Refreshing the Mandate to NHS England: 2014-15
Optical Confederation response

1. The Optical Confederation represents the 12,000 optometrists, the 6,000 dispensing opticians, and 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 Opticians (FODO). As a Confederation, we work with others to improve eye health for the public good.

2. As a Confederation, we welcome the government's proposals to refresh the Mandate for NHS England. This is only sensible and pragmatic in the light of evolving circumstances.

Transforming Services

3. We also fully support the Government's views that

   "to achieve these priorities will mean changing the way the NHS thinks about and provides services to people, carers and families" and that "NHS England has a crucial role as a system leader in *setting the tone for the behaviours and change* we want to see from the NHS."[1]

4. As a sector, we feel that this is a key area in which the Government's reforms are at risk of failing and where urgent action needs to be taken through the Mandate, before it is too late and old-style behaviours become embedded in the new organisation.

5. There are two areas in our view where this is particularly apparent

   - Clinical Commissioning Groups' understanding of and willingness to work and form partnerships with the private sector (particularly in primary care beyond GP practices)
   - NHS England Area Teams failing to understand that they are part of a single organisation and unilaterally taking action outside a Single Operating Model.

[1] *Refreshing the Mandate to NHS England: 2014-15*, Department of Health, July 2013, paragraph 54, p.21. Part of the extract has been italicised for emphasis.

Private Sector providers

6. Community optical providers already operate in a highly competitive, open-market system regulated by the General Optical Council, the Competition Commission and the Advertising Standards Authority.

7. This has brought significant benefits to the public, patients and the NHS in the form of competitive pressures improving access, quality, choice and value. Uniquely in the NHS, only the optical sector operates in this genuinely open market way with low barriers to market entry driving up competition, quality and choice.

8. These mechanisms and benefits are however, very poorly understood at all levels of the NHS. The NHS remains at heart a bureaucratic organisation which often seeks to impose systems and mechanisms on community optical practices, which have been developed for other, higher risk and non-market facing services (e.g. in acute trusts) and which are not only inappropriate in primary care, but also add significantly to costs to providers without patient or public benefit.

9. The ponderous, standard NHS contract and processes for commissioning community eye health services at local level in the community are cases in point. We would very much welcome the opportunity to work with NHS England and the Department of Health to streamline these processes to bring benefits to patients and the NHS, whilst minimising costs.

NHS England Area Teams

10. As a Confederation, we strongly and publicly supported the abolition of Primary Care Trusts (PCTs) and their replacement by a Single Operating Model for NHS England. However, as noted above, in our view the NHS is and remains at heart a bureaucratic organisation. Regrettably and despite the Government's best efforts, there are symptoms of Area Teams simply becoming super PCTs and replicating the problems those organisations generated.

11. In part, this was to be expected since many of the individuals who now work in Area Teams previously held senior roles in PCTs and have imported that "bureaucratic mindset" with them.

12. In particular there seems to be a lack of clarity in thinking in NHS England at senior level about what should best be done locally and what is more cost effectively done nationally. In the case of community eye health services for instance, by far the most effective, lowest risk and cost effective model is for most services to be commissioned locally (to meet needs) but against the existing national pathways with local variation simply dealing with volumes, location and cost.

13. It seems to us that, with the departure of key managers from NHS England and a weakening of grip at the Centre, the Area Teams have been very much strengthened and encouraged to go their own ways. This is not a recipe for innovation but rather for duplication, unnecessary cost and waste while standards fall (as we saw with PCTs). Much of this mind-set is still operating to stifle the intended "autonomy of local organisations, clinicians, nurses and other front line professionals to improve and innovate"[2].

14. We would be very keen therefore to see the Government re-emphasising in a revised Mandate that NHS England is one organisation with a Single Operating Model throughout its Area Teams, and that these teams are not autonomous local health authorities, but rather part of an organic whole.

15. There is a challenge in the consultation (Question 17) about additional leadership to support NHS England in delivery. If this is code for strengthening central grip, then we support it. However, we would also make the point that more and better leadership and possibly fewer leaders might be the better solution. Too many generals do not make for an effective army and, in our view, in order to fund pre-existing commitments, the leaderships should also be tasked with finding further significant savings in the bureaucratic overhead on the NHS to be released for reinvestment in front-line care.

Consultation Questions

16. It is against this background of what we perceive to be a somewhat unstable start by NHS England, but with our ongoing strong support for a clinically-run patient focused NHS, that we are pleased to respond to the specific consultation questions below.

