ALL PARTY PARLIAMENTARY GROUP: Primary Care and Public Health

Inquiry into Delivering the Five Year Forward View: Behavioural change, information and signposting.

Optical Confederation and Local Optical Committee Support Unit

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 Optical Confederation also represents manufacturers, distributors and importers. As a Confederation we work with others to improve eye health for the public good.

Local Optical Committee Support Unit (LOCSU) provides quality, practical support to Local and Regional Optical Committees (LOCs) in England to help them to develop, negotiate and implement local objectives in respect of primary ophthalmic services.

Q1) How can we accelerate positive behavioural change towards prevention and self care in the population and who should be responsible for this?

In addition to their role in preventing avoidable sight loss, community optical practices are ideally placed, together with partners in primary care, to deliver public health services to provide help and advice on everyday health issues, such as smoking, alcohol and weight in line with the *Five Year Forward View's* focus on prevention in primary care. The recent Healthy Living Optician initiative launched in Dudley which follows the established Healthy Living Pharmacy programme provides a framework for the commissioning of a portfolio of valuable public health services under one 'brand' together with a robust accreditation process.[1]

The population of England is ageing: by 2037 life expectancy at birth is projected to reach 84.1 years for males and 87.3 years for females, an increase of almost 5 years from 2012 and a trend which is expected to continue[2]. This inevitably creates its challenges in terms of pressures on the health and

[1] Dudley opticians to offer health checks through pilot schemes. *Optometry Today*, 15th August 2015. http://www.optometry.co.uk/news-and-features/news/?article=7616

[2] Office for National Statistics. 2013. http://www.ons.gov.uk/ons/rel/lifetables/historic-and-projected-data-from-the-period-and-cohort-life-tables/2012-based/info-surviving-to-age-100.html

social care systems and especially when the NHS has a £22bn funding gap to close and social care is facing similar pressures. Demand for hospital eye services has increased by 8% in the past two years creating capacity pressures in secondary care.[3] In 2013-14 there were a total of 6,807,664 ophthalmology outpatient appointments in England. This represents the second highest number by speciality across all hospital departments.[4] As many as 78.1% of cases attending eye casualty are deemed 'non serious', with 50-70% of cases not constituting either an accident or an emergency.[5]

In our view the only way the NHS in England can make ends meet over the lifetime of this Parliament is to keep individuals independent, well and out of hospital and the care system, especially as they age. As NHS England's own *Five Year Forward View* recognises, this means reinvigorating primary care and managing more patients, in a more holistic way, outside hospital and in the community.[6]

Optometry is a relatively under-recognised part of the primary care workforce that can make a major contribution to the development of 24/7 integrated primary care. Regrettably, the emphasis has again been mainly on GP, and to some extent pharmacy services, and experimenting with more structural and organisational change. However, as all the evidence and our BMA colleagues have shown, the GP system is already overloaded and cannot cope with more work, even with 5,000 more GPs pledged. What is needed is a system that supports the population - and older people in particular – in a more holistic way. The crucial elements of this - sight, hearing, balance, teeth, medicines management, flu vaccination, weight, continence and mobility - can all be delivered effectively in primary care. This needs leadership from the professions to work in a more joined-up way around individuals and their support systems (including social care, carers and the voluntary sector) at local level. Key requirements are:

- cross-referral between primary care professions for first-line care
- simple but secure IT connectivity between primary care professionals (e.g. GPs, optometrists, community hearing, dentistry, pharmacy) and between those professions and secondary care to facilitate shared care, joined-up working and rapid intervention and support by professionals when and wherever needed
- better use of the flexibilities in the new primary care contracts agreed over the past 10 years to achieve these aims.

