THE COLLEGE OF OPTOMETRISTS

Optical Confederation
The voice of UK optics

Liberating the NHS: No decision about me, without me
Further consultation on proposals to secure shared decision-making

Thank you for the opportunity to comment on this further consultation.

Overview

1.) We very much support the direction of travel set out in this consultation document, especially with regard to traditional NHS services where choice and personalisation of care have been less evident over the years. We welcome the recognition of the benefits of self-referral (paragraph 5.23), and would like to note that this is the norm in the optical sector.

2.) As noted in our responses to the previous tranche of *Liberating the NHS* consultations, in community optical practice, we already deliver the majority of the objectives in this consultation paper and have done so for at least 30 years. Operating as we do in an open market where all patients have a wide choice of optical provider, the "personalisation" and "no decision about me, without me" philosophies are already an integral part of the community optical practice culture.

3.) It is against this background that we raise the following particular issues:

- Whilst extending personalisation to the more traditional parts of the NHS, we would caution against inadvertently jeopardising the personalisation systems that already operate successfully in the more open-market areas of NHS care, such as community eye care.

- The need for simple and proportionate connectivity of community optical practices to NHSmail and Choose & Book so patients can exercise choice over referrals easily and efficiently.

- The need for a common approach to glaucoma diagnostics glaucoma referral refinement in the community so that patients have greater choice and shorter waiting times.

- The need for a two week standard for wet Age-related Macular Degeneration (wet AMD) as for cancer patients.

Community Optical Practice

4.) In this and previous consultations, we have been at pains to point out that community eye care:

- already operates in an effective but highly regulated market;

- has its own independent regulator, the General Optical Council; which together mean the principles of "no decision about me, without me" are already embedded in our practice.

5.) In the community eye health sector, patients and the public are already "treated as grown-ups" (Executive Summary paragraph 4), with a free choice of any qualified optical provider anywhere in the UK. Moreover, they have the ability to have their sight tested in one practice and then choose another practice for the dispensing of any necessary vision correction such as spectacles or contact lenses. As far as primary eye care is concerned therefore, patients already have autonomy over the time, location and provider of their care and a wide choice of interventions to choose from.

6.) This open-market based system means that providers have to compete to attract each and every patient (NHS or otherwise) on the basis of the quality, access, choice and outcomes they provide. Dissatisfied patients can simply go elsewhere which, over time, edges less popular providers out of the market.

7.) It is important therefore that, when rolling out this programme to the wider NHS requirements designed to drive choice in traditional acute hospitals, providers are not inappropriately transferred across to the already well performing optics sector. An unnecessary extra burden of well intentioned new directives would be unlikely to improve patients' ability to reach decisions about their care but could add costs and burdens to the community eye care which is counterproductive for patients.

8.) A good example here is the issue of regulation by Monitor. The community optical sector is already well regulated by the General Optical Council, our NHS national contractual and performer listing arrangements, professional duties on clinicians and normal market regulation (the Office of Fair Trading and Advertising Standards Agency, for example). There is no need therefore for any further regulation by Monitor which would simply duplicate the regulation already in place and add additional burdens to the clinical front-line in breach of the Better Regulation principles.

9.) The Department of Health has clarified that registration with the Care Quality Commission (CQC) is not required for community eye care providers on the grounds that:

- they are already "registered" with PCT clusters (in future, the NHS Commissioning Board Local Area Teams) including in respect of premises, equipment, record-keeping and staff;

- their Primary Ophthalmic Services contract compliance framework already replicates the CQC requirements based on *Standards for Better Health*; and

- community eye care is below the risk threshold for CQC regulation.

10.) It is to be hoped that Ministers reach a similar decisions about regulation by Monitor.

Information and Awareness

11.) The one area where community eye health does need NHS Commissioning Board and Health & Wellbeing Board assistance is in the challenge of getting eye health information to the public.

12.) However what the eye health community has found extremely difficult – without support – is to persuade the public of the importance of regular sight testing to avoid long term visual impairment (and hence significantly reduce down-stream costs to health and social care).

13.) 50% of sight loss in the UK is estimated to be avoidable through early detection by regular sight testing, according to the RNIB.

14.) As a sector, we have in recent years carried a strong eye health and blindness prevention message through our national representative bodies (as has the voluntary sector) and would be very keen to build on this through working with the NHS Commissioning Board, clinical commissioning groups (CCGs) and Health and Wellbeing Boards (HWBs):

- through local eye health professional networks; and
- on eye health profile-raising nationally.

15.) "Official sanction" and support would help enormously to get across the message about the importance of eye health to the members of the general public who are at risk of eye disease and sight loss.