We would also be very keen as a sector to be actively involved in

- the development of the Vulnerable Older People's Plan
- NHS England's plan to reduce pressures on urgent and emergency services
- NHS England's plans to develop more integrated services
- streamlining the NHS Standard Contract, AQP processes and quality standards for low risk community services
- developing an appropriate and proportionate response to the Francis and Berwick Reports for community eye health services
- the extension of the "friends and family test" to GPs (in the first instance as this will affect the rest of primary care) and then primary care more widely including, in community eye health services, to achieve the benefits without overburdening the front-line and small business.

17. We are happy for this response to be made public.

[2] *Refreshing the Mandate to NHS England: 2014-15*, Department of Health, July 2013, para 4, p. 5

Question 1: What views do you have on the proposed approach to refreshing the mandate?
Question 2: What views do you have on assessing NHS England's progress to date against the objectives.

Answers 1 and 2: We support the approach. Eye health forms part of and impacts on each of the five priority areas identified by government[3] . There is still a disconnect however between the three outcomes frameworks – public health, NHS and social care. We hope that the update planned for this autumn[4] will begin to address this in order to further assist commissioners.

Ophthalmic Clinical Networks

As a Confederation, we very strongly support the "promoting and strengthening [of] the autonomy of local organisations, clinicians, nurses and other front line professionals to improve and innovate"[5].

We also welcome the emphasis on reducing health inequalities and unjustified variations[6] and, in our sector, very much welcome the Government's establishment of Local Eye Health Networks to address these challenges.

Local Eye Health Networks will be supported in this role by the Clinical Council for Eye Health Commissioning, a high level Clinical Senate for ophthalmics and optics, which has been established precisely to support both NHS England in its role as a system leader and Local Eye Health Networks at local level.

Contact has already been made between the Clinical Council and the Medical, Nursing and Primary Care Directors of NHS England and we look forward to supporting NHS England in its clinical leadership role via this means.

We further support the Francis enquiry and the Berwick recommendations [7]where serious failings occurred in the hospital sector. As the Government has recognised, responses to Francis must be proportionate. Furthemore, controls developed for the hospital sector may not be applicable to private sector primary care providers, where risks are far lower and different incentives to provide high quality care already apply. We would be very keen to work with the Department of Health and NHS England to clarify this further.

[3] *Refreshing the Mandate to NHS England: 2014-15*, Department of Health, July 2013, para 2, p.4
[4] *Refreshing the Mandate to NHS England: 2014-15*, Department of Health, July 2013, para 12, p.7
[5] *Refreshing the Mandate to NHS England: 2014-15*, Department of Health, July 2013, para 4, p.5
[6] *Refreshing the Mandate to NHS England: 2014-15*, Department of Health, July 2013, para 6, p.5
[7] *Refreshing the Mandate to NHS England: 2014-15*, Department of Health, July 2013, para 9, p. 6-7

Totality of Resource

We also support the aim of the NHS, "working with social care and other key partners to drive better integration of care across different services so that the taxpayer's money is spent effectively"[8]. However, in our experience, the NHS is still primarily a public sector focussed organisation and blind to the possibilities that private providers (e.g. community eye care providers) can bring.

For instance the consultation document rightly highlights the pressures on emergency services in paragraph 9. In 2013, NHS experimental statistics estimated 3.1% of A&E visits were for ophthalmological reasons[9], and other estimates have been as high as 6%[10]. There is considerable scope to reduce this number through management in the community by community optical practices. For example, research by the internationally renowned Moorfields Eye Hospital indicates that 37% of ophthalmic A&E cases could be managed in primary care[11]. Despite this growing body of evidence, the NHS in England has been slow to innovate. Today, Wales has a national Primary Eye Acute Referral Service (PEARS) with a local audit showing it reduced referrals to hospital by 80%[12]. The Grampian model in Scotland has also shown to reduce eye casualty attendance by 57% and yet, in England the vast majority of the population have no access to such a service[13].

It would be good to see national implementation given impetus through therevised Mandate.

Question 3: What views do you have on the proposal to help people live well and longer?

Answer 3: We fully support this, but would argue that while mortality is being improved, quality of remaining life also has to improve. Preventing unnecessary sensory impairment, such as sight loss, is a key part of this and should be considered in the NHS England Programme. Please see also our response below to Questions 8-10.

Question 4: What views do you have on using the refreshed Mandate to reflect the plans to strengthen A & E services?

