



## **EQUITY & EXCELLENCE: LIBERATING THE NHS**

Together the Optical Confederation represents the 12,000 optometrists, 6,000 dispensing opticians and 8,000 optical businesses in the UK who provide high quality and accessible eye care services to the whole population. . This includes the 7,250 retail outlets, equipment, frames and lens manufacturers, IT suppliers, distributors and a further 51,000 support staff.

The Confederation is a coalition of the five optical national 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).

### **The UK Optical Sector**

First just a few words about how the UK eye care sector operates. All community eye care – both NHS and private – is already delivered through a highly-competitive, open (any willing provider) retail market model. Within the national contract, apart from baseline requirements in respect of premises, equipment and record keeping, there is no control of market entry. Funding follows the patient in a very direct way, all patients have value for a practice and practices compete vigorously with one another on quality, access and choice constantly competing to drive up standards and attract more patients. Those that do not simply go out of business as patients vote with their feet and others come in who can meet patients' needs and wishes. This private/public mix creates arguably the most efficient model of NHS care.

### **Overview**

It is against this background that the Optical Confederation welcomes the White Paper.

In particular we applaud the government's sensible decision to retain the high-quality, low cost NHS sight testing as a nationally commissioned and negotiated service on quality and cost-effectiveness grounds; it is this that drives the effectiveness of the highly competitive optical market

We also welcome the proposal to abolish PCTs and SHAs and, in particular, to eliminate the unnecessary bureaucracy and over-regulation which in recent years has

added unnecessary burdens and costs to front-line care in our sector with no discernable benefit for patients, the NHS or the public.

We do however request clarification on a number of specific issues, detailed below (with paragraph references in brackets)

### **Specific Issues**

#### **4.) We will put patients at the heart of the NHS, through an information revolution and greater choice and control:**

**a.) Shared decision-making will become the norm: *no decision about me without me.***

**b.) Patients will have access to the information they want, to make choices about their care. They will have increased control over their own records.**

The optical sector has for many years empowered patients by allowing them to take part in the decision making process about their care (4a). Moreover, information about a patient's treatment and care is available upon request from their optical practice.

However, whilst we fully accept the right of patients to access optical records, we would point out that, in our view, although the NHS requires us to keep records for 7 years, the records themselves are actually owned by the practice (and usually retained for 10 years) and form part of the practice's "good will" and resale value in which the practice owners have invested. We would be happy to work with the Department of Health to find a fair solution to this.

**f.) We will strengthen the collective voice of patients and public through arrangements led by local authorities, and at national level, through a powerful new consumer champion, Health Watch England, located in the Care Quality Commission.**

Whilst we support the development of Health Watch and its subsuming the functions of LINKs, we would be opposed to giving Health Watch a formal role in seeking patients' views.

Within the optical sector we already have excellent patient and customer feedback loops – all optical businesses need them to survive in the open market within which we operate. We also have rigorous complaints procedures including at both practice and whole business (e.g. Specsavers, Boots, Vision Express, Tesco, Asda) level and independently to the Optical Consumer Complaints Service (OCCS) and the General Optical Council.

Giving Health Watch a formal role in this area would, in our view, add another unnecessary burden on front-line care in our sector and would not provide the flexibility

needed for optical businesses to be able to respond to their own patients' needs and concerns.

**5.1.) Money will follow the patient through transparent, comprehensive and stable payment systems across the NHS to promote high quality care, drive efficiency, and support patient choice.**

The highly competitive, open market in which community optical practices operate delivers high levels of quality, access and choice to all patients (including housebound patients) in all localities. Almost uniquely in the NHS, money directly follows the patient and practices compete for each and every patient. If not, they go out of business and others move in to take their place.

**6.s.) Monitor will become an economic regulator, to promote effective and efficient providers of health and care, to promote competition, regulate prices and safeguard the continuity of services.**

Our sector is not large and is already highly regulated both by the General Optical Council in respect of eye care specifically and by the general retail regulatory framework provided by the Office of Fair Trading, trading standards, the Advertising Standards Authority etc.

As a point of principle therefore, and in line with the Government's aims of keeping bureaucracy to a minimum, we do not think Monitor should have powers in relation to our sector as these would simply duplicate existing regulation and drive up costs for the NHS and patients without any benefit.

We agree with Secretary of State Vince Cable comments:

“One of the great risks with government when it can't spend is that it tries to look as if it is doing something by regulating instead. But the regulatory burden is a check on business growth and everything we can do to lighten it will help” (Speech 10 June 2010)<sup>1</sup>.

We very much welcome therefore the assurances we have recently been given by the Department of Health that community optical practice will not be brought within Monitor's remit.