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[3] "Hospital Outpatient Activity - 2011-12." HSCIC http://www.hscic.gov.uk/catalogue/PUB09379/hosp-outp-acti-11-12-all-atte-tab.xls and "Hospital Outpatient Activity - 2013-14." HSCIC. http://www.hscic.gov.uk/catalogue/PUB16722/hosp-outp-acti-2013-14-all-atte-tab.xlsx

[4] Hospital Outpatient Activity. 2013-14. HSCIC. http://www.hscic.gov.uk/catalogue/PUB16722/hosp-outp-acti-2013-14-all-atte-tab.xlsx

[5] Hau S, Ioannidis A, Masaoutis P, Verma S. Patterns of ophthalmological complaints presenting to a dedicated ophthalmic Accident & Emergency department: inappropriate use and patients' perspective. Emerg Med J. 2008

[6] Five Year Forward View. NHS. 2014. https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

- development of an Optometrist Independent Prescribing Framework in England.

Commissioning of comprehensive eye services has been shown to prevent unnecessary hospital attendances; this should be commissioned everywhere: we recommend that an England-wide framework is developed to encourage the further development of community eye services at scale and pace. There are 2.6 million eye related GP appointments[7] and 270,000 A&E visits[8] eye-related problems every year which could be better and faster managed in primary care. There is now sufficient evidence from across the UK that where Minor Eye Conditions Services (MECS) are commissioned, allowing community optical practices to accept referrals from GPs, pharmacists and other professionals for patients with eye problems that are outside the scope of the NHS sight test. 78% of patients referred to these services can be managed out of hospital.[9] Successful implementation of MECS in primary care will reduce attendances at A&E for eye related problems and referrals to ophthalmology outpatient clinics.

Currently these services are commissioned piecemeal by individual CCGs with high transaction costs. To date only 32% of CCGs have commissioned MECS locally leading to duplication of cost and effort and resulting in postcode lotteries, and confusion amongst the public. It is important that urgent eye care appointments are made available in the community, and are seen as the first port of call for referrals, thereby easing the burden on hospitals. The problem of patchy services has been avoided in Scotland and Wales where these additional services are standardised and universally with very low transaction costs. In some cases such as NHS Grampian this has enabled all minor and urgent work to be transferred to primary care, freeing up hospital resources.[10]

While we recognise that CCGs are now well established at the heart of the English health landscape, significant savings could still be achieved across the system by agreeing a national pathway with common standards, outcomes and experience measures that all areas would implement – ideally at one fixed fee to save commissioning costs.

Planning to develop a significantly streamlined version of the NHS Standard Contract, for use when contracting for less complex services of relatively low financial value is welcome, but should be prioritised so that the new version can be made available for April 2016.

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[7] Sheldrick JH, Wilson AD, Vernon SA, Sheldrick CM. Management of ophthalmic disease in general practice.. Br J Gen Pract. 1993 Nov;43(376):459-62.

[8]Sheldrick JH, Vernon SA, Wilson A. Study of diagnostic accord between general practitioners and an ophthalmologist. BMJ. 1992 Apr 25;304(6834):1096-8.

[9] Minor Eye Conditions Service (MECS) Pathway. LOCSU. 2015. http://www.locsu.co.uk/uploads/community_services_pathways_2015/locsu_mecs_pathway_rev_may_2015_v2.pdf

[10] Delivering Better Health, Better Care Through Continuous Improvement: Lessons from the National Programmes. NHS Scotland. 2008. http://www.gov.scot/Resource/Doc/212120/0056427.pdf

The Vanguard programme is already implementing MECS type schemes, particularly under the Primary and Acute Care model. However MECS is already tested in three UK countries, works and is ready to implement, and should be rolled out across England immediately.

Cost effectiveness of MECS

Combined data from 7,861 episodes across 6 Minor Eye Conditions Services commissioned since April 2013 showed 78% of patients were managed by the optometrist, 17% were referred on to secondary care with more serious problems and 5% were referred to their GP. 92% of patients were likely or extremely likely to recommend the service to friends or family. At an average of £54 per MECS consultation being paid by CCGs, the costs of this service are at least 40% lower than they would have been if all patients had been referred to secondary care.

To further support these emerging models, primary eye care services should be expanded to include services for monitoring of conditions such as glaucoma and age related macular degeneration that can be safely delivered outside of hospital. There is good evidence that such services reduce unnecessary referrals to secondary care[11].

