A Consultation on *Strengthening the NHS Constitution*

1. Thank you for inviting our comments on this consultation. 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 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.

General Support

2. As a Confederation, and representing providers in contract with the NHS since its inception, we
    - have long supported the principles behind the NHS Constitution
    - have publicly welcomed the recommendations of the NHS Future Forum vis-à-vis the NHS Constitution (Annex 2 to consultation document)
    - and, in broad terms, support these proposed improvements.

3. As longstanding independent contractors with the NHS, we are happy to "take account of the NHS Constitution in [our] decisions and actions" (paragraph 12). Indeed by delivering care, as we do, to 21 million patients a year in an open, highly-competitive and professionally-regulated market, where every NHS patient counts and is free to go to any provider of their choice for both clinical care and vision correction, we already more than deliver all the aims of the NHS Constitution.

4. We recognise that the aim of the Government is to use the revised NHS Constitution to empower patients and their families to drive similar levels of quality, access and access choice in traditional, state-owned NHS providers – which we fully endorse.

Integrated Services

5. We also strongly support the principle of more integrated services. There is room for greater use of modern technology, team working and shared care to achieve significant improvement here between community optical practices, hospital eye services (HES), GPs and social services. From our point of view, there are two relevant developments which will help embed the revised NHS Constitution across the whole ophthalmic sector

- the establishment of Local Eye Health Networks (LEHNs) in every NHS Commissioning Board area, where all parties including the voluntary sector (representing both patient voice and providers) should come together to plan and develop services and streamline patient pathways to meet locally identified needs and to deliver QIPP; and
- electronic links between the HES, community optical practices, GP practices, and social services. Separately, we are aiming to "co-produce" a funding bid to NHS Commissioning Board and NHS Connecting for Health to make this possible, building on the pioneering work already underway in Scotland.

Concerns

6. What we would not support, however is the development of a 'NHS Constitution monitoring and compliance service' which would, in our view, impose a burden on both the NHS and community optical practices which neither will be able to afford, driving practices out of business and reducing access for patients both in the community and the hospital sector.

7. It is our view that the NHS and independent providers should be left to get on with implementing the NHS Constitution (as amended) for the benefit of patients, without any additional monitoring superstructure and expense – other than patients and commissioners being able to challenge providers and seek resolution under NHS contracts if they feel the NHS Constitution is not being/has not been delivered in their particular case.

8. We would be very happy, as a Confederation, to work more closely with the NHS Commissioning Board to get this right.

Duty of Candour

9. We also have some concerns not about the principle, but about the implementation of the "duty of candour".

10. As in all other sectors we suspect, we have experience of a mixture of both

    - genuine patient complaints and claims (although comparatively few in optics) - where things have gone wrong, where miscommunications, problems or errors have arisen which need to be admitted and put right and the patient, where appropriate, compensated

    - and "ambulance-chasing" and vexatious claims where innocent clinicians doing their best at the front-line and trying to deal as honestly as possible with patient and their families inadvertently provide ammunition for unsubstantiated complaints, claims, referrals to the General Optical Council, etc. Although these usually end up being dismissed they can waste a lot of time and resource not to mention the worrying effect on practitioners.

11. We strongly believe, therefore that guidance should be issued for both clinicians and the public explaining precisely the
    - aims behind the duty of candour, and
    - how clinicians can implement the duty of candour fairly and openly without unfairly incriminating themselves or the provider they work for.

    This would set the parameters of fairness for patients, clinicians and providers within with the new duty would operate.

12. As a Confederation we would be more than happy to “co-produce” this for the community optical sector, possibly in partnership with our community pharmacy and hearing care colleagues as, quite frequently now, community hearing and community optical services are provided from the same premises.

    It is against this background that we submit our more detailed responses to the consultation questions attached. We are happy for this response to be made public.

Consultation Questions

Q1. What are your views on the proposed changes to strengthen patient involvement in the NHS Constitution?