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[8] *Refreshing the Mandate to NHS England: 2014-15*, Department of Health, July 2013, para 9, p.6-7

[9] Accident and Emergency Attendances in England - 2011-12, Experimental statistics; Publication date: January 23, 2013; Table 14: http://www.hscic.gov.uk/article/2021/Website-Search?productid=10477&q=a+and+e&sort=Relevance&size=10&page=1&area=both#top

[10] Edwards, R S (1987) "Ophthalmic emergencies in a district general hospital casualty department" British Journal of Ophthalmology, 71: p 938-942

[11] Hau et al (2008) "Patterns of ophthalmological complaints presenting to a dedicated ophthalmic A&E department: inappropriate use and patient's perspective" Emergency Medicine Journal, 25(11): p 740-744

[12] http://www.optometry.co.uk/uploads/articles/11abf8a4c36ed28c3e571b5b0896a855_Arbuthnot41105.pdf

[13] http://www.locsu.co.uk/enhanced-services-pathways/enhanced-services-map

Answer 4: Please see our response to Questions 1-2 above under "Totality of Resource". We were surprised, given the statistics, not to see any mention in the announcement on the Government's plans to solve A&E pressures of the potential of community eye care providers to assist in reducing pressures and make savings. It is to be hoped that this lack of joined-up thinking can be rectified as the Government's and NHS England's plans are worked up. A community based acute eye care referrals service (based on existing community optical practices such as those that already operate in Somerset and Stockport) rolled out across every NHS area would reduce eye related attendances at A&E by an estimated 57%[14] (37- 80%[15,16]) resulting in a 100,000 less visits to A&E each year.

Question 5: What views do you have on the proposal to reflect NHS England's ambition to diagnose and support two thirds of the estimated number of people with dementia in England?

Answer 5: We strongly support this objective and would remind NHS England again how important prevention of sensory impairment, particularly sight and hearing, is for dementia patients. This is often overlooked and the services we provide in care homes often report cases of patients wearing the wrong spectacles or, none at all and having their hearing aids improperly adjusted or without batteries inevitably leading to a high degree of frustration and non-participation by patients with dementia who are unable to recognise these problems or correct them for themselves. Working with domiciliary providers, Local Eye Health Networks should be able to help ensure every person with dementia or other disabilities gets the eye health support and care they need.

Question 6: What views do you have on updating the Mandate to make it a priority for NHS England to focus on mental health crisis intervention as part of putting mental health on a par with physical health?

Answer 6: We support this priority.

Question 7: What views do you have on the proposals to ask NHS England to take forward action around new access and/or waiting time standards for mental health services and IAPT services?

Answer 7: We support the proposals. We also support the inclusion of optical practices in 111 and emergency services commissioning to provide consistent and safe out-of-hours services[17].

Question 8: What views do you have on the ambitions and expectations for the vulnerable older peoples' plan?

[14] Conservative estimate based on the Grampian experience in Scotland. Range shown in brackets from other research and PEARS systems)

[15] Hau et al (2008) "Patterns of ophthalmological complaints presenting to a dedicated ophthalmic A&E department: inappropriate use and patient's perspective" Emergency Medicine Journal, 25(11): p 740-744

[16] http://www.optometry.co.uk/uploads/articles/11abf8a4c36ed28c3e571b5b0896a855_Arbuthnot41105.pdf

[17] *Refreshing the Mandate to NHS England: 2014-15*, Department of Health, July 2013, para 31, p.13-15

Question 9: What views do you have on how we should achieve our ambitions on the vulnerable older peoples' plan, particularly on how to strengthen primary care?
Question 10: how should the ambitions for vulnerable older people be reflected in the refreshed Mandate?

Answers 8-10: We support the Department of Health's and NHS England's ambition to develop a vulnerable older people's plan. Eye health and vision correction *must be* part of this – the link between eye health and falls, mental health, isolation and loss of independence is well-established[18] and the NHS can considerably improve out-of-hospital care by greater attention to sight, hearing, oral health (for eating, lack of pain and social intercourse) mobility and foot care[19].

We welcome the stronger role suggested for general practice at the heart of the community and local NHS[20]. As noted in our responses above we also feel strongly that community eye health practices have a major role to play in integrated out-of-hospital care and, as a Confederation, would be keen to be involved in the discussions to take this forward.

We would also remind the Government and NHS England that Local Eye Health Networks – as part of the new NHS England structure at local level - have an important role to play in developing out-of-hospital services in local communities in partnership with GP hubs.