**1.17) We will seek to break down barriers between health and social care funding to encourage preventative action.**

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<sup>1</sup> <http://www.dius.gov.uk/news/speeches/vince-cable-denning-lecture>

This could open up the possibility of the already established resource of community optometrists and low vision dispensing specialists certifying registration for the visually impaired which could free up scarce ophthalmologist resources in hospital eye departments.

As a Confederation we would be very keen to be involved in further work to develop an appropriate outcomes framework for eye care across the whole NHS and social care spectrum.

We would also support the development of specific quality standards for point of diagnosis support and orientation for people diagnosed as visually or severely visually impaired and quality standards for low vision services across both hospitals and the community.

**1.28) The Department will take forward work to manage the transition and flesh out further policy details in partnership with external organisations, seeking their help and expertise.**

The Optical Confederation and the College of Optometrists look forward to working closely with the Department of Health

- on the transition process, especially to ensure that fragile but cost-effective community schemes are not lost to patients by being overlooked,
- and also in further policy making and assisting implementation of the detail of the reforms as they affect community eye care and patients.

**2.7) The Department will extend national clinical audit to support clinicians across a much wider range of treatments and conditions, and it will extend PROMs across the NHS wherever practical.**

We welcome the extension of PROMs across the NHS, and would support timely and appropriate support for people with low vision/visual impairment/blindness.

We also welcome the recognition recently offered to us by officials that clinical audit beyond current requirements is unlikely to be appropriate for the national sight testing service.

**2.9) The Department will revise and extend quality accounts to reinforce local accountability for performance, encourage peer competition, and provide a clear spur for boards of provider organisations to focus on improving outcomes. Subject to evaluation, we will extend quality accounts to all providers of NHS care from 2011 and continue to strengthen the independent assurance of quality**

**accounts to ensure the content is accurate and fair. We will ensure that nationally comparable information is published, in a way that patients, their families and clinical teams can use.**

In the light of the powerful drivers for continuous quality improvement that already operate in the competitive optical retail market; we welcome the recent clarification from the Department of Health that quality accounts will not apply to community optical practices.

**2.11) We will enable patients to have control of their health records. This will start with access to the records held by their GP and over time this will extend to health records held by all providers. The patient will determine who else can access their records and will easily be able to see changes when they are made to their records.**

As already mentioned, information about a patient's treatment and care is available upon request from their optical practice. However the records themselves are currently owned by the optical practice and must remain so as they form part of the practice value, and have been invested in by the practice owners, in the same way as equipment, fixtures and fittings etc. Please see our response comments on Paragraph 4 above.

This may change when optical practices are linked to the NHS records systems with access to (at least part of) the NHS electronic patient record. However that appears to be many years off at present.

**2.15) The forthcoming Health Bill will contain provisions to put the Information Centre on a firmer statutory footing, with clearer powers across organisations in the health and care system.**

The Optical Confederation very much welcomes this and would like to see a regulation making power covering the Information Centre's responsibilities to stakeholders. Like many others sectors, we feel we have been treated with contempt (and in some cases incompetence) by the Information Centre since it was established which was certainly not the case when the optical statisticians were part of the Department of Health. As a result, optical information has been less good than it might have been and of less use to patients. Requiring the Information Centre through regulations to work with all stakeholders will be an important step forward in data quality and efficiency.

**2.17) The Department will publish an information strategy this autumn to seek views on how best to implement these changes.**

We welcome this and look forward to seeing community optical practice specifically included within it at long last.

We also hope this will include the introduction of a centralised electronic claims and payments system for community optical practice in the same way as for community pharmacy as part of the review of the future of the Business Services Authority (including outsourcing options). This will not only improve efficiency and security, it will result in significant savings for the NHS and optical providers. (As for dental practices the paper option should also be retained for as long as it is required for those practices which have yet fully to computerise.

**2.20 Box) Develop a coherent 24/7 urgent care service in every area in England that makes sense to patients when they have to make choices about their care.**

On grounds of efficiency, access, patient choice and cost, such services should include an out-of-hours minor eye emergency, optometry and dispensing service. These should be based on the evaluated initiatives such as the Primary Eyecare Acute Referral Scheme (PEARS), pioneered by the Welsh Assembly Government, which has demonstrated that optometrists are highly successful in managing the care of patients without a referral to a GP or consultant.

**2.21) We will need to tackle a range of issues... reform the payment system so that money follows the patient and enables the choices to work, information availability and accessibility to enable choice of treatment...**

The optical sector already meets all these objectives to a very high standard. As Bosanquet<sup>2</sup> has reported, it provides an exemplar service for these reforms which could easily be extended to other areas of health care such as community audiology to improve access and choice whilst driving down costs. .

