



Integrating care

Next steps to building a strong, integrated care system across England

About us

FODO is the leading national association for eye care providers working in primary and community care settings. Each year our members provide over 18 million eye examinations and offer a wide range of other eye care services across the UK.

What is your name?

Sue Silvester

2. In what capacity are you responding?

☒ Professional representative body

3. Are you responding on behalf of an organisation?

☒ Yes

☐ No

If 'Yes', please provide the following details:

Organisation name:

FODO, The Association for Eye Care Providers

Email:

healthpolicy@fodo.com

4. Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade?

☐ Strongly agree

☐ Agree

☒ Neutral

☐ Disagree

☐ Strongly disagree

If you have any specific comments or additional information to provide, please provide it in the text box below:

We strongly support:

- putting ICSs on a statutory footing to bring clarity to the current NHS structure below regional level. The number of ICSs may not yet be right, but the principle is
- merging CCGs so that NHS commissioning is less fragmented and serves the needs of larger populations in a more efficient and accountable way on behalf of patients, taxpayers and the wider public sector – including through joint working with other statutory partners. This is also acknowledged in the DHSC's 'Busting Bureaucracy: Empowering frontline staff by reducing excess bureaucracy in the health and care system in England'
- protecting and enhancing patient choice and empowerment, which is also strongly supported by the Health and Social Care Select Committee and patient groups
- the NHS's recommendation to Government and Parliament for "independent recourse and oversight of patient choice" – a strong recommendation and outcome of NHS England's wider consultation on implementing the NHS Long Term Plan
- the decision to guarantee continuing employment for all staff for two years to avert loss of focus while individuals focus on restructuring and their careers. This will be particularly important during the pandemic
- the standard NHS aims of delivering 'better health for the whole population, better quality care for all patients and financially sustainable services for the taxpayer'

We have concerns however about

- governance, transparency and efficiency with commissioners and providers on the same boards and sharing functions – a concern raised by the Health Select Committee in 2019 as part of the initial consultation phase on legislative reform and one which remains unaddressed at this stage
- the power of provider coalitions spanning ICSs. These are highly likely to dominate transformation agendas with acute sector solution when primary care and social care options may offer better outcomes and value through effective patient choice. Charities also highlighted this risk in response to the proposals for legislative change in 2019 and NHS England reassured them it would be mitigated through stronger protections and oversight of patient choice
- whether thinking has evolved on how the powers to establish new trusts will be used
- how evidence of investment in service lines and cost benefits can be demonstrated within block contracts and large, pooled budgets; and whether this will enable service cuts and inefficiencies to be hidden from view
- whether the engrained culture will be able genuinely to shift from 'my organisation first/hospitals first' to collaborative, whole systems working, focused on the needs of individual patients and the public
- how the voice of non-life-threatening but essential NHS services like eye care, and the patient groups whose needs these vital services meet, will be articulated, heard and heeded at all levels within the new system

- the continued absence of guidance about how best value will be tested, contested and assured.

We hope that a follow-up consultation will address these concerns and note that NHS England and NHS Improvement remains “committed to engage openly on how the future procurement regime will operate subject to legislation being brought before Parliament”.

Without further clarity on how the NHS will ensure patients’ rights to choice are protected and how the NHS achieves best value, there are too many unknowns fully to support the proposals at this stage.

We are therefore supportive of CCGs evolving into ICSs but call for further information about, and consultation on, the detail that will underpin the legislative reforms.

To be clear, we remain fully supportive of the goals of the NHS Long Term Plan about rebalancing care so that there is a greater focus on primary prevention and early intervention through providing more care in primary care settings closer to home. However, we are concerned that the current proposals risk creating large ‘super-providers’ or provider coalitions in charge of regional budgets. Further safeguards are therefore necessary to ensure:

- patients’ rights to choice are protected and enhanced
- there is a clear line of sight to, and accountability for, every NHS pound spent, in order to maximise health gain
- capital budgets are invested where they can do most good as part of shared strategic plans, rather than to solve isolated acute sector problems, recognising the risk of long revenue tails impeding future transformation
- there are greater incentives to invest in new models of care which achieve optimal patient access at ‘place’ and which can adapt over time to meet growing population needs
- more care is delivered outside hospital settings in primary care so that people access to more care at ‘place’ and the NHS and taxpayer benefit from better value in the broadest sense.

5. Do you agree that option 2 offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to Parliament and most importantly, to patients?

☐ Strongly agree

☐ Agree

☐ Neutral

☒ Disagree

☐ Strongly disagree

If you have any specific comments or additional information to provide, please provide it in the text box below:

We can understand the immediate attractions of Option 2, including potentially avoiding additional layers of bureaucracy which might occur under Option 1. However, whilst Option 2 might be preferable for these and other reasons from a purely NHS perspective, it is not clear that it goes far enough to give local government and others equal voice and power to deliver the vision set out in the NHS Long Term Plan.