The Clinical Council for Eye Health Commissioning[12] has developed a framework for community ophthalmology services to support the safe transfer to primary care of services previously delivered solely in hospitals. This framework - Community Ophthalmology Framework https://www.rcophth.ac.uk/wp-content/uploads/2015/07/Community-Ophthalmology-Framework.pdf - should be endorsed immediately as national policy to support the NHS in addressing pressure and transition.

We also support the efforts of the Vanguard sites to address perverse incentives, such as tariffs paid for patients being monitored in hospital where this could be done in primary care. We are committed to working with the Vanguard sites, fast followers and hospital eye services to achieve these aims using existing POS contract flexibilities which were established for precisely that purpose.

[11] Parkins, D. J., & Edgar, D. F. (2011). Comparison of the effectiveness of two enhanced glaucoma referral schemes. *Ophthalmic and Physiological Optics*,*31*(4), 343-352.

[12] The scope of the Clinical Council for Eye Health Commissioning is that by bringing together the leading patient and professional bodies involved in eye health, the Council will focus on priority issues related to the commissioning of eye health services, including social care and ophthalmic public health. The Council's advice will be based on the best evidence available and independent of any commercial interests.

A table of evidence supporting the commissioning of eye health community services can be seen here: http://www.locsu.co.uk/uploads/call_to_action/copy_of_community_services_summary_september_2014_3.pdf

Q2) How can we ensure there is consistency of message across the NHS with people clear about where and when to seek health advice?

Optical practices, as an integral part of primary care, should become the first port of call for all eye health problems, as is becoming the case in Scotland and Wales. The majority of optical practices are open 6 days a week with many also open Sundays. Therefore 7 day access to services is already available across the local network of practices which can be used to deliver NHS goals of 7 day access.

Community optical practices have readily available trained professionals, premises and equipment in accessible locations to meet most of the population's eye health needs. All that is needed is the will to activate those resources in a cost-effective way for the benefit of patients and the NHS. Existing Primary Ophthalmic Services (POS) contracts introduced in 2008 specifically provide flexibilities for this but they have not been used at scale. Deploying them would however immediately take pressure off GP surgeries and secondary care as well as improving ophthalmic and wider public health. Eye emergencies are estimated to make up between 1.46-6% of A&E attendances[13] and 1.5-2% of GP consultations are estimated to be eye related[14]. Understandably, GPs will sometimes lack the confidence to deal with patients presenting with certain eye problems. A recent survey found that over half of GPs questioned did not feel confident about dealing with dry eye and thought it could be better dealt with by an optometrist[15].

Optometrists and opticians are eye experts in the community. 12.8 million NHS sight tests per year, commissioned by NHS England under the General Ophthalmic Services (GOS) contract (part of the flexible overarching POS contract), are carried out in total of which the large majority take place in 6,000 community optical practices in England, while over 400,000 NHS sight tests are delivered in a domiciliary setting.[16] 5-6 million private sight tests a year are also carried out, to the same standards, making 19 million sight tests a year at an NHS cost of £0.25 billion. This makes the national NHS sight testing service the best value public health service in the NHS and GOS plays an important public

[13] Commissioning better eye care. 2013. The College of Optometrists and The Royal College of Ophthalmologists. http://www.college-optometrists.org/filemanager/root/site_assets/guidance/urgent_eye_care_template_25_11_13.pdf
[14] 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
[15] GPs lack confidence in treating dry eye, finds research. *Optometry Today*. 18th August 2015. http://www.optometry.co.uk/news-and-features/news/?article=7627
[16] General Ophthalmic Services Activity Statistics. HSCIC. 2014-15. http://www.hscic.gov.uk/catalogue/PUB17930/gene-opht-serv-acti-eng-year-end-mar-15-rep.pdf

health role in providing vision correction for the majority of the population who need it and case detection for those who need further investigation or treatment (about 5% of patients).

A significant challenge for NHS England in achieving this ambition is to address the issue that, despite being providers of NHS primary care services, community optical practices have traditionally been omitted from NHS IT improvements programmes. The lack of infrastructure and connectivity means that community eye health services operate in technological isolation from the rest of the NHS and social care system. This leads to duplication and inefficiency in the system at all points and is a major barrier to improving eye health efficiency and outcomes.

