All Party Parliamentary Group on Primary Care and Public Health

Inquiry into managing demand in primary care: the case for a national strategy: Optical Confederation and Local Optical Committee Support Unit response

The Optical Confederation represents the 13,000 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 work with others to improve eye health for the public good.

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

1) What needs to happen and who needs to be involved to help assist people in looking after their own (a) minor self-limiting illnesses and (b) long term conditions?

Sustained communication across as many mediums as possible, explaining the importance of the people taking greater a role in managing their health, is required to help people self-manage minor self-limiting illness and long-term conditions. This communication should provide clear examples of what constitutes such illnesses and conditions, as well as demonstrating simple ways in which the public can adapt lifestyles to mitigate ill-health (as far as possible). Social media campaigns must be fully utilised: with smartphone penetration

in the UK at 81 per cent of the population as of May 2016, a device-based contact must complement more traditional forms of communication.[1]

However, there also needs to be greater awareness at government and commissioning level that primary care and general practice are not synonymous: primary care also encapsulates community optics, pharmacy, and dentistry and this needs to be better understood. General practice, while comprising the largest portion of primary care, is only one component part of what is a four-profession grouping. Community optical practices as primary care providers can fulfil a vital role, both to reduce demand on A&E departments and GP surgeries alike, and deliver public health information and messages to their patients. They must be better utilised by NHS and local authorities alike to help meet the out-of-hospital care objectives of the Five Year Forward View.

With regard to capacity pressures, there has been an increase of up to 30% in eye clinic attendances over the last five years, while in 2015-2016 there were over 7.3 million ophthalmology outpatient appointments in England, representing the second highest number by speciality across all hospital departments.[2] In addition, there are 270,000 A&E visits eye-related problems and 2.6 million eye related GP appointments every year which could be better and faster managed in primary care.[3] Better commissioning is at least part of the answer to these problems. For example, there is now sufficient evidence from across the UK that where Minor Eye Conditions Services 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

[1] Deloitte. 'There's no place like phone.' https://www.deloitte.co.uk/mobileuk/assets/pdf/Deloitte-Mobile-Consumer-2016-There-is-no-place-like-phone.pdf

[2] 'Increasing demand on hospital eye services risks patients losing vision.' Royal College of Ophthalmologists. https://www.rcophth.ac.uk/2016/03/increasing-demand-on-hospital-eye-services-risks-patients-losing-vision/ http://www.hscic.gov.uk/catalogue/PUB16722/hosp-outp-acti-201314-all-atte-tab.xlsx;
Hospital Outpatient Activity. 2015-2016. NHS Digital.
http://www.content.digital.nhs.uk/catalogue/PUB22596/hosp-epis-stat-outp-all-atte-2015-16-tab.xlsx

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

referred to these services can be managed out of hospital.[4] Commissioning such services can go a long way towards freeing up secondary care and GP capacity.

Furthermore, as primary care providers, community optical practices are also well placed to make use of optometrists' contacts with patients during their regular sight tests to begin conversations with them about the dangers to eye health and general health from smoking, excessive alcohol consumption, poor diets and many more lifestyle factors inimical to eye and general health. These conversations can, if necessary, develop into public health interventions such as health checks. All local authorities should seize the initiative to make every contact count by commissioning such 'Health Living Optical Practices' services (as are beginning to be commissioned in parts of the country) to make best use of capacity and professional skills in community optical practices to encourage individuals to address health issues.

However, it is essential that such interventions are properly commissioned and funded. It is not reasonable or indeed possible for primary care outside of the remit of the core General Ophthalmic Services contract to occur unless specific commissioning and funding is in place. Where it is, there is a clear role for community optics to help meet the prevention agenda outlined in the Five Year Forward View.

For this inquiry to have the greatest effect, the full health context which produces such capacity pressures and bottlenecks must be considered. For example, it should be considered how ophthalmology tariffs can act as revenue centres for trusts, and the incentive in some cases therefore for trusts to keep as much of this activity as they can to offset more expensive care. This is not a simple case of professional remits or agendas but the reality of a highly-fragmented health economy in which each component part must account for its remit and expenditure.

[4] 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

It is essential to understand the nature of referrals, trusts, in the context of demographic, clinical or political imperatives. What works for one area of health care may—and often does—adversely affect others. Addressing the wider issue by taking a whole-systems approach to breaking down barriers through integration is the nub of the Five Year Forward View, but this will only succeed with concerted will, as we say in answer 6. In our view, seeking to simply replicate the Call to Action which regrettably disappeared in the ether will constitute a missed opportunity. We would be very happy to work with the All Party Parliamentary Group on Primary Care and Public Health and government to explain this further.

