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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Chairman: Mike George Secretary: Ann Blackmore

Minutes of the meeting between the OFNC and NHS England
26 November 2015
Skipton House, London and Quarry House, Leeds

Present:

OFNC	**NHS England**
Henrietta Alderman OC	David Roberts
Sir Anthony Garrett OC	David Brown
David Hewlett OC	Emma Wallis
Gordon Ilett OC	
Jon Lindberg BMA	
Prof. Nagasubramanian BMA	
Katrina Venerus OC & LOCSU	
Ann Blackmore OC	

1. Welcome and introductions

1.1 As it was NHS England's turn to chair, David Roberts welcomed all present.

2. Context – autumn statement

2.1 NHS England summarised the outcome of the autumn statement for the NHS and primary care. The government is looking for 10% efficiency savings in primary care. Two key points to note: the intention is to review services, not salami slice, and optics is one area in which expenditure has been increasing rather than decreasing. NHS England was looking at new ways to deliver services to patients, in particular the interface between primary and secondary care.

2.2 OFNC recognised these realities but also pointed out the extremely high efficiency of the optical sector, growing demand and the lack of previous government investment to support the sector. Moreover simply by supporting proper IT integration and connectivity between optical practices and the rest of the NHS and by commending the nationally agreed care pathways to CCGs, considerable efficiencies could be made, as the sector had made repeatedly, not least in response to NHS England's Call to Action. The OFNC also drew attention to potential opportunities but also risks in the vanguards and the proposed new devolution areas if approaches to health and public health did not take account of the current efficiency and possibilities for optics.

2.3 OFNC suggested to NHS England that more thought should be given to the role of optics as part of primary care. NHS sight tests provide a range of public health benefits already: private sight tests leverage benefits to NHS benefits by identifying patients who are subsequently referred, and there is scope for optometrists to support public health messages (eg on obesity, diabetes, smoking cessation) through both NHS funded and privately funded sight test appointments. Other UK countries are already making progress in these areas. Even more importantly optics could play a far larger role in keeping patients out of hospital and in enabling early discharge of patients who did not need hospital based monitoring. OFNC stressed that optics needed to be more integrated in primary and hospital care as the first point of contact for all eye health issues and patients triaged there from GPs surgeries and via NHS 111.

2.4 Concern was also expressed at the public health funding cuts to local authorities which had come out of the blue and without consultation and which might well impact adversely on pre-school vision screening which was already patchy – further adding to inequalities in care and life chances.

2.5 IT connectivity would be essential to achieving these savings. It would also require some national leadership to ensure CCGs had the capacity to prioritise such pathways. It was recognised that CCGs are responsible for commissioning services (beyond GOS) at a local level. However, commissioning should be at least at a regional level to save transaction costs and the professions were prepared to help deliver this at scale and pace through LOCSU. It was also vital to maintain the viability of practices so that they could take both continue to provide a high quality service to less mobile populations and to take on these additional services in communities.

2.6 OFNC reiterated that the two key elements which would most help achieve efficiency gains would be for NHS England to agree and promote care pathways, and to enable connectivity between optical practices and NHS England. NHS England has an important role to play in national leadership, eg on 'enablers' such as pathways and IT, and in setting the mood music against which decisions are made – through the NHS mandate, the Five Year Forward View and guidance and messaging.

3. Public sector pay policy

3.1 NHS England explained that total pay budgets will not increase by more than 1% each year for the duration of this parliament, however it is not yet clear that this will apply equally across all sectors and professions. NHS England also said that there is a continuing expectation of 4% efficiency savings each year, with no increase in costs without a visible increase in savings or efficiencies.

3.2 NHS England suggested that it could be argued that for professions where patients by and large have no difficulty in accessing a service and there was no shortage of practitioners, such as optics, then increases should be targeted at other professions where there are gaps instead. The OFNC pointed out that given that the GOS was already seriously underfunded and subsidised by private sales, then the only way to make savings would be by forcing practices out of business thereby cutting supply and restricting choice and access, which would have precisely the opposite effect on NHS efficiency which NHS England was seeking and would run counter to policies for public health and patient choice.

3.3 OFNC argued that NHS England was once again failing to consider how the optical workforce could be used more effectively, by looking at secondary eye care as well as primary eye care. OFNC reiterated that better use could be made of NHS resources by maintaining patients in the community – preserving good sight was key here – and shifting care from hospitals and GPs to community optical practices.

3.4 NHS England explained that current thinking was that the planning of services should be area-based, not function-based. OFNC felt that community optical practices had a major role in this and were working on viable models in Devo Manc. But roll out to other areas would take some years, unless transaction costs could be minimised and there was better leadership through NHS England in partnership with, or as part of, the Clinical Council for Eye Health Commissioning. Leadership and system guidance was needed to achieve efficiencies at pace and scale and local commissioning across CCGs was still too fragmented.

4. GOS fees

4.1 NHS England explained that their role was to listen to representations from the sector, document those views and provide advice to the Department of Health, whose final responsibility it was to advise Ministers on fee levels.

4.2 OFNC explained that, as has been detailed at length in written submissions in previous years, GOS fees are important to maintain the viability of optical practices. The sector's objective is to ensure fair treatment for optics, within the overall pay envelope, and without excessive bureaucracy or additional unfunded burdens on practices.

