for

- professionals and their professional organisations in leading thinking about what professionalism means in relation to integrated services (the Allied Health Professions have already started an important debate in this area)
- commissioners ensuring that integrated care is properly funded to ensure that it is effective.

Information & IT to drive improved care and better health outcomes (Objective 14)
Further, as we have said in response to our previous consultations under the *Liberating the NHS* programme, there is an urgent need for electronic links between community eye health practices, Hospital Eye Departments and patients' GPs. This should be based on a simple secure NHSmail system that facilitates cheap and affordable connectivity.

We support the White Paper *The Power of Information*[2] to the extent it supports these aims significantly better than any previous NHS information strategy. The policy however still has to be translated into action and we look forward to working with NHS Connecting for Health to achieve this.

We would like to add that in the past, inappropriately onerous information governance (IG) standards, often introduced in undue haste we think following unrelated government breaches of data security and which community providers cannot possibly aspire to, have precluded these essential links that are key to integrating care around patients and improving health outcomes (paragraph 3.11). We are pleased to see that – at long last – a more enlightened approach is being taken and look forward to working with NHS *Connecting for Health* to take this forward.

[2] Department of Health 21 May 2012 http://informationstrategy.dh.gov.uk

Q10.) Do you support the idea of publishing a "Choice Framework" for patients alongside the mandate?

Yes – to the extent that this applies to traditional NHS services and as drafted (although there is still a little work to be done around the reference to optometrist referrals in Annex D.1.c as this has not yet been agreed).

However, as we have argued above, in the case of community eye care providers, choice is already inherent in everything we do – it has to be for practices to survive in our highly competitive open market. We would be resistant, therefore to see the imposition of a further choice framework on community optical providers unless there was any evidence that this was needed to fill any gaps in the existing system – which we very much doubt is the case.

Q10b.) What is the meaning of "veterans" (4.1)? Is this an Americanism or does it mean ex-service people?

For some years now, the Department of Health has encouraged use the term "older people" as in the National Service Framework for Older People. Would this be a better and less confusing term to readers?

Q11.) Does the draft mandate properly reflect the role of the NHS in supporting broader social and economic objectives?

Yes. However we would make the following points.

Commissioning to Meet Health Needs: Community optical practices, optometrists and opticians look forward to working to the new Local Eye Health Professional Networks (LENs) to ensure that the NHS delivers eye health services to the entire population, "understanding the needs of different groups of people such as children or [older people]" (paragraph 4.1). This applies particularly so the case of children where the recommendations of the National Screening Committee for vision screening for children at school entry age is far from universal leading to a postcode lottery about whether children's visual impairment is picked up or not at an age when it can still be corrected. This should be a key commissioning objective but could be lost at the margins between NHSCB, CCG and HWB responsibilities and we would like to see LENs within the NHSCB LATs to be the specifically mandated to look at this issue.

Multi-professional/Input Commissioning: We support and welcome the aim of CCGs being able "to work with local partners to find innovative ways of tackling health challenges and the wider issues ... [in their areas]" and their statutory duties to engage in Health & Wellbeing Boards and other collaborative arrangements such as Community Safety Partnerships". In our case, we look forward very much to engaging with these partnerships through the new Local Eye Health Professional Networks.

Culture and Co-Production: We would also point out that this mandate is seeking to change culture in these objectives and to move us on from the "top-down", the officials know best" management approaches of the 1990s and 2000s into more diffused and collaborative forms of leadership and decision-making. This is no easy task particularly since the mandate

is seeking to use management levers to effect culture change. However, we would observe that the principle of "co-production" which the NHS Commissioning Board and Department of Health have adopted in developing these NHS reforms to date (although far from perfect and occasionally a little too dictatorial still) has nevertheless been a welcome and very positive step in the right direction - maximising skills, intelligence and capacity for "intelligent commissioning" and modernisation in the NHS. We hope it will continue as a key principle of NHS Confederation practice. **We would like to see an objective of "co-production wherever possible" included as a further principle in this mandate.**

Safeguarding

As a profession, we fully support the NHS's role in "continuing to improve safeguarding practice in the NHS" (Objective 16) (paragraph 4.18). However, as in our previous submissions, we would stress that this must be achieved in ways appropriate to the particular sector in question.

The Optical Confederation and College of Optometrists have worked hard to develop agreed guidance on safeguarding children and adults for community optical practice with the Department of Health's safeguarding leads and we commend this to the NHS Commissioning Board for universal adoption. (Occasionally we are still seeing old PCTs and PCT clusters attempting to impose inappropriate requirements which would directly put patients (and in some cases practitioners) at risk.)

Further Small but Important Points

Much of the work of the community eye health sector, in addition to identifying preventable or ameliorable sight threatening pathologies, is to keep good sight good ie keep the healthy, healthy paragraph 2.37). Much of our work, therefore, is about promoting, prolonging and sustaining eye health. It would be helpful if this could be reflected by the use of the term "eye health services" rather than "eye care services" in paragraph 5.17.

We fully support the emphasis on a sustainable efficiency (QIPP) in Objective 22 (paragraph 6.1).

The phrase "This Government" (paragraph 2.1) is political and as such has no place in an official government document - the term should of course be "The Government"

Further Information

We are happy for this response to be made public. Please do not hesitate to contact us, if you wish to follow up any of the points above in more detail, or if you would like more detailed information.

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 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 Opticians (FODO). As a Confederation, we work with others to improve eye health for the public good.

Submitted by Mark Nevin
On behalf of the College of Optometrists and the Optical Confederation