

## NHS England consultation: Improving General Practice: a Call to Action

### Optical Confederation response

**Q.1 - What is your name?**

A.1 Ben Cook

**Q.2 What is your email address?**

A.2 [bencook@opticalconfederation.org.uk](mailto:bencook@opticalconfederation.org.uk)

**Q.3 What is your ethnic group?**

A.3 White British

**Q.4 What is your gender?**

A.4 Male

**Q.5 What are the first three or four digits of your postcode?**

A.5 W26L

**Q.6 Are you providing a response as an individual, or on behalf of an organisation?**

A.6. Organisation

**Q.7 If you are responding on behalf of an organisation, which organisation is it?**

A.7. The Optical Confederation represents the 12,000 optometrists, the 6,000 dispensing opticians, and 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 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.

**Q.8 Which of the following areas of healthcare are you representing?**

- Commissioners of healthcare services
- Acute services
- Mental health services
- Primary care services
- Community based care

- Patients and service users
- Other

**Q.9 Do you believe that the current system of primary care in England needs to change and improve?**

**A.9** Yes.

**Information, choice and control**

**Q.10**

- **How do we go further in publishing – and getting practices to publish – an increasing range of comparative public information?**
- **How can we best work in partnership with CQC and the new Chief Inspector role whose inspections and ratings regime is designed to improve transparency?**
- **How do we stimulate new forms of patient involvement and insight, including introducing the Friends and Family Test in general practice?**
- **How best do we roll out new models of patient choice?**

**A.10** As far as the information by practice, etc, is concerned; there is a real danger of information overload for patients and the public at present. The information needs to be there and accessible of course, but not all patients will wish to drill down into as much detail as the data enthusiasts within the “health family”, nor will it be easy for them to assess what is the appropriate balance for them between a number of competing indicators. We would suggest, therefore, that a very simple system be produced such as the one now agreed for food labelling.

Far more important than practice publications, in our view, is better sign-posting for patients between and across primary care services. Patients need to begin to understand that they can receive much of the care they need, as well as helping themselves remain healthy, from community providers within their local area. The hospital sector should be the location for acute and high level interventions but very much the exception rather than the rule for routine care.

**Clinical Leadership and Innovation**

**Q.11**

- **How can we best stimulate and create space for clinically-led innovation?**

**- How can we challenge and support local health communities, including CCGs and health and wellbeing boards, to develop more stretching ambitions for primary care?**

**- How do we best support integration pioneers in testing new ways of commissioning and contracting for integrated primary care and community services for people with physical and mental health conditions?**

**- How can we best mobilise existing improvement resource (e.g. NHS IQ) and facilitate access to other potential external support for primary care transformation?**

**A.11** In a clinically-led, patient-focussed NHS, all clinicians and professionals should be afforded the space to lead, innovate and improve. There should be specific financial incentives for general medical practices to work closely with other primary care services (eye health, pharmacy, community hearing, dentistry, community nursing) to deliver

- a joined-up approach
- joined-up commissioning
- integrated care
- better outcomes

We emphasise here that we are talking about clinical leadership rather than uni-professional domination. GPs should be encouraged to recognise and work closely with other clinical disciplines on a basis of partnership in order that every local professional can contribute to, and play a full part, in better care and better outcomes – keeping the majority of citizens well and fit from within their own community.

In eye health, optometrists and opticians should take responsibility for maintaining the eye health of citizens in the community, dealing with minor eye emergencies, managing stable conditions, notifying GPs and others of potential co-morbidities identified (e.g. diabetes, stroke, heart problems, etc) and liaising directly with the hospital ophthalmology services and social services. GPs should however always be copied in to correspondence and communications as clinical coordinators where this is required.