Urgent Care

16.) As a sector, we welcome the fact that "plans are in place to ensure that every area of England has a coherent 24/7 urgent care service in place by April 2013... supported by the new NHS 111 telephone number, which will enable patients with urgent health care needs to be directed to their most appropriate local health services" (Paragraph 2.13).

17.) Once again, we would urge that this includes a locally commissioned urgent eye health service (one model is the LOC Support Unit pathway[1] which is in turn based on the successful models provided by Acute Eye Care Scheme (ACES) in Somerset[2] and the various

[1] http://www.locsu.co.uk/enhanced-services-pathways/primary-eyecare-assessment-and-referral-pears/ (Last accessed: August 2012)
[2] Liberating the NHS: Eye Care – Making a Reality of Equity and Excellence, N Bosanquet, Dec 2010, pp.47

PEARS models around England). This would give patients suffering from red eye, painful or sight loss threatening eye conditions the choice of accessing urgent care from a community optometrist without having to travel to an eye casualty unit or having to go through their GP.

Diagnostic Test Providers

18.) We welcome the announcement that "during 2012-13, we will set out which tests will be priorities for comprehensive inclusion in Choose and Book from April 2013." (Paragraph 4.8). In our view this should include glaucoma referral refinement as a national service albeit commissioned locally[3]. NHS Evidence recently published commissioning guidance showing savings from a repeat measures service of up to 62% against the hospital eye service tariff, a saving of £15,000 per 100,000 population[4].

19.) Glaucoma and ocular hypertension referrals already form a significant part of the work in the hospital eye service. It is also estimated that two thirds of those with glaucoma are currently undiagnosed, so not accessing care[5].

20.) To meet this need, in our view, the NHS Commissioning Board should designate glaucoma referral refinement as an additional Primary Ophthalmic Service which would mean that:

- all CCGs would be required to commission such a service according to local need;
- not all optical practices would have to provide the service (so as to guarantee throughput and skills maintenance).

21.) Ideally these services should be commissioned through the new local Eye Health Professional Networks to ensure that the system is fully integrated through agreed pathways with the hospital eye service and that the practices which offer the service see sufficient volumes of patients to guarantee quality, viability and outcomes.

Wet AMD

22.) The consultation document refers to areas "where diagnosis is needed urgently" (e.g. paragraphs 4.10, 6.6). The example usually given is the cancer two week wait and the clarification that "providers [can] continue to use Choose and Book to list these services and allow direct bookings to them" (paragraph 4.10) even though they will be exempted from the proposals in this consultation document.

23.) We would strongly urge, on clinical grounds, that the NHS Commissioning Board should also look to implement a maximum two week wait (from identification to an appointment with a hospital consultant) for wet age-related macular degeneration (wet AMD). In the past decade, treatments for wet AMD have become available which can prevent the loss of

[3] Liberating the NHS: Eye Care – Making a Reality of Equity and Excellence, N Bosanquet, Dec 2010
[4] NHS Evidence (2011) Avoiding unnecessary referral for glaucoma: use of a repeat measurement scheme.
[5] Hitchings RA. Glaucoma: an area of darkness. Eye, 2009;23, 1764–74.

vision and blindness which was inevitable in the past. These, however, have to be applied promptly (within two weeks of case finding) and it would be helpful for the NHS Commissioning Board to develop a model pathway and contract for CCGs to apply in such circumstances. We would be more than willing to work with the NHS Commissioning Board to develop such a pathway and model contract.

Direct Access to Diagnostic Testing

24.) Key to facilitating direct referral from community optical practice to the hospital of a patient's choice is the extension of flexible, easy-to-use access to Choose and Book systems for optical practices, coupled with (as noted above) simple and proportionate IT links through NHSmail. Better connectivity would make it easier and more efficient for patients to choose their preferred providers for onward referrals from optometrists. Currently to use Choose and Book optical practices have to use a standalone system or refer the patient via their GP – neither of which is in the spirit either of *The Power of Information* or *No decision about me, without me.*

25.) We would urge the Department of Health (and in future the NHS Commissioning Board) to discuss as a matter of urgency how this might be achieved with the national negotiating body, the Optical Fees Review Committee (OFRC).

Eye Health for Newborns and the Very Young

26.) As a sector, we would be keen to engage with further developments of the *Preparation for Birth and Beyond: A Resource Pack For Leaders of Community Groups and Activities* to ensure that prospective and new parents (and fellow health and care professionals) have the essential information they need to spot eye health problems in newborns and young children early, to ensure these are investigated and wherever possible corrected (paragraph 5.11).