**2.23) In future, the NHS Commissioning Board will have a key role in promoting and extending choice and control.**

Within community eye care, the establishment of the new NHS Commissioning Board provides an opportunity to ensure the same level of high quality enhanced eye care services is delivered throughout the country by the publication of national quality standards (pathways) for glaucoma referral, stable glaucoma management, stable diabetic retinopathy management, cataract, minor eye emergencies and low vision.

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<sup>2</sup> "Liberating the NHS: Eye Care - making a reality of equity and excellence", Professor Nick Bosanquet, Imperial College, October 2010

This will guarantee universal standards whilst reducing transaction and other costs to the benefit of both the NHS and patients.

**2.24) LINKs will become the local Health Watch, creating a strong local infrastructure, and we will enhance the role of local authorities in promoting choice and complaints advocacy, through the Health Watch arrangements they commission.**

As previously noted, whilst we support the development of Health Watch and its subsuming the functions of LINKs, we would be opposed to giving Health Watch a formal role in seeking patients' views.

Within the optical sector we already have excellent patient and customer feedback loops – all optical businesses need them to survive in the open market within which we operate. We also have rigorous complaints procedures including at both practice and whole business level (e.g. Boots, Specavers, Vision Express, Tesco, Asda) and independently to the Optical Consumer Complaints Service (OCCS) and the General Optical Council.

Giving Health Watch a formal role in this area would, in our view, add another unnecessary burden on front-line care in our sector and would not the flexibility needed for optical businesses to be able to respond to their own patients' needs and concerns. We are also concerned over the independence of Health Watch, when it is proposed to be based at and form part of the CQC. We hope the government will ensure that Health Watch will be as independent and respected as the much regretted Community Health Councils the abolition of which the Labour Party now recognises was a mistake under the previous administration.

**3.6) A new NHS Outcomes Framework will provide direction for the NHS, it will include a focussed set of national outcome goals determined by the Secretary of State.**

**3.18) The Department will ... link quality measures in national clinical audits to payment arrangements.**

We support the Government's aim of ensuring accountability within the Liberated NHS through clear outcomes frameworks.

However we would urge the Coalition Government to check very carefully that indicator development does not become an end in itself and a gravy train for "outcomes specialists" and would stress the need for simplicity to maximise users' understanding of outcomes and to minimise data collection, processing and publication costs.

**4.6) Consortia of GP practices, working with other health and care professionals and in partnership with local communities and local authorities, will commission a great majority of NHS services for their patients.**

We look forward to engaging with GP consortia through Local Optical Committees at local level.

Local Optical Committees (LOCs) have been established in all localities since 1977 to represent the views of contractors and professionals locally and to give advice to commissioning groups on optical matters. As expert local committees, they are funded entirely by contractors at no cost to the NHS.

**4.11) The [NHS Commissioning] Board will have five main functions... [one of which is] designing model contracts for local commissioners to adapt and use with providers.**

There are already model contracts for sight testing and for locally commissioned enhanced eye care services in the community and we have strongly supported this national streamlined approach.

All that is missing from the national enhanced services contracts is national quality standards and pathway as described in our response to 2.23 above.

However, unfortunately, in 2008 the sight testing contracts in England become significantly more bureaucratised (simply as far as we can see on grounds of administrative “neatness” and so that they mirrored the contracts for more complicated and higher risk professions) imposing significant additional costs on optical practice without any obvious benefits for patients or the public. As part of these reforms therefore we will be submitting further proposals to the Department of Health to streamline the contracts and remove these unnecessary burdens.

One option we would also like to explore with the government is the abolition of local eye care “performer” (i.e. optometrist) lists. These simply duplicate the requirement of the national General Optical Council (GOC) Register with additional and unnecessary costs for both the NHS and practitioners. The GOC Register is centralised, cost-efficient, always up-to-date and accessible to all on line 24 hours a day. When PCTs were in existence there was just about some argument (although not a very convincing one) to be made for such duplication. However with the National Commissioning Board, there is no need whatsoever for such duplication in optics and we would look forward to working with the government to remove this waste and cost.

**4.17) The Government will strengthen the local democratic legitimacy of the NHS. Building on the power of the local authority to promote local wellbeing, we will**

**establish new statutory arrangements within local authorities – which will be established as “health and wellbeing boards” or within existing strategic partnerships – to take on the function of joining up the commissioning of local NHS services, social care and health improvement. These health and wellbeing boards allow local authorities to take a strategic approach and promote integration across health and adult social care, children’s services, including safeguarding, and the wider local authority agenda.**

Throughout the country there are examples of excellent practice of joint working between the NHS and Local Optical Committees representing local NHS eye care contractors and practitioners.

The Optical Confederation and College of Optometrists would happy to prepare some best practice guidance for

- GP consortia on how to engage with Local Optical Committees;
- Local Optical Committees on how best to engage with GP consortia

based on this evidence.