4.3 NHS England outlined that given the restricted resources and the pressures for efficiency savings, the options that they could consider included:

- Keeping the fee in line with overall expenditure, but net of volume (ie the total paid out in GOS could not increase, which could result in a fee cut if there were an increase in demand for NHS sight tests)
- Freeze the fee, net of volume (as above, any volume increase to be met within the current amount)
- Freeze the fee and accept a volume increase.
- Make a recommendation for a fee increase as well as planning for volume increase.

4.4 NHS England suggested that government would use the September 2015 CPI figure of 0%, although the OFNC pointed out that the Chancellor himself had indicated that this was likely to return to 2% in the coming year.

4.5 NHS England emphasised that a concern is the inability to control volume and therefore the totality of GOS expenditure. OFNC pointed out that this was also relatively easy to predict over time being largely linked to age and growth in rates of childhood myopia in the Western world and that, even so, such sums were insignificant in total primary care expenditure whilst very significant in health benefit and in saving long-term expenditure .

4.5 OFNC reiterated that it supported the Five Year Forward View because of its aims to take bureaucratic costs out of the system and return them to the front-line where demand was growing.

In recognition of the constraints, and in an effort to ensure financial stability across the sector and for the NHS , the OFNC would be willing to negotiate for a multi-year settlement at the going rate for primary care (to include grants) – subject to the usual provisos on variances, and provided there was no significant investment of resources in primary care generally which should also benefit eye health, and provided that the objectives of the Five Year Forward View of reducing unnecessary bureaucracy were applied. OFNC asked that this offer be put specifically to Ministers.

IT bid

5.1 The formal IT bid had been submitted at the end of October 2015, as NHS England had requested. NHS England confirmed that it was under consideration. They noted that as part of that process a number of policy issues had to be resolved, that the published infrastructure fund underspend was being recovered and that the bid was in competition with other capital fund bids.

5.2 OFNC pointed out that the lack of integration and connectivity created a massive inefficiency in the system and prevented a proper approach to shared care. The investment requested in the IT bid would not bring commercial advantage to practices, it was purely designed to enable proper provision and sharing of NHS information, records and images to improve care outside hospital. This could be resolved for a very small investment which, unlike most NHS IT investment, would have no ongoing revenue consequences for the NHS England and maintenance and devaluation would fall to the sector to meet.

5.3 It was noted that one way to try and break the log jam would be to raise these issues with the Minster direct (subsequently done at a meeting of Optical Confederation CEOs with Alistair Burt on 15 December). David Brown committed to clarifying timescales for consideration of the bid and to report back to the OFNC.

Action: David Brown to report back on progress on IT bid.

6. National pathways

6.1 OFNC made clear that it was both inefficient and frustrating to have to negotiate with multiple different commissioners in order to deliver the same service in different localities. Each area made slight tweaks to bits of the pathway. NHS England should consider promoting agreed national pathways – ideally with nationally agreed tariffs. The Clinical Council could be a route to sign off such national pathways, to cover core primary care services such as MECS/PEARS, cataracts and repeat readings.

6.2 It was agreed that the optical sector should lead on clinical pathways, and draw up a list of what the optical sector would like to see pathways for, while NHS England would review the approach to commissioning (David Brown to talk to the DRS team) and develop commissioning templates, as is happening for other primary care professions. Both sides agreed to take this forward ready for the next optical sector/NHS England meeting scheduled for 10 February 2016.

Action: David Brown to talk to DRS team re commissioning and templates.
Action: Katrina Venerus to draw up list of potential national pathways.

7. Education and training

7.1 OFNC noted that while many of the primary care services that should transfer to community optical practices fell within the core competencies of practitioners, there would also need to be some upskilling to ensure the entire workforce was fit for purpose. In Wales and Scotland funding had been made available for this. This was because the benefits accrued to the wider NHS, not simply the optometrists in receipt of training, as the clinical skills would be shared, and it would free up clinical time and physical premises.

7.2 It was agreed that the OFNC needed to engage with Health Education England on this. . David Roberts suggested that CET grants should ideally also be a matter for HEE; however that was not a matter for this discussion. In the meantime David Roberts agreed to identify a contact in HEE for the OFNC to discuss these matters with.

Action: David Roberts to identify appropriate contact at Health Education England

8. Vouchers

8.1 It was recognised that whilst this was primarily a responsibility of the Department of Health NHS England did provide input. OFNC explained that one concern was whether vouchers were going to the right people: in particular should exemptions be age (pension) related, or connected to prevalence for certain age groups. It was agreed that this issue should be pursued with the Department.

Action: Ann to write to Derek Busby at DoH on behalf of OFNC.

8.2 The issue of vouchers for spectacles for those with special facial characteristics was currently with Ministers and NHS England anticipated an outcome shortly. (Subsequent to the meeting OFNC was consulted by DoH on changes to the regulations re special facial characteristics.)

9. Next steps

9.1 It was agreed that David Roberts would report back to OFNC on the IT bid, and on the scope for national care pathways and a template for commissioning.

9.2 David Roberts informed OFNC that advice would go to Ministers, informed by the discussions and points made this meeting, following the recommendations of the Doctors and Dentists Review Board (expected end of February).

9.3 It was agreed that the aim would be to announce fees before the start of the financial year if at all possible.

Next Meeting

9.4 Autumn 2016 – OFNC to arrange and chair.

Ann Blackmore
Secretary OFNC
29 January 2016