OFNC
Association of British Dispensing Opticians
Association of Optometrists
British Medical Association
Federation of Ophthalmic and Dispensing Opticians
Optometric Fees Negotiating Committee
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Chair: Trevor Warburton Secretary: Ann Blackmore

Optometric Fees Negotiating Committee
Bid to NHS England for fees and grants for 2019/20

Summary

The OFNC is bidding for:

- an increase in the GOS fee for mandatory services of 3%
- an increase in the GOS fee for additional services of 4%
- an increase in CET grants of 3%
- an increase in pre-registrant supervisor grants of 5%

In addition, we would like to see:

- an increase of 5% to voucher values
- a clear ongoing commitment to deliver a digital connectivity solution at pace
- NHS England publicly state that its long term aspiration is to expand NHS primary eye care services, on similar lines to the service now provided to patients in Wales, with clear encouragement for local commissioning of primary eye care services, beyond the national sight testing service, as part of the national plan to meet growing eye health need.

These changes are vital if community eye care providers are to fulfil their strategic potential as key deliverers of primary and secondary eye care services.

Our bid takes into account:

- the continued efficiencies demonstrated by optical practices performing GOS during three years of frozen fees
- the rising cost of delivering the GOS sight test, partly due to general inflationary pressure, but also because changing demographics mean a significant proportion of GOS patients increasingly need longer sight test appointments
- a strategic view of the future of NHS care, and specifically of the role in primary care that the optical sector in England can play, including:
  - the impact that financial stress will have on the national primary infrastructure as and when practices close – particularly in areas of high deprivation
  - the significant savings that a fully utilised primary eye care sector will generate for NHS secondary care, relieving pressure on overstretched hospital eye services and A&E departments, as well as relieving pressure on general practitioners.

Context

In the November 2018 Budget the Chancellor of the Exchequer confirmed the Prime Minister's announcement that the era of austerity was over. He also confirmed that the Government had decided to provide substantial extra, long-term funding to help the NHS meet the growing pressures it is facing, and the Secretary of State for Health and Social Care has recently reaffirmed the government's commitment to prevention and more community based services. In turn, the NHS has committed to publishing a long term (10 year) plan setting out how those resources will be used to provide improved services for patients.

We welcome the fact that the Government is providing investment over a longer period, which will give stability to the health service. We also welcome the Government's recognition that the pay cap needs to be lifted so that clinical staff's contribution to health care can be recognised and rewarded. We would expect that these principles – providing long term stability in funding, recognising the increasing pressures and costs on health services, and ensuring that healthcare workers can be fairly paid – to apply to all NHS funded services, including primary eye care services.

The NHS sight test has been substantially underfunded now for many years – as we have made clear in our negotiations with NHS England each year. GOS contract holders have faced increasing costs, demonstrated efficiency savings and continued to deliver a high quality service, despite many years of fee increases below inflation and most recently three years of fees being frozen. This situation is not sustainable, as the Government has recognised more widely across the NHS. We trust that a fair settlement will therefore be achieved for primary eye care this year.

Argument

1) Efficiency savings

For the last three years GOS contractors have continued to provide NHS-funded sight tests with no increase in fees, which were insufficient to cover the cost of providing the test even before the freeze began. At the same time we have seen an increase in general inflation (both RPI and CPI) and wage inflation, meaning that there have been significant cuts in GOS fees in real terms.

Over this period contractors have had to absorb significant administrative costs arising from PCSE's disastrous handling of optical support services including GOS payments, CET grant payments and administration of performers' lists. At the same time, they have incurred new costs arising from Government policy changes affecting employers, such as pension auto-enrolment, the apprenticeship levy and National Minimum Wage increases.

Contractors have also absorbed the cost of increased policy and regulatory requirements, most recently the Government's decision to require even small optical practices to appoint a statutory Data Protection Officer under the Data Protection Act 2018.

In the course of the 2018 OFNC negotiations, the NHS England negotiating team noted that an NHS Counter Fraud Authority (NHSCFA) report estimated the optical sector was subject to large-scale fraud and/or accidental mis-claiming both from patients and providers, which they suggested indicated substantial scope for further efficiency savings. We expressed concern with this assumption at the time and would be extremely concerned if NHS England continued to hold to this view. NHSCFA has not made the report available to anyone in the optical sector and we have expressed our strong reservations about the accuracy of the assumptions on which it is based. Moreover, we would point out that the first report of the Post Payment Verification pilot carried out by the NHS Business Services Authority in 2018, based on the highest level of conversion rates in the

two trial areas, found no reported cases of fraud and a reclaim rate of only 2.4%. This suggests that there is little if any scope for further efficiency savings in this area.