Decisions after a diagnosis

27.) An important consultation of the post-diagnosis needs and wishes of blind and partially sighted people was carried out in 2011-12 and the results published as *Seeing it my Way*[6] at the Vision UK 2012 conference on 12th June 2012. This identified particular weaknesses of support, information and orientation at the point of diagnosis of visual impairment or severe visual impairment (blindness). This was not a criticism of the clinicians concerned, but rather of the system and pathway design under which (traditionally) clinicians both in the community and the hospital sector have been obliged to operate.

28.) Possibilities now exist with a clinician-led, patient-focused NHS, to correct these omissions and the UK Vision Strategy is actively working to turn the outcomes of the consultation into commissioning standards for health and social care.

[6] Seeing it my way: A universal quality and outcomes framework for blind and partially sighted people, 2012 – Available to download from the UK Vision Strategy website - http://www.vision2020uk.org.uk/ukvisionstrategy/default.asp

29.) Once finalised, we would commend these to the NHS Commissioning Board, local eye health professional networks and local authorities for adoption in health and social care contracts in order fully to implement the aims of *No decision about me, without me* into eye care and visual impairment services across the NHS and Social Care.

30.) In addition, we are concerned that inappropriate rationing of cataract surgery means that commissioners are denying patients the opportunity to reach a shared decision about whether they undergo clinically justified surgery to which they are entitled. Together with the Royal College of Ophthalmologists and the Local Optical Unit Support Unit, we recently published a statement on these issues[7].

31.) We look forward to working with the Department of Health and, from next April, the NHS Commissioning Board on these challenges at national level.

Regulations

32.) We welcome the recognition that "regulations are one of the levers in the new system which could be used to give effect to changes or extensions of choice policy" (paragraph 7.4). As noted above, we would recommend amendment of the Primary Ophthalmic Services Regulations to make the commissioning of glaucoma referral refinement an "additional service" under those regulations. As described at paragraph 20 above this would ensure quality and consistency whilst achieving better choice, outcomes and capacity management across the whole eye health system.

Consultation questions

33.) We hope the proposals above provide concrete steps and actions to deliver shared decisions about eye care and treatments. In the light of the above, our responses to the five consultation questions are below.

Q1.) **Will the proposals provide patients with more opportunities to make shared decisions about their care and treatment in the following areas?**

- **a.** In Primary Care? **Yes**
- **b.** Before a diagnosis? **Yes - subject to the reforms we have proposed above.**
- **c.** At referral? **Yes - subject to the proposals we have made above.**
- **d.** After a diagnosis? **Yes - subject to the proposals we have made above**.

Q2.) **Are the proposals set out in this document realistic and achievable?** Yes, they already operate in community optical practice and care should be taken not to disrupt this very successful system other than in the areas where we have proposed improvements above**.**

As highlighted in our joint statement, there is evidence that commissioners in some areas are imposing arbitrary bans on clinically justified cataract surgery, denying patients their right to reach a shared decision on whether they wish to undergo

[7] http://www.college-optometrists.org/en/knowledge-centre/news/index.cfm/Cataract%202012

treatment to which the Department has said they are entitled[8]. We would therefore welcome a focus on how patients should be involved in decisions about care is available in their area.

Q3.) Looking at the proposals collectively, are there any specific areas that we have not recognised appropriately in the consultation document?

Yes, the consultation document – rightly – looks at improving traditional NHS providers and bringing them more into line with independent sector provision. However it does not, in our view, pay sufficient attention to ensuring that, in doing so, it does not inappropriately disrupt successful independent care systems by the imposition of new regimes designed to drive change in the NHS acute care system.

Q4.) Have we identified the right means of making sure that patients will have an opportunity to make shared decisions, to be more involved in decisions about their care across the majority of NHS funded services?

Yes, except for the issue of simple but effective IT links which are core to achieving the desired results (in particular - as noted above – easy access to NHSmail and Choose and Book for optical practices). There is a significant risk of the imposition of inappropriate information governance standards on community optical practice, of which we have real experience, which has created unnecessary obstacles to connectivity. More flexible approaches need to be developed to deliver shared decisions, choice and personalised eye care.

Q5.) Do you feel that these proposals go far enough and fast enough in extending choice and making "no decision about me, without me" a reality?

Yes. Sensibly paced and sustained progress is preferable to no progress at all.

Further Information

34.) 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.

35.) 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.

36.) 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);

[8] http://www.college-optometrists.org/en/knowledge-centre/news/index.cfm/Cataract%202012

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 Ben Cook
On behalf of the College of Optometrists and the Optical Confederation