**4.23) Monitor will take on the responsibility of regulating all providers of NHS Care, irrespective of their status.**

The UK optical market is small, £2.8bn in total of which only 10% derives from the NHS sight testing service. It is a highly competitive, genuinely open market where funding directly follows the patient and, unlike most parts of the NHS, practices simply go out of business if they do not deliver on quality, access and choice as patients vote with their feet. At the same time the sector is already tightly regulated by the General Optical Council in respect of optical services and the Office of Fair Trading, the Advertising Standards Authority etc in respect of retail activities in the same way as any other retail businesses.

For these reasons, we believe the new system of licensing and market management by Monitor should not apply to community optical practices and we very much welcome the assurances we have recently been given by Department of Health officials that that is also their view and that community optical practice will not be brought within Monitor’s remit.

**4.27) Providers will have a joint licence overseen by both Monitor and CQC, to maintain essential levels of safety and quality and ensure continuity of essential services.**

Please see our responses to 6.s) and 4.23) above.

**4.27) Monitor will be turned into the economic regulator by the health and social care sectors, with three key functions... [one of which will be] to set efficient prices, or maximum prices, for NHS-funded services, in order to promote fair competition and drive productivity.**

Please see our responses to 6.s) and 4.23) above.

**4.33) The professions will have a leading role in deciding the structure and content of training, and quality standards.**

In community eye care we already do - and in a very direct way - in liaison with the General Optical Council, the eight optical universities, the College of Optometrists and the Association of British Dispensing Opticians Training College in Kent. Being outside centralised NHS workforce planning controls and funding regimes enables us to review annually current and future workforce needs and to respond rapidly and flexibly to changing workforce configuration and business needs. As a result we always have adequate and flexible supplies of staff who earn good salaries with some headroom but no significant oversupply.

In addition optical practices also invest heavily in technology, non-clinical staff training and their premises at no cost to the NHS.

Understandably we would be strongly opposed to any changes in this system which works well without any cost to the NHS (other than the very low level training grants for pre-registration optometrists and ongoing Continuing Education and Training which is part of the national NHS contract.

**4.33) All providers of health care services will pay to meet the costs of education and training.**

Please see our response above. Given that optical training is delivered entirely outside the NHS system by the private sector, it follows that community optical practice should be excluded from these proposals. It would clearly be iniquitous for optical practices to have to fund the training of other non-optical professions.

**5.9) NHS services will increasingly be empowered to be the customers of a more plural system of IT and other suppliers.**

We support this. The bureaucracy and “our way or no way” approach of NHS Connecting for Health did not help anyone struggling to develop or implement flexible IT

solutions at local level. Community optical practice was never properly involved in the development of national or local plans. We hope this will be remedied in future.

**5.12) Payment will depend on quality of care and outcomes, not just volume. Penalties for poor quality will encourage providers to get care right first time.**

**5.14) Providers who wish to provide NHS-funded services must be licensed by Monitor, who will assess financial viability.**

Please see our responses to 6.s) and 4.23) above which demonstrate why these new arrangements should not apply to community optical practice. We welcome the reassurances recently given by Department of Health officials that these requirements will not apply to community optical practice for those reasons .

**5.17) Further efficiencies need to be made ...for example through working with the Carbon Trust and similar bodies on carbon reduction programmes that reduce energy consumption and expenditure.**

The competitive optical market already provides powerful incentives on practices and businesses to minimise costs including fuel, packaging and transport costs. Although will fully support the work of the Carbon Trust and the government's green goals, we feel there is no need for further bureaucracy to make these work in the community optical sector.

**6.2) The Department will take this forward in partnership with external organisations, seeking their help and expertise in developing proposals that work in practice, for example, on shared decision-making and choice.**

The Optical Confederation and the College of Optometrists look forward to working closely with the Department on the development of proposals that work in practice.

**6.4) Later this year, the Government will also publish for consultation a NHS information strategy, and a document on the move to a provider-led education and training system.**

**6.5) The Department of Health will carry out a series of consultations with patients, their representative groups and the public, NHS staff, their representative and professional bodies... and independent sectors. This will run in parallel to the formal consultation on the proposals above.**

The Optical Confederation and the College of Optometrists look forward to being a part of these consultations.

**6.7) The principal legislative reforms will include ... enshrining improvement in healthcare outcomes as the central purpose of the NHS.**

**6.11) Quality accounts expanded to all providers of NHS care (April 2011);  
Expanded validity, collection and use of PROMs (from April 2011);  
International Classification of Disease (ICD) 10 clinical diagnosis coding  
system introduced (from 2012-13).**

We will also be responding separately to the four more detailed consultation papers, which support this White Paper, namely:

- Commissioning for Patients
- Democratic Legitimacy in Health
- Transparency in Outcomes
- Regulating Health Care Providers.

**Optical Confederation  
5<sup>th</sup> October 2010**