Therefore, on the basis of the increased costs that GOS contractors face and the efficiency savings that they have already delivered and continue to deliver, we propose that GOS fees for both mandatory and additional services should be increased by at least 2%.to reflect increases in remuneration and the underlying costs of operating a community practice.

2) Rising cost of delivering the sight test – impact of demographics

We appreciate that the GOS fee is set as an average, recognising that the time needed to conduct a sight test would vary depending on the circumstances of individual patients. This approach is administratively sensible for both government and providers. However, the assumptions on which the average time and therefore the fee were calculated have not been reviewed since 2004. Changes in demographics, specifically the ageing population, mean that a growing proportion of GOS patients require significantly longer sight test times, either because of ophthalmic co-morbidities (which may require more tests to be undertaken as part of a routine sight test) or simply because by virtue of their age (and the fact that they have other systemic co-morbidities which result in increased frailty) a sight test will take longer.

We have conducted an informal survey of our members and all have reported that the average time they allow for a sight test has had to increase to accommodate these changes. These increases are in the region of allowing 20-25% longer per patient. This of course further drives up the cost of providing the GOS sight test.

In Scotland the new GOS contract includes a code for a double eye examination when the practitioner expects an eye examination to take much longer than normal. The Scottish Government Health Department introduced this change to meet the needs of patients with health and communication problems where the standard primary eye examination time was not sufficient to perform all the appropriate tests, capture the necessary information and impart the advice afterwards.

Rather than seek an additional coding for double time appointments in specific cases, we propose that the GOS fee for mandatory services should increase by a further 1% to reflect this change, in addition to the general increase of 2% proposed above, leading to a total claim for an increase in GOS fees for mandatory services of 3%.

These considerations apply to an even greater degree to the GOS fee for additional services, since the age and frailty of domiciliary patients – and therefore the time needed to test them – is also increasing. Given that these considerations apply to the entire patient cohort, we propose a higher increase of 2% for additional services to reflect this, resulting in a total increase of 4%.

We also note that NHS England are currently developing proposals to facilitate the provision of GOS services to people with severe learning disabilities, potentially as a GOS additional service. We welcome this intention, but it will be important that the fees for any such service are agreed at an appropriate level.

3) The strategic case for NHS England

Maintaining England's primary eye care infrastructure – a network of optical practices, in convenient locations, across the whole country – is essential to ensure that patients can continue to access GOS

services. This is also critical if NHS England is to deliver its aspirations for moving more services out of hospitals and into the community and reducing the pressure on GP services.

Primary ophthalmic services are a vital part of the health service. They benefit not only the individuals who use that service but also provide a wider public and economic benefit. Uncorrected refractive error isolates individuals, makes them vulnerable (e.g. to falls), which can result in other health and social care costs, and inhibits their ability to be economically productive. Added to which, routine sight tests can identify sight and other health problems at an early stage and enable them to be addressed, preventing the need for costly treatment further down the line. Providing effective and efficient primary eye care in the community is therefore an essential part of ensuring that the country has a healthy, active and productive population

(i) - maintaining the primary healthcare infrastructure

The long term effect of rising service delivery costs coupled with inadequate GOS fees will be optical practices falling below the viability threshold – particularly smaller practices in deprived areas and serving discrete communities. There is anecdotal evidence that this is happening and it is clear that the current position of year on year underfunding of eye care services is unsustainable. The situation is acute and, as we reach a viability tipping point, the loss of practices, particularly in deprived or poorly served neighbourhoods, could well happen suddenly and irreversibly on a wider scale with little warning.

This would have a widespread and permanent impact in terms of reduced patient access to primary eye care services, particularly in areas of high deprivation. University of Leeds research on accessing health services demonstrates the importance of maintaining good geographic coverage of primary care services[1] (see annex 1). Its importance in addressing health inequalities, a Government and NHS England priority, was recognised at a Public Health England workshop in 20 November 2018, supported by both NHS England and the Department of Health and Social Care.

(ii) – building capacity to relieve pressures on NHS secondary care

Community optical practices are providing more and more NHS primary eye care in high street and other community settings. These services are commissioned locally and are key to moving care into more appropriate community settings. In eye care, just as in general medicine, dentistry and pharmacy, primary eye care should be the first point of contact for patients with eye health issues or injuries, with clinicians in optical practices triaging referrals to secondary care, thus reducing pressures on GPs.

