Parliamentary Inquiry into Capacity Problems in NHS Eye Care Services and Avoidable Sight Loss in England – Call for Evidence

5.5 (E) From health profession bodies, charities, research and health industry organisations with an interest in eye health commissioning and planning

Optical Confederation and Local Optical Committee Support Unit response

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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.

Q1. How effective are the following at assessing the eye health needs of their local populations?

- **(a) CCGs**
- **(b) STPs**

A) It is difficult to say whether CCGs are effective at assessing eye health needs as this is the responsibility of local authorities' public health teams. However, while CCGs should work closely with public health teams to gain the most comprehensive understanding of local population eye health needs this does not always happen. Eye health needs assessments (EHNAs) and joint strategic needs assessment (JSNAs) are in-depth demographic studies of local populations' eye health/general health needs and offer the best available tool for assessment; we urge CCGs to make best use of these, and always take local needs into account. As well as doing so, CCGs should also work with local eye health networks (LEHNs) as these NHS England funded bodies are best placed to assess required outcomes locally and drive and support engagement. Failing to do this runs the risk of CCGs poorly scoping services in which, for example, existing unmet need is underestimated.

B) Unfortunately, few STPs have eye health on their agenda presently. Given that the role of assessment largely sits outside CCGs as explained, it is therefore unsurprising that the STPs which cover them are not yet fulfilling this role. And in some cases, STPs are still formalising structures which is further delaying adequate planning for eye health.

Q2. Compared to other areas of health and social care what priority do you consider the following give to eye health services?

- (a) CCGs
- (b) STPs

A) While an increasing number of CCGs are beginning to give a greater priority to eye health services, on the whole CCGs have not prioritised eye health sufficiently

since they were established in 2013. This is all the more disappointing given the priority that the public itself gives to eye health: adults are more afraid of losing their sight than they are of developing serious conditions such as Alzheimer's, Parkinson's, or heart disease, or of having to use a wheelchair.[1] Prioritising eye health outcomes can reduce the incidence of sight loss: over 30% of sight loss can be avoided through early identification of sight-threatening pathologies and even more through correcting refractive error.[2] When considering priorities, CCGs need to be aware of the co-morbidities of eye health including dementia, diabetes, unhealthy life styles, falls amongst the elderly and mental health conditions such as depression and anxiety. CCGs must synchronise their priorities with that of their patients.

B) Eye health is even lower on the STP agenda than that of CCGs. STPs have largely focused on secondary care to date. While this was to some extent expected and understandable, we have serious concerns at this point that STPs overall are not giving eye health the focus it needs.

Q3. How effective are (a) CCGs at commissioning and (b) STPs at planning eye health services to meet local patient demand? Please explain why.

A) The effectiveness of CCG eye health commissioning varies greatly. Strong local relationships between primary and secondary care, public health, wider local authorities, professionals, and patients are the key to effective commissioning. In some areas (for example Greater Manchester) this has been on the whole good. It is when CCGs appreciate the unnecessary number of ophthalmology outpatient appointments at their local trusts that eye health needs are evaluated and planned in

[1] 'Blindness feared more than Alzheimer's, Parkinson's and heart disease,' RNIB. 2014. http://www.rnib.org.uk/blindness-feared-more-alzheimer%E2%80%99s-parkinson%E2%80%99s-and-heart-disease.

[2] 'Future of Sight Loss UK (1): The economic impact of partial sight and blindness in the UK adult population,' Access Economics (RNIB). 2009. http://www.rnib.org.uk/sites/default/files/FSUK_Report.pdf

a more organised way. The more effective CCGs recognise that over the five years to 2016 the number of attendances in specialist secondary eye care services has risen by more than 30% and currently ophthalmology outpatients constitute the second largest number by speciality (over 7 million), yet 78% of incidences of minor eye conditions are deemed non-serious and can be treated by community optometrists.[3]

Unfortunately, however, it is too often the case that CCGs are reactive rather than proactive in commissioning for eye health. CCGs' primary focus on secondary care, rather than extended primary care services means that they are especially susceptible to urgent requests from hospital trusts, or following unexpected incidents. Furthermore, where local ties are weak, siloed thinking inevitably reigns to the detriment of holistic patient-focused outcomes.