### **Freeing up time and resources**

#### **Q.12**

**- How might we develop QOF so that that we preserve its essential features but create more flexibility for practices and reduce the feel of a tick-box culture?**

**- How can we get best value from enhanced services and reduce process-oriented measures?**

- How should general practice IT systems develop to support more efficient and integrated working?**
- How can we help improve the productivity of practice systems and processes, for example through the Productive General Practice programme?**
- How can we help ensure that practices are making most effective use of all practice staff, including practice nurses and practice managers?**
- How do we engage practice managers more effectively?**

**A.12** A key to greater efficiency, from our perspective, is for general medical practice IT systems to be closely linked to, and ideally integrated, with other primary care, hospital and social care systems. Communicating electronically to all clinicians involved in the patient's care should be the norm rather than the (currently) very rare exception.

### **Defining practice accountabilities for high quality**

#### **Q.13**

- Should we seek to develop a joint concordat with key partners that re-affirms and refreshes the core features of general practice?**
- How can we put general practice at the heart of more integrated out-of-hospital services and give GPs and practices greater responsibility for coordinating care for patients?**
- How should we define high quality general practice and their responsibilities/accountabilities, through the GP contract?**
- How do we create synergy with the new system of CQC ratings and inspections to create a clearer sense of what patients can expect from good general practice?**

**A.13** Whether or not to develop a new joint concordat is largely a matter for the medical profession in the first instance. However, if this were to be developed, we would wish to see the Optical Confederation and wider optical sector engaged as active partners.

A joint concordat or any revised joint concordat should set out the role of GMPs as 'first among equals' clinical and community leaders rather than simply 'gatekeepers' to care. Financial control and probity are of course vital but they should be ancillary and support functions to the achievement of agreed and shared health care and outcome goals.

## **GP contract: incentives for outcomes**

### **Q.14**

- How far should we create stronger incentives for both inter-practice collaboration and collaboration with other primary care providers, acute, community and social care services?**
- How can we better stimulate and recognise/reward quality of care for people with co-morbidities and complex health and care problems?**
- How far should we seek to reward practices for wider outcomes, such as enhancing quality of care for long term conditions and reducing avoidable emergency admissions, or reducing incidence of strokes and heart attacks, or improving patient experience of integrated care?**
- What is the potential future role for PMS and APMS contracts in stimulating innovative approaches or helping address particular local challenges?**

**A.14** As far as incentives are concerned, we have already set out how we believe the community eye health sector can contribute significantly to supporting local communities in terms of achieving wider health outcomes such as quality of care for long term conditions, reductions in avoidable emergency admissions (3% of A&E episodes are for eye problems most of which can be treated in community practice), better take-up of smoking cessation (smoking increases the risk of age-related macular degeneration threefold - Cong, R , et al (2008). Smoking and the risk of age-related macular degeneration: a meta-analysis. *Ann Epidemiol*; 18:647–656), rehabilitation following strokes and more integrated care.

Perhaps in these regards, further thought could be given to the development of specific 'local health outcomes and service allocations', as part of main allocations, which would be made available to the local community, via general medical practice or CCGs, for use in tackling outcomes improvement and service re-design in the community. The allocations would need to be equitably based, for example using deprivation indices, the difference being that those who delivered improved health outcomes to a demonstrable standard against a national template year-on-year would have autonomy about how to use their allocations whereas those which did not would have to accept a more directive based approach from NHS England.

## **Safe, controlled investment**

### **Q.15**

- How can CCGs, local authorities and NHS England best collaborate to develop integrated commissioning plans for out-of-hospital services?**
- How can we support health investment analysis that allows for optimal balance of resources between acute and community services?**

**- additional investment in services provided by general practice, how can CCGs and NHS England best provide assurance that any perceived conflicts of interest have been properly managed?**

**- How do we track value from investment and adjust investment plans to reflect evidence of outcomes?**

**- How can NHS England and CCGs work together to make more effective use of existing community estates and, where necessary, allow investment in new or expanded premises?**

**A.15** The Government has already made a small amount of investment through NHS England to fund Local Eye Health Networks across the whole country. These should bring together all partners in eye health and visual impairment services including CCGs, NHS England, Health and Well-being Boards, Local Authorities, the hospital ophthalmology and community eye health sectors, voluntary sector and patients.

Local Eye Health Networks provide the ideal local vehicles for bringing all parties together to achieve the optimal balance of resources across the community with full transparency, declarations of interest and clear decision-making, ensuring that any perceived conflicts of interest are properly managed.