This shift in eye care services will provide a direct financial benefit at national level, by absorbing growth in patient demand which would otherwise increase hospital eye service waiting times and deficits, as well as benefiting patients and the NHS at local level. NHS England must therefore continue to lead a joined-up and strategic approach to the planning of ophthalmic services and capacity across community optical practice and hospital eye services, beyond the national sight testing service, as recommended by the Transforming Elective Care (Ophthalmology) programme[2] and *See the Light: improving capacity in NHS eye care in England*[3] . This should include encouraging commissioning of wider primary eye care services across larger geographical footprints

[1] https://medhealth.leeds.ac.uk/profile/600/355/professor_darren_shickle/viewall
[2] https://www.england.nhs.uk/elective-care-transformation/
[3] All Party Parliamentary Group (APPG) on Eye Health and Visual impairment, London, 2018

There have been many developments in optical primary care in other parts of the UK in recent years which have demonstrated benefits for the public and the NHS. Most recently, the Scottish Government's Health and Sport Committee published a report[4] which shows that prior to the introduction of the new Scottish GOS contract in 2006, approximately 25% of acute / emergency eye cases were managed in the community setting. Now over 80% of acute eye conditions are managed by optometrists. This has shifted the balance of care away from hospitals, freeing up resources to deal with more complex care. In 2016/17 over 1 million cases of people living with, or at risk of, eye disease were recorded in data collated by Information Services Division Scotland (ISD).

The results are clear for all to see. Since 2005 new outpatient attendance in England has risen by 38% from 1.34 million to 1.92 million in 2017 while total outpatient attendance has risen by 40% from 4.64 million to 7.6 million. Over the same period total outpatient attendance in Scotland has increased by 8%. An estimate of the cost savings from this change to delivering eye care in the community suggests the NHS in Scotland "saved" £43 million in 2016/7 when ISD costs for hospital outpatient care are compared with optometry costs.

We urge NHS England to consider carefully how this evidence can inform the strategy for eye health services in England.

NHS England should be willing as a minimum to:

- state publicly that its long term aspiration is to expand NHS primary optical services on similar lines to the service now provided to patients in Wales, and
- encourage commissioning of primary eye case, beyond the national sight testing service, across wider footprints such as STP or regional office areas.

(iii) – ensuring the necessary IT infrastructure

It also, of course, remains vital to improve the existing infrastructure to enable all optical practices to connect seamlessly and efficiently to the NHS electronically. A healthcare system focussed on meeting the needs of patients, reducing the time wasted duplicating the collection and sharing of information, and enabling clinicians in different parts of primary and secondary care to communicate efficiently and effectively is an essential part of a modern health service. And it is equally essential that optical practices are part of that networked healthcare system.

This issue has been under discussion for many years. We were disappointed that the additional £6m funding discussed at the beginning of 2018 proved undeliverable However, we are encouraged by the work NHS England has been leading on this during 2018. It is vital that this work is continued at pace, and results in a real, properly funded solution that provides sustainable and effective connectivity – to enable secure paperless referral to secondary care and (equally important) prompt feedback from secondary care on the quality of referrals – at an affordable cost to practices.

(iv) - planning for the future

We are open to the idea of a multi-year agreement for GOS fees, to give certainty to the sector and NHS England. This would accord well with the long term settlement that the Government has made on the NHS and the NHS long term plan for the effective delivery of those resources.

We propose this could take the form of:

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[4] https://digitalpublications.parliament.scot/Committees/Report/HS/2018/11/12/Preventative-Action-and-Public-Health#

- the increases for mandatory and additional GOS services proposed above, together with the other changes proposed in the remainder of this bid, in 2019/20
- an increase of 2% to GOS fees in 2020/21, subject to any other changes agreed between us in the 2020/21 negotiation round
- a further increase of 2% to GOS fees in 2021/22, again subject to any other changes agreed between us in the 2021/22 negotiation round

4) Education and training

The growth of NHS primary eye care services delivered in the community creates new education and training requirements for individual practitioners and their employers. These include wider clinical experience, more mentoring provision, and placements for other clinicians (e.g. trainee GPs, nurses, and ophthalmologists).

The General Optical Council's ongoing Education Strategic Review (ESR) should take account of these changing and new requirements. It is likely to result in major structural changes to the academic and pre-registration training of optometrists, dispensing opticians, contact lens opticians and Independent Prescribers in the next few years. This will include changes to the way training is provided and assessed - for instance, involving more clinical experience in the early stages of training, and potentially the use of new routes such as graduate-level apprenticeships.

