House of Commons Public Accounts Committee:
***Inquiry into* Access to general practice in England**

Optical Confederation and Local Optical Committee Support Unit response

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The Optical Confederation represents the 12,000 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 Optical Confederation also represents manufacturers, distributors and importers. 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 and Regional Optical Committees (LOCs) in England to help them to develop, negotiate and implement local objectives in respect of primary ophthalmic services.

Summary

- The National Audit Office's report, *Stocktake of access to general practice in England*, raises a number of concerns on the increasing difficulty in obtaining a GP appointment, particularly for patients living in deprived or rural areas, and finds that demand is increasing faster than capacity, with number of consultations increasing by an estimated 3.5 % on average per year between 2004 -05 – 2014-15 and general practice staff increasing by 2% on average per year in the same period[1].

- It has long been our view that the only way of meeting the Government's objectives, the challenges of demographic change, growing expectations and financial constraint is by investing in, reinvigorating and reinventing the primary care sector in its totality. This cannot be done by working with professions in isolation. It requires the contribution and commitment of the entire primary care workforce.

- With approximately 1.5 – 2 % of GP consultations estimated to be eye-related[2] (and approximately and 270,000 eye-related A&E visits per year)[3], we

[1] NAO (2015) Stock take of Access to General Practice, https://www.nao.org.uk/wp-content/uploads/2015/11/Stocktake-of-access-to-general-practice-in-England.pdf
[2] RCGP Weekly Returns Service Annual Prevalence report. 2007. http://www.rcgp.org.uk/clinical-and-research/~/media/Files/CIRC/CIRC-76-80/BRU_Annual_prevalence_report_2007.ashx
[3] 11 Sheldrick JH, Vernon SA, Wilson A. Study of diagnostic accord between general practitioners and an ophthalmologist. BMJ. 1992 Apr 25;304(6834):1096-8.

believe that community optometry should be utilised to its full extent to relieve pressure on General Practice, as well as other areas of the NHS.

Response

It has long been our view that the only way of meeting the Government's objectives, as set out in the Five Year Forward View, including the challenges of demographic change, growing expectations and financial constraint, is by investing in, reinvigorating and reinventing the primary care sector in its totality. This cannot be done by working with professions in isolation. It requires the contribution and commitment of the entire primary care workforce.

One important question for primary care is what can be done to alleviate pressure on GPs. We welcome a recent report from NHS Alliance and Primary Care Foundation which identifies that 16% of GP's time could be spared by directing patients to other members of the primary care team[4]. We strongly believe that optical practices should be the first port of call for all eye health, to provide a better service for patients and to further help reduce pressure on GPs.

Optometrists and opticians are eye experts in the community. 12.8 million NHS sight tests per year, commissioned by NHS England under the General Ophthalmic Services (GOS) contract (part of the flexible overarching POS contract), are carried out in total, of which the large majority take place in 6,000 community optical practices in England. Over 400,000 NHS sight tests are delivered in a domiciliary setting, for those unable to attend a community practice. 5-6 million private sight tests a year are also carried out, to the same standards, making 19 million sight tests a year at an NHS cost of £0.25 billion. This makes the national NHS sight testing service the best value public health service in the NHS and GOS plays an important public health role in providing vision correction for the majority of the population who need it and case detection for those who need further investigation or treatment (about 5% of patients).

But opticians and optometrists have the skills and capacity to deliver more services in the community, above and beyond the sight test. 1.5 – 2 % of GP appointments are eye-related (as well as 270,000 eye-related A&E visits every year) which could be better and faster managed in primary care. This would provide a more efficient and cost effective service, would free-up capacity in secondary care, and would better meet the needs of patients.

In addition, the majority of optical practices are open 6 days a week with many also open Sundays. Therefore access to 7 day services is already available across the local network of practices which can be used to deliver NHS goals of 7 day services.

[4] Clay, H et al (2015), Making Time in General Practice, http://www.nhsalliance.org/wp-content/uploads/2015/10/Making-Time-in-General-Practice-FULL-REPORT-06-10-15.pdf

While there are successful community services being delivered in community optical practices across the country, there are significant barriers to these services being implemented at a greater scale.

Community eye care services are commissioned by CCGs and the commissioning of these services across the country is patchy and inconsistent. To date, only 32% of CCGs have commissioned Minor Eye Conditions Services (MECS) locally leading to duplication of cost and effort and resulting in postcode lotteries, and confusion amongst the public.

While we recognise that CCGs are now well established at the heart of the English health landscape, significant savings could still be achieved across the system by agreeing a national pathway with common standards, outcomes and experience measures that all areas would implement – ideally at one fixed fee to save commissioning costs – as is the case in Scotland and Wales.

Another barrier is the NHS Standard Contract, which is unwieldy and unnecessarily bureaucratic for providers of small-scale services, and may serve to act as a disincentive to small providers contracting with the NHS. We are pleased that NHS England is producing a streamlined version of the standard contract for use when contracting for less complex services of relatively low financial value, and this should be prioritised so that the new version can be made available for April 2016.