A1. We support these changes. Patient involvement, feedback, candour, making every contact count, integrated care, dignity respect and compassion are already provided in the community optical sector, driven by the market system in which we operate. We therefore welcome these improvements across the rest of the NHS.

As far as the specific drafting amendments are concerned (Annex 4, Page 2, first paragraph) we welcome the addition of the words "to stay as well as we can to the end of our lives". This was sadly missed from the NHS Outcomes Framework when published.

We wonder however whether "it works as the limits of science" is quite right and query whether we do not in fact mean "it is evidence- and clinically-based and works at the limits of science"?

Q2. What do you think about our proposals as set out in the NHS Constitution the importance of patient and staff feedback towards improving NHS services?

A2. We agree with this principle but, as described above, would be strongly opposed to a bureaucratic superstructure to monitor this. Operating as we do in a genuinely open market where patients easily vote with their feet and have a wide choice of local providers, we already welcome patient and staff feedback and this is key to business survival. Practices which do not act on feedback simply go out of business and are replaced by others which do and which welcome the patients and the funding they bring. We would be strongly opposed to any heavy monitoring mechanism which imposed additional bureaucratic burdens on the optical front-line adding unnecessarily to costs and making the optical market less efficient in meeting the needs of patients.

Q3. Do you agree with, or have any suggestions about, amending this pledge to make it more specific as suggested?

A3. That will depend on the precise wording proposed following the publication of the Francis Report. As noted above, we are very clear that there should be guidance for patients, providers and professionals about precisely what this means and how disclosures under this pledge are to be viewed by all parties.

We very much support candour in acknowledging errors and putting them right but are also aware of the small number of persistent and vexatious claimants, often supported by "ambulance-chasing" firms of solicitors, who seek compensation when none is genuinely merited. Defending such cases can have significant costs for the sector and, whilst we want all patients who

have a genuine grievance to have it properly resolved, we do not want to give added incentive, through niceness or naivety on the part of front-line practitioners, to patients or their families to pursue unjustified claims.

Q4. What are your views on including in the NHS Constitution a new responsibility for staff to make "every contact count" with the aim of improving health and well-being of patients.

A4. This should of course be what professionals qua professionals actually do. The challenge here is that patients cannot expect every aspect of their health and well-being to be dealt with in a single clinical encounter, particularly not during a sight test in community optical practice.

As part of a sight test optometrists and opticians will already discuss with patients their medical history, visual needs, history of any pathologies, medications and any family history of eye disease. They will also give advice – where appropriate about risks to eye health eg from smoking etc. It would, however, in our view, be inappropriate for eye health professionals to go further than this although, if they spotted something non-eye related but which they suspected could be serious, like all professionals they would advise the patient to visit their GP or seek hospital assistance.

We hope therefore that the NHS Commissioning Board and Department of Health will look very carefully at what is expected under this responsibility and will work with the optical representative and professional bodies to get his right, including where necessary appropriate funding for additional work.

Q5. Do the proposed changes to the NHS Constitution make it sufficiently clear to patients, their families and carers how the NHS supports them through care that is co-ordinated and tailored around their needs and preferences?

A5. Yes. We support the wording of the current proposed amendment in Annex 4, page 8, paragraph 1.

We are slightly concerned however at the proposed removal of the words of "doing nothing" (Annex 4, Page 7, second paragraph). We would prefer the wording to remain viz "what they involve and their risks and benefits **including of doing nothing**." Otherwise the revised Constitution will be inadvertently driving a clinical model where patients are accustomed to expect an intervention for every condition where sometimes this is just not appropriate and not in the patient's best interest.

We also have concerns about the new pledge to support patients in using relevant and reliable information about NHS services (Annex 4 – page 7, second paragraph). We would be in favour of NHS support for patients in using reliable information about local services, e.g. where this is provided via the NHS CB Local Area Team but would be strongly opposed to a new requirement on contractors to support patients generally in the use of

information about the local NHS. Perhaps this could be should be made clearer in guidance?