Local Eye Health Networks have a particular responsibility in supporting the commissioners, providers and the public in achieving value for money in terms of health outcomes, shorter and more streamlined care pathways and more efficient use of resources and should be held to account for that, possibly by demonstrating use of targeted funds as outlined in our answer to Question 14 above.

As far as the estate is concerned, community optical practices operate in an open, market-driven system and, in order to meet patient convenience and demand, inevitably carry a certain amount of spare capacity in terms of estate. This could certainly be used to better effect by the NHS not only by providing more routine eye health services in the community but also shared care with ophthalmologists and, where necessary, first line ophthalmology clinics in the community.

The Optical Confederation would be very keen to work with government and NHS England to develop a framework for this within which local solutions might be developed.

## **Market Management**

**Q.16**

**- How do we ensure a consistent and disciplined approach to identifying and remedying poor performance, including effective partnership with the CQC?**

- How do we develop a more consistent and effective approach to new market entry, e.g. how far this should be targeted at areas of greater deprivation and/or lower capacity and/or limited patient choice?**
- How might we stimulate new, innovative provider models that offer both greater quality for patients and satisfying careers for those working in general practice and primary care?**
- What are the potential opportunities for 'primary care plus' contracts, built on co-commissioning between NHS England, CCGs and local authorities?**

**A.16** As noted above in our response to Q15, uniquely within the NHS, community optical practices operate in a genuinely open market system with very low barriers to market entry. This provides an in-built mechanism of high competitiveness which delivers high standards of clinical quality, service quality, access, choice and value.

It is key that when commissioners, acting on the advice of Local Eye Health Networks, go out to tender for new or re-designed services, all potential providers have an opportunity to comment on the service specifications and, if suitable, to bid for the contracts.

In most parts of England, Local Optical Committees (LOCs) have formed company bodies for this purpose which should always be involved. In some locations, these may also put forward joint bids with the local Hospital Eye Service or voluntary providers. For more details on LOCs, please visit: <http://www.locsu.co.uk/>

## **Workforce Development**

### **Q.17**

- How can we and our national and local partners best support improvements in recruitment, retention and return to practice?**
- What are the strategic priorities for improvements in education and training to reflect the evolving role of general practice, the changing profile of the general practice workforce and the challenges facing the health service in the next ten years?**
- What developments would help provide more structured careers for GPs, practice nurses and other primary care practitioners?**
- What factors are likely to promote and support good employment practice, e.g. practices providing training and development opportunities for practice nurses and practice managers?**

**A.17** From a partners' perspective, it would seem important that career development and pathways are developed early for those GPs who wish to develop into

community and clinical leaders. This will require an additional set of skills to those required for, say, managing a practice or dealing with individual patients.

It is also important, in our view, that skills and career development in leadership, champion-ship and management are valued as highly as specialist clinical skills or academic success.

### **Specific Issues and Questions**

#### **Q.18**

- How do we ensure that people with more complex health and care needs have a named clinician with responsibility for coordinating their care? Should people with more complex needs have a named GP with responsibility for overseeing their care?**
- How can we strengthen general practice accountability for the quality of out-of-hours services provided to patients and ensure that OOH services are more integrated both with daytime general practice and with wider urgent care services?**
- How do we stimulate more convenient routine access to general practice services, including ease of making appointments, speed of contact for urgent problems (whether telephone or face-to-face), ability to book less urgent appointments in advance, ability to communicate electronically (e.g. online consultations) and, particularly for working-age adults, availability of evening/weekend slots?**
- How do we stimulate general practice responsiveness to access preferences of their populations?**
- How far should there be a shift of resources from acute to out-of-hospital care? How far should this flow into general practice and how far into wider community services?**

A.18 Community optical practices are more than happy to work with a named GP whose role is to co-ordinate and oversee the care of patients with complex health and care needs.

### **Analytical Pack**

**Q.19 Do you have suggestions for the development of our analytical pack? If so please detail them below.**

A.19 We have no further suggestions to make.

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