[18] Hodge, Barr and Knox (2010) Evaluation of emotional support; 5: Douglas et al (2006) Network 1000 College of Optometrists and The British Geriatric Society. *The importance of vision in preventing falls, a*vailable from http://tinyurl.com/vision-falls. Accessed 11.2.2013.
Abdelhafiz, A.H. and Austin, C.A Visual factors should be assessed in older people presenting with falls or hip fracture *Age and Ageing* 2003 32(1), 26-30
Ivers RQ, Cumming RG, Mitchell P et al. Visual impairment and falls in older adults: the Blue Mountains Eye Study. *J. Amer Ger. Soc*. 1998 46(1): 58-64
Cummings SR. Treatable and untreatable risk factors for hip fracture. *Bone* 1996 18(3 suppl): 165S-167S
Jack DI, Smith T, Neoh C et al. Prevalence of low vision in elderly patients admitted to an acute geriatric unit in Liverpool: elderly people who fall are more likely to have low vision *Gerontology* 1995 41(5), 280-5
Patino CM, McKean-Cowdin R, Azen SP et al Central and peripheral visual impairment and the risk of falls and falls with injury *Ophthalmology* 2010 117(2) 199-206
Knudtson MD, Klein BE, Klein R Biomarker of aging and falling: the Beaver Dam eye study *Arch Gerontol Geriatr* 2009 49(1) 22-26
Kuang TM, Tsai SY, Hsu WM et al Visual impairment and falls in the elderly: the Shihpai Eye Study *J Chin Med Assoc* 2008 71(9) 467-72
Kulmala J, Era P, Parssinen O et al Lowered vision as a risk factor for injurious accidents in older people *Aging Clin Exp Res* 2008 20(1) 25-30
Lamoureux El, Chong E, Want JJ et al Visual impairment, causes of vision loss, and falls; the Singapore Malay eye study *Invest Ophthalmol Vis Sci* 2008 49(2) 528-33
De Boer MR, Pluijm SM, Lips P et al Different aspects of visual impairment as risk factors for falls and fractures in older men and women *J Bone Miner Res* 2004 19(9) 1539-47
Coleman AL, Stone K, Ewing SK et al Higher risk of multiple falls among elderly women who lose visual acuity *Ophthalmology* 2004 111(5) 857-62
[19] *Refreshing the Mandate to NHS England: 2014-15*, Department of Health, July 2013, para 31, p.13-15
[20] *Refreshing the Mandate to NHS England: 2014-15*, Department of Health, July 2013, para 32, p.15

Similarly Local Eye Health Networks can play a key role in stimulating new models of provision for integrated out of hospital care and NHS England should look, in our view, to these groups to lead this process.

Question 11: What views do you have on updating the Mandate to reflect the Francis enquiry and the review of Winterbourne view hospital?

Answer 11: We very much support the objective "to ensure that vulnerable people, particularly those with learning disabilities and autism receive safe, appropriate, high quality care" (current Mandate Paragraph 4.5) and support the Government's plans to update this in the light of the Concordat which NHS England signed up to.

We would also point out that a national pathway for eye health for adults with learning disabilities has been developed but that so far only four areas of the country have such services[21]. This is regrettable and should be a matter of priority for CCGs and Local Eye Health Networks in 2014-15.

Question 12: What views do you have on updating the objective to reflect NHS England's role in supporting person centred and coordinated care?

Answer 12: We support and would like to see more joined-up thinking especially around eye health, visual impairment and support for people who are newly visually impaired.

In particular, we would like to see far more ECLO (Eye Clinic Liaison Officer) posts funded to ensure seamless working at the health and social care boundary and the adoption of the UK Vision Strategy *Seeing It My Way* standards[22] as part of the commissioning of integrated support services.

Question 13: What views do you have of updating the existing objective to reflect the pledges in "Better Health Outcomes for Children and Young People."

Answer 13: Again, this is an area of care we fully support and would urge the Mandate to require Area Teams to work closely with Local Authorities to ensure that the recommendations of the UK National Screening Committee in respect of vision screening for four and five year olds is implemented nationally.

Question 14: What views do you have on updating the existing objective to reflect the challenge for NHS England to introduce the "friends and family" test assessed to General Practice and Community

[21] Atlas of Optical Variation - http://www.locsu.co.uk/enhanced-services-pathways/enhanced-services-map (Last accessed: September 2013)

[22] http://www.vision2020uk.org.uk/ukvisionstrategy/page.asp?section=301&sectionTitle=Seeing+it+my+way&search=Seeing+it+my+way (Last accessed: September 2013)

and Mental Health services by the end of December 2014 and the rest of NHS funded services by the end of March 2015?.