For once, these reforms offer the opportunity genuinely to bring health and social care together to meet the population's changing needs while shaping service delivery around the needs and wishes of individual patients. This is what is genuinely new and transformational.

Being a predominantly 'healthcare body' with NHS CEO etc, Option 2 will doubtless succeed in delivering and exerting 'grip' in NHS terms in the short term. However, it is unlikely to deliver the joint working to shared goals, public benefit and the genuinely transformative agenda envisaged in the NHS Long Term Plan over the medium to long-term. It would be a forced, not a genuine, partnership and the history of local authorities sitting on statutory health boards etc is not encouraging.

NHS bodies and local authorities already have powers and duties to collaborate, can make joint appointment and pool budgets for a common purpose. Bringing Foundation Trusts within these duties is sensible, and arguably overdue, but something else needs to drive change to deliver the vision. It is not clear that an NHS body-led model will achieve this now, any more than it has in the past.

What might succeed on the other hand is a statutory joint committee model of equal partners with 'skin in the game'. This would need an accountable (to all parties) officer charged with delivering the change that has been agreed and control over the shared/pooled resources allocated to achieve it.

This would be a bolder way forward than Option 2 but one which might secure local democratic buy-in and eventual success.

6. Do you agree that, other than mandatory participation of NHS bodies and Local Authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs?

☐ Strongly agree

☐ Agree

☐ Neutral

☒ Disagree

☐ Strongly disagree

If you have any specific comments or additional information to provide, please provide it in the text box below:

This proposal is too narrow, permissive and imbalanced for the weighty public responsibilities and significant amounts of public resources involved.

If ICSs are to work under either of the proposed structural solutions, governance and voice will be essential. At the very least, there should be mandatory seats at the table to give a meaningful voice to primary care (not only PCNs but other primary care networks), public health at supra-place level, patients and the public. It is unclear from this consultation whether and where clinical senates or LPNs still fit in and what role they will have. Yet it is precisely joined-up expert clinical voices of this kind which need to be given genuine power at board meetings and not be relegated merely to the position of sounding boards for structural and investment decisions already made.

7. Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHSE should be either transferred or delegated to ICS bodies?

☐ Strongly agree

☐ Agree

☒ Neutral

☐ Disagree

☐ Strongly disagree

If you have any specific comments or additional information to provide, please provide it in the text box below:

Whether transfer or delegation is appropriate or safe depends largely on the service in question. Some services are most efficiently and equitably commissioned at a national level (especially rare or standardised services). In others, the additional costs of more local commissioning are outweighed by local 'fit' and sensitivity to local circumstances.

For instance, in primary eye care, we already have a mixed-level system established by the Primary Ophthalmic Services (POS) contract in 2008.

The General Ophthalmic Services (GOS) element of POS works extremely well and is the right level of subsidiarity for the national sight-testing and case-finding service which (although underfunded since 2008) is commissioned once at low cost. It also offers patient choice at all levels and provides accessible and equitable services in all locations without waiting lists or service delays. This makes it one of the most cost-effective and equitable services in the NHS. As the service is patient choice-driven, it also draws catchment from beyond any single 'place'. It therefore guarantees access for all and a standardised service (set out in primary legislation) irrespective of where people live. The overwhelming view of providers and local commissioners who understand the service is that a service which works

so well and so clearly in the public interest, should be preserved as a national service. This is clearly in the public interest and holds true in all four nations of the UK. In short, we agree with NHS England – NHS Improvement that “many services, such as those in the highly specialised services portfolio, [should] continue to be planned and commissioned on a national footprint”.

Where the 2008 reforms have not worked so well is where CCGs have locally commissioned primary eye care services (POS). This has resulted in piecemeal, sometimes short term, fragmented services and has seriously impeded planning, demand management and outpatient transformation as well as adding to costs. The result has been a postcode lottery in many places, especially in urban areas where CCG boundaries can cross home/work localities. Patients are unclear what additional eye care services can be accessed where and so are driven back to other NHS access points such as GPs and A&E creating unnecessary pressures on those services.

Commissioning enhanced primary eye care services at ICS or multi-ICS level, rather than a CCG level, therefore makes a lot of sense. If done well, it will reduce NHS costs, relieve pressure on hospitals, A&E and GPs and is something which we have long called for in the eye care sector.

We would also like to add that primary eye care has always operated through networks, established under statute as Local Optical Committees (LOCs). LOCs already operate on local authority boundaries as ICSs will. As we have said in response to previous consultations, LOCs are cost-efficient vehicles for articulating local voice (funded by a levy on the profession rather than the NHS) which can easily adapt to work in tandem with PCNs at ‘place’ and ICSs at ‘system’ level.

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