We also have a concern about family and carers being involved in health care decisions (Annex 4, Page 7, final paragraph) and suggest adding back in the point that family and carer involvement is normally at the patient's discretion viz "where appropriate this right includes your family and carers *where you wish this."*

Q6. Do you think it is helpful for the NHS Constitution to set out these additional rights on making a complaint and seeking redress?
Q7. Do the additional new rights make the complaints process easier to understand and make clear to patients what they should expect when they make a complaint?

A6 & 7. Yes, these changes simply reflect the changes already implemented in regulations and contracts.

Q8. Do the proposed changes to the NHS Constitution make clear how the NHS will safeguard and use patient data?

A8. Yes.

Q9. Do you agree with the proposed changes to the wording of the staff duties and the aims surrounding the rights and responsibilities of staff? What do you think about the changes to make clear to staff around what they can expect from the NHS to ensure a positive working environment?

A9. Yes. We broadly support the new drafting (Annex 4, Page 13) but, in the light of our comments above, wonder whether the wording should not be "to take appropriate opportunities to encourage and support patients and colleagues, etc rather than "to take every appropriate opportunity".

Q10. Do you agree with the wording used to emphasise the parity of mental and physical health? Are there any further changes that you think should be made that are feasible to include in the NHS constitution?
A10. Yes. We have no further changes to propose.

Q11. What are your views on the wording used to highlight the importance of ensuring that the tenets of dignity, respect and compassion are sufficiently represented in the NHS constitution?

A11. These are appropriate and we support them.

We wonder, however, whether the reciprocity of respect should not be included in the new wording (in Annex 4, Page 3, Paragraph 3) viz: "respect, dignity, compassion and care should be at the core of how patients and staff are treated **and treat others within the NHS** not only because that is the right thing to do but because patients' safety, experience and outcomes, etc."

We support the inclusion of gender reassignment, marital and civil partnership status (Annex 4, page 3 paragraph 1), but question whether this should not, for consistency, also be replicated in the 5th paragraph on page 5?

Q12. Do you agree with the suggestion for including a new pledge for same sex accommodation?

A12. Yes, but this has to be reasonable in a health service which is there for all and subject to considerable financial pressure. We therefore support the fact that the pledge applies only to "sleeping accommodation".

Q13. Do the proposed changes to the NHS Constitution make it clear what patients, staff and the public can expect from local authorities and that local authorities must take account of the Constitution in their decisions and actions?

A13. Yes. However we are not entirely clear about what the "other local authority services" means on Annex 4, page 4, first paragraph.

Q14. Have you seen further examples of good practice in raising awareness in embedding the NHS Constitution that should be taken into account in these plans?

A14. No.

Q15. Do you have further recommendations for re-launching – rolling out and embedding the Constitution from next Spring?

A15. No other than to observe that this should be both local and proportionate.

We would also add here the longstanding issue that community optical practices are currently still not permitted to use the NHS logo despite providing NHS services since 1948 and despite repeated requests from the Optical Confederation and our predecessor bodies to enable them to do so. It is difficult to conceive how community optical providers can promote the NHS Constitution when they are not even allowed to promote the NHS through use of the logo, e.g. on their practice premises or stationery.

Q16. To help shape our future consultation, do you have views on how the NHS Constitution should be given great attraction to help people know what they should do when their expectations of the NHS are not met?

A16. We think the current proposals go far enough and should be allowed to bed down and be evaluated before further reforms are implemented.

Q17 How can we ensure the NHS Constitution is accessible and usable to individuals of different backgrounds and to different sections of society.

A17. We have no further advice to add on this point.

Q18. Are there any ways in which the proposed changes set out in this consultation could have an adverse impact directly or indirectly on groups with protected characteristics? If so, how?

A18. No.

Q19. Do you have any further comments about our proposals for strengthening the NHS Constitution?

A19. No.

Submitted on behalf of the Optical Confederation by Ben Cook
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