It is not yet clear how all the changes will play out in practice. However, it is clear that the routes to registration for optical professionals are likely to become more varied in the next few years and that the need for ongoing clinical and professional development after registration is likely to grow as the sector provides more eye care in a community setting. These changes will have financial implications for providers of education and assessment, employers, students, and pre-registration optometrists.

(i) - medium term issues

To ensure that community optical practice continues to evolve and maximises its potential in eye care delivery to meet growing national demand, it will be important that NHS England and Health Education England (HEE) support ongoing training and development of all relevant optical professionals, as they do in other clinical professions.

Pre-registrants and newly qualified registrants need more access to clinical expertise in secondary care settings. In addition, experienced optometrists wishing to upskill (via higher qualifications such as independent prescribing or to enable glaucoma shared care) often find it difficult to obtain suitable hospital placements. Meeting this demand for training placements will require some financial support. One option would be for NHS England and/or HEE to fund the sector to develop eye care training centres linked to secondary care, on similar lines to the "teach and treat clinics" in Scotland[5]. It would be necessary to develop a business case to assess the cost of setting up and running such centres and the benefits they would provide.

Second, given expanding scope of practice outside hospitals, there will be a growing need for some form of clinical mentorship programme, e.g. for 2-3 years, post registration. This would involve additional funding, perhaps on the model of the pre-registration supervisory grant but at a more realistic level to the work and loss of chair time involved.

[5] https://www.nes.scot.nhs.uk/education-and-training/by-discipline/optometry/teach-and-treat-clinics.aspx

We would welcome the opportunity to work with NHS England and HEE over the coming year to start to work through how such systems might operate reflecting the arrangements for other primary care professions.

(ii) - short term measures

While we would like to see progress in time for 2019/20, we recognise that some of these initiatives will take longer. In the interim it will therefore be important to ensure that students continue to receive the support they need and that registrants maintain and develop the skills the NHS and their patients need.

To that end we propose:

- The pre-registration supervisors grant needs to increase by 5%. This is because the grant is currently set so low (far below that paid to other professions) that not only does it not in any respect cover costs of the pre-registration supervisor, it is in fact more than taken up in [fees to the College of Optometrists and] fees charged by hospital trusts (the latter in effect simply recycled into the NHS)
- CET grants – increase of 3%, to reflect actual time out of practice

We also need to ensure a proper strategic approach (including funding) for continuing professional development of all registrants. We would welcome the opportunity to work with Health Education England to expand the existing training provision through DOCET, including opening up access to dispensing and contact lens opticians who are increasingly taking on extended roles in primary eye care services.

5) Ensuring voucher values are fit for purpose

Patients who need spectacles are facing an increasingly reduced choice within the value of the spectacle vouchers funded by the NHS contrary to the government's original policy intention that eligible citizens should be able to obtain spectacles which meet their needs via the NHS. This is not a financial issue for GOS contractors, except in so far as most practitioners want to be able to deliver the government's commitment to providing spectacles for their patients within the voucher value. A key reason for this is well rehearsed – the fact that the Department for Health and Social Care persists in linking any increase in the value of an optical voucher (a patient benefit) to any increase in the costs of a medical prescription (a patient charge). The entirely reasonable desire to keep an increase in patient charges to a minimum has, year on year, had the perverse outcome of reducing the value of a patient benefit (optical vouchers). Addressing this anomaly is long overdue. As a first step we would strongly argue for an increase of 5% to this patient benefit, to correct for years of reduction in funding.

OFNC

26 November 2018

Annex 1

Accessing primary eye care in deprived areas.

In ongoing work studying access to health services in deprived area, carried out by the University of Leeds, it was shown that:

"Geographical proximity to an optometrist is a strong predictor of uptake of GOS sight tests. In Tower Hamlets in London, 13% of people living within 0.1 km of a sight test provider had a sight test in any 1 year.35 This level is maintained up to 0.3 km but declines thereafter to 4% among people living 1 km away from an optometrist. Attenuation was particularly steep after 0.8 km, hence, it was suggested that there should be an optometrist within a 15 min walk of every resident.[6]

The team have also mapped the location of optical practices and GP practices against deprivation scores. This shows that GP surgeries skew towards areas of high deprivation (largely because funding targets such areas) while optical practices, which receive no specific funding to support deprived communities and must therefore operate on market principles, are skewed away from areas of low deprivation.

[6] *Shickle D, et al. Br J Ophthalmol 2014;0:1–5. doi:10.1136/bjophthalmol-2014-305345*