Optical Confederation Submission to the Health Select Committee Inquiry into Public Expenditure on Health and Social Care

Summary

- 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] Careful planning by all health and social care professionals in order to slow, or even to halt, this expected rise, must continue to be a key priority.
- Most hospital urgent eye care services report that they struggle to keep pace with demand. Demand for hospital eye emergency services is thought to be increasing. However, most urgent eye conditions are non-acute and relatively straightforward to treat.
- 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.
- 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 This document sets out the response of the Optical Confederation to the Health Select Committee inquiry into Public Expenditure on Health and Social Care. It builds upon written evidence submitted to the Committee on the same topic in September 2011[4].

1.2 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

[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] http://www.opticalconfederation.org.uk/downloads/consultations/OC%20Submission%20to%20HSC%20Inquiry%20into%20Public%20Expenditure.pdf

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.

2.) Progress on making efficiencies through the integration of health and social care services.

2.1 The increase in demand for NHS eye care services requires careful planning by all health and social care professionals in order to slow, or even to halt, this rise. Some progress has been made with the establishment of Local Eye Health Networks (LEHNs) across all NHS England Local Areas.

2.2 The aim is that these LEHNs will bring together all local eye health stakeholders in a clinically-led, patient- and population-focussed model to achieve progress against the sight loss indicator locally. This will involve assessing local eye health needs, redesigning pathways as necessary in line with QIPP principles and maximising the deployment of resources across primary, secondary, social and voluntary sector care for health gain.

2.3 As previously mentioned, eye care services can be a lead area for QIPP, freeing up resources in the NHS, and delivering quality improvements at low cost. A 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 sizeable results, and provides guidance to support the commissioning of better eye care services across the NHS.[5] Moreover, the recently formed Clinical Council for Eye Health Commissioning will also aim to offer united, evidence-based clinical advice and guidance to those commissioning and delivering eye health services in England on issues where national leadership is needed.

2.4 The Clinical Council for Eye Health Commissioning plans to work in partnership with NHS England, to support the development of services to meet local needs and improve outcomes based on best evidence and in the most patient sensitive and cost-effective ways. The Clinical Council is now contributing to the development of NICE accredited commissioning guidance on cataract and glaucoma services. The Council will then move on to look at the best ways of improving the quality and efficiency of services for age-related macular degeneration and diabetic retinopathy in line with indicator 4.12 of the Public Health Outcomes Framework[6].

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

[6] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216162/Improving-outcomes-and-supporting-transparency-part-21.pdf, p.112-114.

3. IT

3.1 In line with the NHS's vision for referrals to be completely paperless by 2018, the interconnectivity of community optical, GP, Choose and Book and hospital eye service IT systems should be made a priority by government as it will enable rapid exchange of clinical, referral, financial and audit data. The Scottish Government is already making good progress towards this goal and, as a Confederation, we warmly welcomed NHS England's announcement in June 2012 that they were in the early stages of developing a national specification for primary ophthalmic services (POS) claims and payments, an important first step towards greater connectivity in England and collecting outcomes data. We look forward to working with all relevant stakeholders to achieve integrated IT systems, as mentioned above, as their absence is a major obstacle to integrated eye care.

4.) Reports of particular financial pressures in the system, such as funding for General Practice, and for Accident and Emergency services

4.1 Urgent eye care is provided by GPs, optometrists, A&E departments, minor injury units, eye casualty departments and rapid-access outpatient clinics. An urgent eye condition is any eye condition that is of recent onset and is distressing or is believed by the patient, carer or referring health professional to present an imminent threat to vision or general health. However many patients treated by the urgent eye care service have non-urgent conditions, particularly patients who self-refer to eye casualty.

4.2 Most hospital urgent eye care services report that they struggle to keep pace with demand. Demand for hospital eye emergency services is thought to be increasing. Evidence from London, shows that over a five year period up to 2011, demand at two major eye casualty units increased by seven and ten per cent year on year[7] and eye emergencies are estimated to make up 1.46-6% of accident and emergency attendances[8]. However, most urgent eye conditions are non-acute and relatively straightforward to treat[9].

4.3 To make services more accessible and reduce pressure on hospital eye casualty, a significant proportion of patients can be diagnosed and managed in a primary care instead by a healthcare professional with a slit lamp (which allows you to see the front and back of the eye in detail and is needed to diagnose most urgent eye conditions) and the skills and experience to use it. GPs do not usually have slit lamps or enough experience of using one, but community optometrists do and are well placed to promptly diagnose, triage and treat patients with urgent eye problems safely and efficiently.

4.4 Other efficiencies could be made by nationwide adoption of a number of successful enhanced eye care services, namely in glaucoma referral refinement,

[7] Smith HB, Daniel CS, Verma S Eye Casualty Services in London Eye (Lond) 2013 Mar;27 (3):320-8 Epub 2013 Feb 1

[8] Flitcroft DI, Westcott M, Wormald R, Touquet R. Who should see eye casualties?: a comparison of eye care in an accident and emergency department with a dedicated eye casualty.. *J Accid Emerg Med*. 1995 12(1):23-7.

[9] Bhatt R, Sandramouli S Evidence-based practice in acute ophthalmology. *Eye* 2007; 21(7):976-83. Epub 2006 Apr 28. Review.

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.[10] Adopting these schemes has also freed up significant capacity in secondary eye care to focus on patients facing acute or chronic sight loss.

5. Falls prevention

5.1 The impacts of sight loss on older people are well documented, including the role uncorrected visual problems play in falls and performance of everyday tasks[11]. The full financial cost of these falls to the NHS and social care has not been calculated, however it is conservatively estimated by the Royal National Institute of Blind People at £25 million per year[12].

[10] http://www.locsu.co.uk/enhanced-services-pathways/

[11] Studies have shown that falls can be reduced by as much as 14% when visual impairment is considered as part of a falls reduction plan (Day L, Filders B, Gordon I et al, Randomised factorial trail of falls prevention among older people living in their own homes, BMJ, 325: 128, 2002)

[12] http://www.rnib.org.uk/aboutus/Research/reports/inclusion/Pages/falls_costs.aspx