A further problem is that monies intended to fund the hospital eye service are covered in block contracts or syphoned off for other areas of NHS and Foundation Trust work. In short, there is no means of tracking the funds invested against the patients seen and outcomes achieved. This is likely to worsen with the move to accountable care systems where there is likely to be even more pressure on the ophthalmic front-line, less clarity about service and budget lines and, combined with the loosening of all quality metrics except financial balance, downward pressure on care and less good outcomes for patients. Already some 20 NHS patients a month are losing their sight for want of capacity. As the NHS moves back to the status quo ante 1989 and transparency is lost, clear budget, service lines and healthcare

[3]C. McEwan, 'Increasing demand on hospital eye services risks patients losing vision,' Royal College of Ophthalmologists. 2016. https://www.rcophth.ac.uk/2016/03/increasing-demand-on-hospital-eye-services-risks-patients-losing-vision/;
'Hospital Outpatient Activity - 2015-16,' NHS Digital. http://www.content.digital.nhs.uk/catalogue/PUB22596/hosp-epis-stat-outp-all-atte-2015-16-tab.xlsx;
J.H. Sheldrick; S.A. Vernon; A. Wilson, 'Study of diagnostic accord between general practitioners and an ophthalmologist.' British Medical Journal. April 1992 Volume 304 Issue 6834. http://europepmc.org/articles/PMC1881924

resource groups are needed to ensure transparency so that accountable care systems can be genuinely held to account.

B) So far there is little evidence for STPs planning eye health services to meet local patient demand. There is great potential for the 44 STPs to assume the lead role in directing the commissioning of new models at scale (while not holding contracts themselves) given their larger footprints, which would to some extent mitigate the problematic fragmentation which currently exists with over 200 CCGs in existence. While local factors always come into play, and in lieu of national pathways—which would offer the most cost-effective commissioning solution for the NHS—commissioning on the small local scale of CCGs is an unnecessary use of time and resources. STPs could provide economies of scale allowing service redesign for eye health resources to realise great savings. However, so far that potential has been unrealised.

Q4. Do you think the priority of eye health should be raised at the local area to meet existing and/or future patient demand? Yes or no, please explain why?

Yes, but in fact engaged local groups are already doing this. LOCs—bodies referred to in statute to represent optical contractors and practitioners—work closely with CCGs (and STPs) and trusts to appraise them of local eye health requirements and negotiate extended primary care services. In addition, LEHNs bring local stakeholders together to suggest ways to meet current and future demand for eye health services. An example of this is the London LEHN and NHS England publication on 'Achieving Better Outcomes.'[4] These groups of local eye health experts are often the key drivers of outcomes in given regions and NHS commissioners must fully engage with them

[4] 'Eye Health Network for London,' NHS England. http://www.londonsenate.nhs.uk/wp-content/uploads/2015/07/Item-5-2015-07-21-LCSC-Final-London-Eye-Health-Network-Achieving-Better-Outcomes.pdf

in their patients' interests. Support from NHS and the Government should be offered as required.

Q5. Please tell us about examples which are currently meeting demand for eye health services and/or which are enabling them to improve as a result of:

- (a) commissioning by CCGs and/or
- (b) planning by STPs.