2) Is it necessary to commission self-care and how can this be done effectively?

We do not think it is necessary to commission self-care. We think this would be impractical, potentially confusing to the public and likely to be expensive. Instead, we think that the types of services outlined in 1) should be commissioned by clinical commissioning groups (CCGs) and local authorities in order to make best use of professionals' skills and contacts with the public.

3) What training is necessary to support primary care staff in educating people to look after themselves and who is providing this training?

For health professionals, including optical professionals, public health interventions to educate people to look after their health will broadly fall under the expected competencies of the role; robust accreditation processes should however be put into place for participating practitioners. For non-clinical practice staff, training would be required. This would typically be provided and funded by local authorities' public health teams.

4) How can local health expertise such as pharmacy, health coaches, patient groups and charities, etc be incorporated into the system to help manage demand?

We note that this question fails to reference community optics as a mechanism for helping managing demand. This is an oversight as community optics as a primary care profession has a major role to play in managing demand, as explained above. It is important that all

possible avenues are explored to both take pressures off secondary care and GP surgeries as well as implement prevention strategies to manage demand.

5) What else has to happen to improve joint working locally to engage people in their health and wellbeing and so reduce service demand?

One important way to improve joint working locally is to ensure that local NHS providers are IT interconnected with other providers. At present, despite being providers of NHS primary care services, community optical practices are omitted from NHS IT improvement programmes. Despite our repeated requests, NHS England has not agreed to make the relatively small but significant investment needed to end community optical practices' technological isolation from the rest of health and social care. This isolation has led to duplication in the system at all points and continues to be a major barrier to improving eye health efficiency and outcomes. It is important that this be rectified by integrating community optical practices into existing IT health architecture. Doing so will allow practices to better work with local health colleagues to engage people in managing their health and wellbeing, so helping to reduce overall demand.

6) What impact have Government policies such as the Five Year Forward View and GP Forward View had in managing demand and how can we move towards that much sought after whole-systems NHS?

The Five Year Forward View has been important for bringing prevention and integration to the forefront of the health agenda. However, while it has successfully outlined the kind of change that needs to take place the pace of change has been frustratingly slow. While some commissioners have recognised the importance to begin commissioning out of hospital care in accordance with the Five Year Forward View, others have not. Sustainable Transformation Plans (STPs) have, due to the complexity of their implementation, tied up much of health infrastructure; their bigger footprints and integrated approach, however, is a step in the right direction away from the intensely fragmented nature of current health with all the well-known 'postcode lottery' ramifications. It should be noted that this is our present

assumption of how the impact of STPs will manifest. Given that they are entirely new entities it is not possible to know what their impact will be in reality.

However, in our view the only way to make out-of-hospital care a national reality is through national care pathways. Commissioning community services that utilise the core skills of optometrists and opticians at a national level will significantly reduce costs and administration, as CCGs currently must engage the services of commissioning support units to develop service specifications, negotiate fees, and draw up contracts for each individual community service they commission. Community services should be commissioned with a standard national service specification, including pathways, accreditation, and clinical governance requirements, for which frameworks already exist.[5] Standardised electronic data collection, reporting, clinical audit, performance monitoring and evaluation of outcomes should be integral to the commissioning of these services. We would be pleased to work with government and commissioners in seeking to achieve this.

In terms of whether the Forward View has helped to manage demand, this is difficult to judge. But the fact that the overall number of GP consultations had increased by 15% in the five years to May 2015 indicates that the Forward View's impact has yet to be felt, although it is recognised that its effects will be long-term.[6] While it is obviously positive—and necessary—that there was such a focus on prevention in the Forward View, without concrete action such as commissioning the types of services discussed in this consultation response, there is the risk that that its good intentions will remain unrealised. Put simply, the health service cannot go on in its current guise without serious and concerted change of the type we have outlined. There is now a consensus; what is needed is the will—at all levels but especially politically—to drive this through.

[5] 'Community Services Pathways.' Local Optical Committee Support Unit. http://www.locsu.co.uk/community-services-pathways/

[6] 'Causes of GP crisis revealed in new analysis.' King's Fund. https://www.kingsfund.org.uk/press/press-releases/causes-gp-crisis-revealed-new-analysis