Optical Confederation Submission to the Health Select Committee Inquiry into Public Expenditure

Summary

- Opticians and optical practices remain an under-utilised NHS resource and should be a lead area in the delivery of the Quality, Innovation, Productivity and Prevention (QIPP) agenda, freeing up capacity in secondary eye care and providing better access for patients.
- In 2008, 1.8 million people were registered with partial sight and blindness and this is set to grow by 115 per cent to over 4 million people by 2050.[1] Yet, around half of all sight loss is thought to be preventable, rising to up to 70% amongst the elderly.[2]
- Sight loss is also associated with a higher risk of falls and reduced ability to live independently. This problem has not been adequately addressed by the NHS to date despite the total annual health, social and economic costs of sight loss, estimated to be £22 billion in 2008.[3] Unless action is taken, these costs will rise markedly in line with increasing sight loss and blindness over the coming years.
- Preventing visual impairment can deliver substantial downstream cost savings which should be factored into the efficiency gains. These provide a better overall interface between the health care and social care, which will bring about longer-term improvements in efficiency, preventive care and reablement.

1. Introduction

1.1 The Optical Confederation represents the 12,000 optometrists, the 6,000 dispensing opticians and 7,000 optical businesses 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 Ophthalmic and Dispensing Opticians (FODO). As a Confederation, we work with others to improve eye health for the public good. The Optical Confederation welcomes this opportunity to submit comments to the inquiry on public expenditure, and would be willing to support the Health Select Committee in making equity and excellence in eye care a reality.

1.2. We have concerns that, to date, UK Governments have failed to address the issue of rising visual impairment in the UK population – half of which, the RNIB estimates to be preventable. A recent report[4] outlined the magnitude of this problem of visual impairment in the UK, and the impact of an ageing population on the eye health of the nation in the future.

2. Rising to the Nicholson Challenge

2.1 The implications of the Nicholson challenge will be diverse, affecting all parts of NHS provision. For eye care, this will require a rethink of the totality of the services. The Bosanquet Report (2010) demonstrates that eye care, like other services, will need to make the most efficient and effective use of all available resources in order to address rising visual impairment.

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[1] Epivision (2009) for RNIB Future Sight Loss UK (2)

[2] Tate et al (2005) The prevalence of visual impairment in the UK; A review of the literature www.rnib.org.uk/xpedio/groups/public/documents/PublicWebsite/public_prevalencereport.doc

[3] Access Economics (2009) for RNIB Future Sight Loss UK (1)

[4] Bosanquet, N (2010) *Liberating the NHS: Eye Care, Making a Reality of Equity and Excellence*

2.2 Community eye care services are flexible and can rapidly respond to service demands. Each year, the optical bodies review forward workforce needs and liaise directly with universities and training agencies to ensure these are met. This flexibility means that community optical practices are well positioned to do much more to address waiting lists in secondary eye care, while freeing hospital capacity for new treatments and therapies.

2.2 We would recommend a number of successful enhanced eye care services be adopted nationwide, namely in glaucoma referral refinement, management of stable glaucoma, and primary eyecare assessment in community optical practices. These tried and tested schemes have delivered better patient outcomes, local cost savings, reduced waiting times and helped to deliver a local patient-centred service without increasing patient risk. Adopting these schemes has also freed up significant capacity in secondary eye care to focus on patients facing acute or chronic sight loss.

3. Delivering QIPP

3.1 We believe that eye care services can be a lead area for QIPP, freeing up resources in the NHS, and delivering quality improvements at low cost. A recent and very noteworthy innovation in eye care is the development of the Commissioning Toolkit for Eye Care by the UK Vision Strategy. This toolkit highlights why eye care services should be prioritised, the potential for a small investment to deliver sizable results, and provides guidance to support the commissioning of better eye care services across the NHS.[5] Furthermore, the Royal College of Ophthalmologists and the College of Optometrists are jointly bringing together the evidence base in supplementary commissioning guidelines for Clinical Commissioning Groups.

3.2 Delivering improved eye care services should start with national quality standards agreed by NICE and endorsed by the Royal Colleges, to be commended by the NHS Commissioning Board to PCTs and Clinical Commissioning Groups for early adoption. Local commissioners should understand the magnitude of the challenge of visual impairment, which is often misunderstood by focussing on local data for registered blindness and visual impairment, which understates the true figures (as significant numbers are still not registered).

3.3 The existing access and demand management controls in community eye care operate well. Under a memorandum of understanding, the NHS funds only clinically necessary sight tests. However, many working age adults, who are self-funding, who should attend for regular sight tests, do not come forward for one, with a risk of non-detection of visual impairment and (often preventable) downstream costs for the NHS and social care. This should be addressed by raising public awareness about eye health.

4. Low vision services

4.1 With regard to social care resource allocation, low vision services are the Cinderella of Cinderella services and much personal independence is compromised through inadequate assessment, a lack of point of diagnosis support and supply of low vision aids. This will only get worse as budgets are stretched (as noted in the Committee's recent Report on Public Expenditure, councils will need to sustain further efficiency savings of up to 3.5% per annum throughout the Spending Review Period to avoid reducing their levels of care[6]), unless low vision is prioritised, for example through advice and guidance (on the range of low vision services) to Social Care departments and frontline staff.

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[5] http://www.commissioningforeyecare.org.uk/

[6] Second Report of Session 2010–11, HC 512, p.29-30