A) While CCG commissioning remains patchy, many CCGs have been proactive and commissioned extended primary care services in line with NHS England's and the Government's out of hospital integrated care agenda. NHS funded Minor Eye Conditions Services (MECs), which sees community optometrists carry out investigations and treatment for things like red painful eyes and 'floaters' in vision, have been commissioned by 55% of CCGs across England.[5] For the present NHS year, over two-thirds (68%) of all patients presenting for the first time with a minor eye condition are being discharged having visited their community optometrist. With a MECs in place, CCGs can save significantly on ophthalmology first appointment tariffs and ensure that ophthalmologists see more of the complex presentations which only they are equipped to manage. This allows the eye care pathway in its entirety to become more efficient and improve consequentially. However, as shown, nearly half of CCGs still have not commissioned MECs. Where extended primary care services are not commissioned by the NHS, patients are more likely to turn to secondary care or be referred unnecessarily. As an illustration of this, a recent study in south east London has shown that in Lambeth and Lewisham where MECs is commissioned, first attendances to secondary care as referred by GPs were reduced by nearly 27%, as compared to neighbouring Southwark where MECs is not commissioned.[28]

[5] This includes commissioners which have given a written intent to commission these services. In addition, 58% of CCGs have commissioned Cataract Referral, 40% Cataract post-operative and 79% Glaucoma Repeat Readings Services on the same basis.

B) STPs potentially offer a better solution than the current piece-meal commissioning due to their bigger footprints and focus on integrated care. As we have said, regrettably, in general they have not dedicated enough time to the role of extended primary care services in complementing secondary care to achieve this. However, there are some examples where STPs have planned effectively to meet eye health demand and improve the wider pathway.

In Greater Manchester, a formal Eye Health Transformation Plan has been agreed at STP level to address demand and capacity issues and improve quality and patient safety. This has many strands to it in progress, including building on good examples of CCG commissioning to be scaled up across the STP/devolutionary footprint. This means the proposal for a single Greater Manchester-wide primary eyecare service across the whole area which will also include greater stepped down care to primary and community care. This is alongside population health improvement by early detection through regular sight tests, as well as building for demand from groups which often do not access health care.

There are other examples of good engagement at STP level such as in Lancashire, where optometry has been invited to the primary care programme board as a regular representative and the STP is encouraging an optometry offer, and Staffordshire where the STP is considering a combined Community Optometry and Ophthalmology Service. Optical representation is an important component for ensuring that the potential of community optics is understood in local NHS decision making structures.

Unfortunately, though, incidences of effective eye health planning by STPs are few and far between. This must change.

Q6. How do you think the commissioning, planning and delivery of eye care services can be improved at?

- (a) the local level, and
- (b) the national level

A) Under the current commissioning architecture, engagement at all levels is the key locally for improving commissioning, planning and delivery. CCGs and STPs must make better use of planning resources such as EHNAs and work with local public health teams whether these are in place or not. CCGs must also engage with local experts including LOCs and LEHNs and patient representatives. This is important from the planning phase, as a poorly scoped service will fail to deliver objectives and key performance indicators and potentially result in unintended consequences.

Regular communication through the planning, tendering (where permitted), mobilisation and delivery phases is essential. Making use of best practice examples across wider areas is also necessary. While each area is different and will have a unique demographic mix, generally speaking, eye heath pathways have many common elements and so can base service design on existing successful services. Siloed and territorial working must be avoided otherwise eye care services will fail to reach the expected standard of integration and patient outcomes will suffer.

For STPs, this will mean building upon successes at CCG level and learning lessons from where service design has been inadequate to meet demand, underestimated unmet demand, been too reactive especially in secondary care, or engendered unrealistic expectations.

B) National commissioning for eye health outside of the national diabetic screening programme does not currently exist. Therefore, this question is difficult to answer within the current commissioning landscape. However, for commissioners to meet national demand and improve eye health outcomes across the whole country we

would like to see a national commissioning programme of minor eye conditions services (MECs), and other extended primary care programmes. It is concerning that the successful models of national primary care services implemented in Scotland and Wales do not exist in England. Commissioning community services that utilise the core skills of optometrists and dispensing opticians at a national level will significantly reduce costs and administration as CCGs currently have to 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.[6] Local optical committees and the specialist contracting vehicles associated with them would have a key role in driving local patient outcomes under national pathways, building on their experience of local pathways.

