Written Evidence from Optical Federation and LOCSU

Optical Confederation and Local Optical Committee Support Unit

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.

How effective have STPs been in joining up health and social care across their footprints, and in engaging parts of the system outside the acute healthcare sector, for example primary care, local authorities, public health, mental health and voluntary sector partners? How effectively are they engaging local communities and their representatives?

We do not feel that most STPs have been effective in driving integration and engagement. STP planning and delivery has been inconsistent across the country. Some areas, for example the devolved Greater Manchester area, *have* been successful in engaging the whole of primary care in the planning of strategic system reform and service redesign discussions. They have included eye care, which is

frequently not remembered when plans are made to involve primary care. But other areas have not engaged anyone beyond acute services, and some that have involved primary care have limited this to GPs and not involved the other primary care services such as eye health. Unfortunately, it is the latter that is more representative.

The Optical Confederation finds this situation, and more specifically the lack optometry engagement, disappointing and surprising given that the pressures across the acute ophthalmic pathway are both very well documented and currently under investigation.

In 2015-16 there were over 7 million ophthalmology appointments - the second most numerous by specialty (http://digital.nhs.uk/catalogue/PUB22596). More than 10% of all outpatient appointments in England are for eye care and between 2010 – 2015, attendances grew by 30% (https://www.rcophth.ac.uk/2016/03/increasing-demand-on-hospital-eye-services-risks-patients-losing-vision/).

These pressures are leading to unnecessary sight loss and patient distress. These capacity issues are now the subject of investigation by the All Party Parliamentary Group on Eye Care and Visual Impairment (http://www.rnib.org.uk/appginquiry).

STPs represent a good opportunity for all elements of public service provision to address these sorts of issues but as it stands we are concerned that this opportunity is being missed.

It has been shown that 78% of instances of minor eye conditions are deemed non-serious and can therefore be expertly treated by community optometrists and dispensing opticians (http://europepmc.org/articles/PMC1881924). Properly commissioned community pathways, such as those developed by LOCSU, fulfill many of the objectives of STPs and the Five Year Forward View by providing out-of-hospital professional eye health care at convenient locations for patients (http://www.locsu.co.uk/community-services-pathways/). STP managers need to

engage better with these types of alternatives to secondary care to help them meet NHS England and the Government's stated objectives.

How reliable are the ratings in the Sustainability and Transformation Partnerships Progress Dashboard, and what do they tell us about the state of the plans and the relationships that underpin them?

These dashboards are important for CCG/STP and acute business intelligence teams but do not appear to be relevant for community optical practice. We note that while there is a section for general practice, other primary care professions are omitted. Is there scope for their inclusion?

What do the available evidence, and experience so far, tell us about the deliverability of STP plans given the financial and workforce pressures across the NHS and local government? Are the demands being made of STP plans through the NHS Mandate and the NHS Shared Planning Guidance deliverable, and can STPs ensure the fulfillment of the requirements of the NHS Constitution?

Experience to date shows us that STP plans and planning are both inconsistent and variable. Many plans demonstrate a priority to address out-patient waits and capacity issues but do not demonstrate at a specialty level how this will be achieved.

STP planning has not been transparent or inclusive. For example, some plans will state that there has been primary care involvement but this usually means GP involvement. Wider primary care will not have been involved. This results in local meetings where professionals are informed of STP plans, rather than being involved in their development.

Further, as commissioners are developing STP plans, local CCG-based commissioning has come to a standstill. The Optical Confederation, via LOCSU, is aware of several stalled projects across the country. These projects could have had a positive effect on acute capacity pressures across optical pathways if commissioned locally. Our concern is that NHS planning capacity has been diverted to STP design and implementation—which is overwhelmingly focused on secondary care. Therefore, ironically, the primary care services that could alleviate acute issues are not being commissioned.

Looking across all STPs, are there any major areas where the content of the plans needs to be tested for credibility and realism? Are there any major gaps? For example, are proposals in some plans to reduce bed capacity credible?; are the NHS efficiency estimates in STPs robust?; is the workforce available to enable the implementation of STPs?; or is the timescale for the changes proposed in STPs realistic?

Ophthalmology is the biggest elective care specialty. Cataracts are the highest volume elective procedure. If ophthalmic services are not being prioritised, then there is an issue with STP design and implementation. STPs are derived from the Five Year Forward View which placed great emphasis on the scope for out-of-hospital care to help mitigate some of the huge pressures on secondary capacity as above. While minor eye conditions and monitoring services will not directly impact upon bed capacity, they certainly will free up consultant capacity—providing that acute decommissioning complements community commissioning at the service design stage.

How will the development of STPs into Accountable Care Systems (ACSs) change the delivery of care in an area?

The development of ACSs should be positive as long as primary care, and organisations designed to deliver primary care in community settings such as local optical committee contracting vehicles (known as 'LOC Companies'), are included within the ACS. This will ensure that specific primary care targets and deliverables are included in ACS metrics. We are concerned about the lack of transparency around the structure, development and measurables of ACSs. In particular, there needs to be transparency regarding money flows into ACOs.

What governance, management and leadership arrangements need to be created to enable STP planning and implementation to be carried out effectively? Are additional, or different, arrangements required for areas which are developing ACSs?

Successful STP and ACS development is going to require clear and dedicated leadership from within the NHS. This may require resources currently engaged in other NHS organisations, for example CCGs and NHSE, to be deployed in leading STP and ACS development. In all areas local primary care, not just general practice, need to be involved in the development of structural plans, service delivery and ACS / STP evaluation.

What legislative, policy and/or other barriers are there to effective STP and ACS governance and implementation, and what needs to be done by national bodies and national leaders in the NHS to support the implementation of STPs and ACSs?

The central issue is that there is no legislation at all relating to STPs and ACSs. Consequently, plans can be subject to variability with no process for challenge. As outlined above, the success of STPs and ACSs will be predicated on the ability of the current NHS to lead the process in conjunction with local clinical leaders from across

the whole of primary care and other sectors.

What public engagement will be necessary to enable STPs/ACSs to succeed, and how should that engagement be undertaken?

There will need to be significant public engagement to ensure that the benefits of the STP and ACS process are realised. As STPs were formed there was no, or very little, public engagement. This has unfortunately given rise to a widely-held public view that STPs, and by association ACOs and ACSs, are simply organisations to cover either cutting or privatising individual services and the NHS more generally.

All STP and ACS plans must be completely transparent and open to public scrutiny. There needs involvement from professional groups across all care tiers and, crucially all sectors in primary care, not just GPs. Finally, all STPs and ACSs must be evaluated publicly with processes to change plans at scale if they prove to be either unworkable or unsuccessful.

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