Department of Health

October - November 2015

Consultation response form

Setting the mandate to NHS England for 2016 to 2017

Consultation Questions

1) Do you agree with our aims for the mandate to NHS England?

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 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 welcome the government's proposals to refresh the Mandate for NHS England and broadly support the aims set for 2016-17.

However in general, as a sector, we continue to have concerns about the bureaucratic and 'clunky' mode of operating of NHS commissioning, which confuses tick-box systems with outcomes and has little understanding of value (as opposed to cost), of risk-benefit analysis, of market-facing systems (such as eye health, community hearing or pharmacy). or how to minimise costs and maximise benefits to patients.

This is clearly seen in the eye health sector where care is not being shifted out of hospital at pace or scale and where national leadership is sadly lacking. This is evident in the system which has 209 CCGs (and even then not all) developing their own pathways and models to move care out of hospital - a key Mandate objective - rather than looking to existing well established and evidence based pathways to move faster, more safely and more cheaply (minimising transaction costs).

An alternative would be to seek advice from the national Clinical Council for Eye Health Commissioning (which NHS England attends) to provide leadership and consistency and to removing pressures on GPs, A&E and hospital services at scale and pace.

This leadership deficit at national level, which the Mandate does little to address, is one of the main reasons why the NHS is still struggling to implement the aims of the Five Year Forward View and to close the funding gap.

Such leadership as there is seems focussed on achieving administrative neatness in bureaucratic procedures such as contracts management which, we recognise, should ultimately reduce costs and which we therefore support; however not to the extent that

displaces genuine system leadership and imposes 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 . The impracticable (in primary care) recent Accessible Information Standard is a case in point. This seems to have been pursued without regard to costs or the impact on providers.

Set out NHS England's contribution to our goals for the health and care system as a whole, in line with this Government's manifesto commitments.

We recognise and support the need for accurate reporting of deliverables to ensure quality and reduce unwarranted variation across England. However this is already in place for the NHS sight testing service and will be further enhanced when NHS England fully implements e-GOS through the new contracted-out Primary Care Services (PCS) system which we were led to believe would be by 2017 i.e. during the period of this Mandate.

Endorse the NHS's own plan for change, the Five Year Forward View

As a Confederation, we strongly support the Five Year Forward View and the possibilities it presents for innovation and collaboration across primary and secondary care.

Preservation of the benefits of the national General Ophthalmic Services (GOS) sight-testing system - open access, low transaction cost, patient-focussed, demand led and high national standards - is paramount but there is far more routine eye care which can easily be transferred to the community to free up capacity in under pressure hospital eye departments[1], reduce pressures on GPs (1.5 - 2%[2]) and A&E (1.46 - 6% of attendances[3]).

It is regrettable that none of the Vanguard sites have considered eye health (or sensory impairment more widely) given the key Mandate objective of maintaining health, well-being and independence (especially of older people) and keeping patients out of hospital (another key Mandate aim).

Sporadic and piecemeal commissioning is not the answer if the Mandate goals are to be achieved. Helpfully 'Devo Manc' does seem to be considering such developments at pace and scale to meet demand and improve care which we strongly support. We will look to other Local Eye Health Networks (LEHNs) to work similarly, with any further devolution sites which are announced, to achieve similar benefits and deliver the Five Year Forward View.

Set a mandate that is more strategic, clearer and more accessible to the public

Operating as we do in a fiercely competitive, patient- focussed, market-facing system, community optical providers bend over backwards to meet patients' needs and wishes and to maintain their loyalty. We therefore welcome the aim of creating clearer lines of

[1] Smith HB, Daniel CS and Verma S. "Eye casualty services in London." Eye. 27.3. 2013; 320-328.

[2] RCGP Weekly Returns Service Annual Prevalence report. 2007. http://www.rcgp.org.uk/clinical-and-research/~/media/Files/CIRC/CIRC-76-80/BRU_Annual_prevalence_report_2007.ashx

[3] Commissioning better eye care, 2013. http://www.college-optometrists.org/filemanager/root/site_assets/guidance/urgent_eye_care_template_25_11_13.pdf

accountability between the non-market facing parts of the NHS and the public and would be keen, as a sector, to support this similarly to drive improvement and efficiency in those sectors.

We remain concerned, however,

- that there is still a major gap in the NHS outcomes framework which overlooks the role many parts of the NHS play in keeping people (without long term conditions) well, healthy and participating in society - most of what primary care does falls into this category

- the disconnect between the three outcomes frameworks – public health, NHS and social care.

Adding new local level measures to compare quality for local CCG populations, as proposed, is only likely in our views to add further confusion for the public and patients.

As a Confederation we strongly and publicly supported the abolition of Primary Care Trusts (PCTs) and their replacement with a Single Operating Model (SOM) for NHS England to streamline processes and reduce duplication. We have further developed a health outcomes dimension to this SOM via a national package of local eye health indicators to support Local Eye Health Networks (LEHNs) and commissioners[4].

To add another layer of complexity to reporting metrics seems to run counter to this trend of promoting transparency and outcomes and would not, in our view, be desirable. No information is cost free and this, in our view, this would just add more cost into the system if applied to eye care.