CCGs and STPs should also make use of the VISION 2020 UK Ophthalmic Public Health Committee: Portfolio of Indicators for Eye Health and Care, which are designed to review and monitor population eye health, care and wellbeing (at national and local level) and embed an eye health perspective in the use and interpretation of mainstream Outcome Frameworks.[7]

Q7. What effect would raising the priority of eye health at a national/ strategic level (such as the NHS Mandate) have on improving commissioning across England and at the local level, and planning and delivery by STPs, to help meet current and future demand for services?

[6] Such as those produced by LOCSU. http://www.locsu.co.uk/community-services-pathways/
[7] Portfolio of Indicators for Eye Health and Care, VISION 2020 UK Ophthalmic Public Health Committee. 2015. http://www.vision2020uk.org.uk/vision-2020-uk-ophthalmic-public-health-committee-portfolio-of-indicators-for-eye-health-and-care/

We would support such an initiative. In some areas, eye health is considered 'too difficult,' due to the strong local opinions of trusts and consultants resistance to service redesign and structural reform. If CCGs were empowered with such a mandate for eye health, this would present them with the necessary authority to challenge entrenched local certainties and instigate change as required.

At present, too much time and resource is wasted on local discussion relating to local (or even personal) opinion and not on the required patient outcomes. It is often the case that CCGs and now STPs make it clear that eye health is not a priority to them. This lack or prioritisation stems in part from their immutable requirement to address existing mandated priorities, as well as limited resources making it impossible to prioritise every health matter at a local level.

Q8. The Public Health Outcomes Framework (PHOF) includes an indicator to highlight the rate of preventable sight loss in the population. The PHOF Data Tool shows significant variation in the rate of preventable sight loss for each local authority.

- At the national, CCG and STP-levels, how can the scrutiny of commissioning and planning of eye health services and eye health outcomes be improved?

While commissioning bodies should also have regard for the Public Health Outcomes Framework, rates of sight loss alone are limited in improving outcomes. While a high level may indicate poor health services, it could also indicate an effective registration processes which would suggest effective health services with robust awareness of registration requirements. The indicator was chosen because it is measurable with current data; not because it was a holistic solution to data needs.

What is required are real and meaningful outcome measures with improved data at all levels. There is still a lack of data available regarding eye health nationally and

locally. CCGs and trusts struggle with assessing need with the current data sets. As an illustration of this, LOCSU recently worked with one trust to be informed that the trust was unable to identify how many patients they had on their glaucoma register, despite the utilisation of an electronic database. Data such at this, at an organisational level, should be standard to allow for adequate service design. Hospitals should be tasked with ensuring diagnoses are accurately recorded for all patients and performance management measures should be implemented to support this. Episode and clinical data need to be effectively gathered, retained and then analysed to enable audit of outcomes, evaluation of pathways and future commissioning decisions. In addition, data should be shared between primary and secondary care; failure to do so will make health care integration difficult to achieve.

Q9. Please provide any other information that you feel the APPG should be made aware of in support of your response. Links to relevant reports or research can also be included or you can email them along with your response to the inquiry at APPGinquiry@rnib.org.uk.

As stated in our response, there are now over 7 million ophthalmology outpatient appointments each year: the second highest by speciality with 270,000 A&E visits for eye-related problems every year which could be better and faster managed in primary care. For this inquiry to have the greatest effect, we think that the APPG must recognise the full context which produces these types of statistics. With that in mind, while there is a general consensus that too many patients unnecessarily enter hospital eye services for eye health issues (notwithstanding occasional disagreement at local level), it is the case that ophthalmology tariffs can act as revenue centres for trusts. There is an 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 expenditure.

Within primary care and secondary care there are completing imperatives across demographic, clinical, and political fields. Our view is that the Five Year Forward View and new models of care it established are the right way to drive through whole-systems approach to breaking down barriers through integration. NHS England and other health bodies are working to achieve this. The fundamental question is whether the political will at national and local level exists to cement this. We welcome the APPG raising the issues it has done; what will matter following the consultation process is whether it can act to implement the sorts of changes we have outlined through.