Answer 14: Whilst we understand the thinking behind this objective, we have concerns about how the "friends and family test" will be rolled out for all the services by the end of March 2015.

The community eye health sector sees some 21 million patients a year and to survey and report on each of those from a "friends and family perspective" would add an impossible burden to businesses. Moreover operating, as we do, in an open and highly competitive commercial market, optical practices already have incentives to ensure that they are precisely the places where "friends and family" will want to attend – in fact most friends and family do already attend the practice where their relatives work.

We would be very keen therefore to engage with NHS England (and our primary care colleagues in general medical practice, dentistry, pharmacy and hearing) to work out how such a system might best apply in community optical practices to achieve the benefits the Government wishes to see but without adding unnecessarily to the burdens on small businesses.

Question 15: What views do you have on these proposals to improve patient safety?

Answer 15. As a Confederation we naturally welcome all initiatives to improve patient safety and, as a sector, already have a patient safety record second to none. Our experience however is that, every time there is a review of NHS complaints, the burdens on practices become heavier without adding significantly to patient benefit in our sector. We would be very keen, therefore, to be involved in the Department of Health's review of complaints as well as how this information is shared and used to protect patients[23].

Question 16: What views do you have on the proposal to update the Mandate for NHS England to work with Monitor towards a fair playing field for providers?

Answer 16: This is not applicable to community optical practice. Nevertheless we fully support developing a fair level playing field for all providers, including those from the private sector. A key goal however should be to ensure that this does not result in additional unnecessary bureaucracy within the commissioning process (adding cost to the NHS) or on providers.

Question 17: What views do you have on the proposal for Government to provide additional leadership on delivery of agreed pre-existing Government commitments?

Answer 17: We are not convinced. Please see our comments at paragraph 15 above.

[23] *Refreshing the Mandate to NHS England: 2014-15*, Department of Health, July 2013, para 52, p.20

Question 18: What views do you have on the proposal to update the objective to challenge NHS England to support the NHS to go digital by 2018?

Answer 18: We support the proposal. We particularly welcome NHS England's proposals to move to electronic claims and payments for the NHS sight testing service.

Question 19: what views do you have on the proposal to be more explicit on the expectation around reporting?

Answer 19: We understand why the Government proposes to extend this to GP practices and also at the level of consultant-led teams in specific specialties. However we cannot see how this proposal would be appropriate in the community optical sector. Community eye care is recognised as low risk by our regulator (the General Optical Council) and community optical practices already operate in an open and highly competitive market and compete vigorously with one another to attract each and every patient on grounds of access, quality and choice. In our market, NHS funding genuinely follows the patient and practices bend over backwards to meet patients' needs and wishes and to maintain their loyalty.

The NHS sight testing reporting system already provides data to enable Area Teams to establish outliers on various quality measures and to investigate whether improvements are required. To add further to this would not seem justified by any evidence or against any criteria.

We would be very concerned if further reporting burdens were imposed on community optical practices without justification. Many are struggling to survive and continue providing an accessible service to NHS patients without any of the NHS guarantees or subsidies which apply in other clinical areas. To impose further unnecessary burdens on small providers would risk pushing many out of business and this would most definitely not be in the public interest.

Question 20: What views do you have on the proposals to update the objective in asking NHS England to support the recovery of the economy where they can make an important contribution?

Answer 20: We support the proposals. We hope it will be noted that, as a sector and together with pharmacy and hearing care, we are often the only remaining NHS clinical outlets and retail premises keeping the high street alive.

Question 21: What views do you have on the proposals to make better use of resources?

Question 21: As noted above, in our view, NHS England bureaucracy (especially in the Area Teams) could helpfully be looked at again and any

resources saved directed to frontline care. This would also be a means of genuinely empowering the clinical frontline to innovate and develop services to meet local needs[24].

The bureaucracy surrounding the standard NHS contract and commissioning process – especially AQP - could be radically simplified in respect of community eye health services to deliver less bureaucracy and a better focus on outcomes and quality. We would be keen, as a sector, to assist and play our full part in this.

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[24] *Refreshing the Mandate to NHS England: 2014-15*, Department of Health, July 2013, paragraph 4, p.5