Set a mandate with a long-term duration

We welcome the proposal of a longer term Mandate and the possibility of agreeing multi-year budgets. The stability of this type of arrangement would allow for more ambitious planning and support innovation and collaborative working.

2) Is there anything else we should be considering in producing the mandate to NHS England?

Yes two things.

1) A requirement for national leadership (not more guidance):

- to drive standards and standardisation where this improves outcome and reduces costs.

- to shift care out of hospitals at scale and pace - in the case of eye care the market will respond to meet demand

- to ruthlessly cut transaction costs, waste and unnecessary bureaucracy from the whole system and not to impose unnecessary administrative burdens on providers, be they public sector (hospital care) or independent (primary care).

2) A commitment for no further organisational upheaval for five years to give the reforms

[4] Public Health Outcomes Framework. Vision2020 website. http://www.vision2020uk.org.uk/public-health-outcomes-framework/

an opportunity to deliver and in particular a strengthening and validation of the embryonic Local Eye Health Networks (LEHNs).

3) What views do you have on our overarching objective of improving outcomes and reducing health inequalities, including by using new measures of comparative quality for local CCG populations to complement the national outcomes measures in the NHS Outcomes Framework?

As a Confederation, we very strongly support the objective of reducing health inequalities and unjustified variations in outcomes for vulnerable groups and across CCG populations. We particularly welcome the focus on high quality person-centred care for the UK's aging population. 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 and the NHS can considerably improve independence and out-of-hospital support by greater attention to sight, hearing, oral health, mobility and foot care in primary care.

That said, we have already expressed our concern about the introduction of yet more measures for comparing quality of care between local CCG populations (when there is already a substantial disconnect between the outcomes frameworks already in use) which we do not think will help meet this aim.

Inequalities in our sector would be reduced more efficiently by NHS England endorsing national pathways that take advantage of existing capacity in community optics to deliver a broader range of services close to home and cost effectively. Public interest would be even better served if these pathways were nationally commissioned.

For instance 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% resulting in 100,000 fewer visits to A&E each year.

There are many other examples of equal scale and benefit. All that is needed is leadership from NHS England.

4) What views do you have on our priorities for the health and care system?

Eye health forms part of and impacts on all of the priorities identified by Government.

Preventing ill health and supporting people to live healthier lives

We agree that while life expectancy is being improved, quality of remaining life must also improve. Preventing unnecessary sensory impairment, such as sight loss, and should be part of local health planning supported by Local Eye Health Networks (LEHNs).

Preschool Screening

Currently, despite the recommendations of the National Screening Committee, screening

of school-entry age children for eye conditions which may inhibit their intellectual and social development is still far from universally commissioned and recent reductions in public health budgets for local authorities may inhibit this further. NHS commissioners should press local authority partners to address this structural inequality as a matter of urgency.

Creating the safest, highest quality health and care service

As noted above, community optical providers operate in a highly competitive, open market system regulated by the General Optical Council, the Competition Commission and the Advertising Standards Authority. 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.

Uniquely in the NHS the optical sector operates in a genuinely open and highly competitive market where there is vigorous competition to attract each and every patient. In our market, NHS funding genuinely follows the patient and practices are strongly incentivised to provide excellent customer service and person-centred care.

Whilst we understand therefore the thinking behind this objective's emphasis on feedback, we have concerns about how the “friends and family test” will be rolled out in community optics.

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. 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 partners in 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.

Maintaining and improving performance against core standards while achieving financial balance

Transforming out-of-hospital care

In eye health, the key (as described above) to both these objectives is to commend the proven national pathways to CCG for implementation at scale and pace. This will significantly reduce transaction costs and eliminate unnecessary variation.

Seven Day Operation

The community optical sector already operates seven days a week and at evenings to meet the needs and convenience of patients. Practices could easily extend this to provide community based urgent eye care services for most conditions to reduce pressure on GPs and A&E. This could be further enhanced by triage straight from 111, GPs and pharmacy to optical practices as part of a reinvigorated, more efficient and more patient-focussed

primary care system.

Driving improvements in efficiency and productivity

Key to further improvements in these areas and to shifting care out of hospital at scale and pace in the eye health sector is IT connectivity between community optical providers and the rest of the NHS system. (See too Mandate paragraph 3.20about collecting patient data only once and sharing).

Bids have been submitted for a small amount of one-off funding to support this and we are hopeful this will be granted in 2016 as part of the primary care investment strategy.

It is on this necessary infrastructure investment that the Mandate's efficiency, outcomes and service transformation deliverables in our sector - described above - depend.

Supporting research, innovation and growth

Research, innovation and growth are all strongly supported by the community optical sector which develops knowledge and innovation at no cost to the NHS which benefits NHS patients (66%) even more than private patients (33%) but without introducing inequalities.

5) What views do you have on how we set objectives for NHS England to reflect their contribution to achieving our priorities?

There are so many transformative care possibilities in the eye health (and other care sectors) which NHS England and CCGs do not have the capacity to reach. There should therefore be positive encouragement to NHS England and CCGs to work with partners in care, such as the optical sector, and through mechanisms established for the purpose, such as the national Clinical Council for Eye Health Commissioning and Local Eye Health Networks (LEHNs) to deliver the change needed to meet the Government's priorities set out in paragraph 1.10.