Robust IT systems in community optical practices, closely linked to, and ideally integrated with, general medical practice and hospital systems, so that patient data can be exchanged safely and efficiently, are key to the successful expansion of primary eye care services. All that is needed to achieve this in eye care is secure and cost-effective IT connections and more realism about effective and proportionate information governance.

HSCIC's work to develop a more accessible Health and Social Care Network as a replacement for N3 is welcome but again need to be prioritised. In line with the Government's ambition for a 'paperless NHS' and the Digital Strategy for Primary Care, communicating electronically with all clinicians involved in the patient's care should be the norm rather than the (currently) very rare exception.

NHS England needs to make a relatively small but significant investment to transform the way community optical practices are integrated with the wider NHS and social care. This signal would encourage providers and IT software suppliers, who have been given false expectations in the past and require more certainty, to play their part in this programme.

As we made clear in our response to NHS England's Call to Action: *Improving eye health and reducing sight loss* last year, the Optical Confederation and LOCSU are very willing to work with NHS England and our partners across primary and hospital care to make safe, accessible community eye services a reality in very short timescales. We hope that the important work identified as part of the Call to Action is followed through on.

Q3) How can we raise levels of health literacy in the population to enable people to make positive health choices for their physical health and wellbeing?

Early detection of sight threatening and other health conditions through the eyes is essential to reduce avoidable sight loss. There is evidence that better access is needed for some seldom heard groups. For example people with learning disabilities are ten times more likely to be blind or partially

sighted than the general population and 6 in 10 people with learning disabilities need glasses and often need support to get used to them.[17]

Better use of existing contract flexibilities is urgently required to improve access to NHS sight tests in primary care for seldom heard groups:

- Commissioning of a national service, based on the LOCSU pathway for Adults and Young People with Learning Disabilities, as developed with the charity SeeAbility[18]
- Commissioning of a national service to make GOS more accessible for children in special schools
- Better designation of temporary facilities as GOS locations for homeless people, gypsies and travellers, vulnerable migrants and sex workers.

In optometry and optics, front-line needs are very closely connected to planning and supply and, by working with the seven UK optical universities, the College of Optometrists and the ABDO College, we are able relatively easily to flex numbers in training to meet likely demand. At the same time, as optical professions, we have continually increased practitioners' skills and competences to the benefit of patients and the NHS. For example, national training and accreditation is already in place for MECS and other primary eye care pathways. Our ambition is to continue that trend.

The challenge in moving services safely to the community is to ensure that the normal time-lags in market responses are shortened and do not inhibit necessary progress. Clarity from NHS England about the direction of travel will encourage community eye health providers to make the necessary investments in work-force training, development and facilities to meet the demand created by system re-design. This is relatively easily achievable in primary eye care but, for a relatively small sector, does need national rather than piecemeal local leadership (which simply adds to costs) to make this happen.

Ophthalmology oversight and/or training for optometrists and opticians beyond core skills are required in some areas for more specialist services that can be provided in primary care. Support for this can be provided by Health Education England working through Local Eye Health Networks (LEHN) and Local Education and Training Boards (LETBs) to achieve successful transformation of NHS primary eye care services at scale.

[17] LOCSU Learning Disabilities Eye Care Pathway. Seeability. 2015. https://www.seeability.org/uploads/files/PDFs_Books_non_Easy_Read/LOCSU-tri-borough-report.pdf
[18] Community Eye Care for Adults & Young People with Learning Disabilities Pathway. LOCSU. 2013. http://www.locsu.co.uk/uploads/enhanced_pathways_2013/locsu_pwld_pathway_rev_nov_2013.pdf

Optometrists with an Independent Prescribing qualification and registration are already available and can play an enhanced role in primary care if they are given authority to write NHS prescriptions to treat conditions affecting the eye. There is currently no provision for this within the NHS in England; however a system to allow registered optometrists to prescribe within the NHS has been operating in Scotland since 2013. A national Optometrist Independent Prescribing Framework should be developed by NHS England that CCGs too can benefit and save work for GPs. This would save considerable work and cost for CCGs and optical practices.