Optical Confederation response to NHS England's consultation on Evidence-Based Interventions

Design Principles

Question 3: Do you agree with our six design principles?

Yes

Phase 1: A focus on 17 proposed interventions

Question 4: Do you agree that selecting circa 17 interventions is about the right number for this first phase?

Yes

Question 5: Are there interventions you think we should add for the first phase?

No

Question 6: Are there interventions we should remove?

No

Question 7: Do you agree this should become an on-going rolling programme, subject to making sufficient progress?

Yes – but dependent upon suitable consultation

Question 8: What positive and negative impact will these changes make to improving access, experience and outcomes for the following groups and how can any mitigated to ensure the changes do not worsen health inequalities for:

- Groups protected under the Equality Act 2010?
- Those individuals such as homeless people /rough sleepers, vulnerable migrants, gypsy traveller groups and carers?

The proposal to include chalazia removal (intervention reference K) relies on the evidence that alternative treatment options are effective in many cases. However, a number of these

self-care options will be far more difficult for some groups of people such as people experiencing homelessness and rough sleepers to implement. There is potential for these groups of people to be disadvantaged, especially as NHS England has not yet taken the simple administrative steps needed to enable access to GOS sight tests for those without a fixed address.

Illustrative Activity Goals

Question 9: At which level should we pitch our ambition?
Ambitious, Moderate, Conservative?

Conservative

Please tell us why:

The effectiveness of any changes should be established before progressing with any service changes.

Question 10: Do you have any suggestions to improve our methodology?

Yes, we note that under point 3 of Appendix 3 you list those that you engaged with. Given the volume of GOS patients that are seen by optical practices and the increase in schemes such as Minor Eye Conditions (MECS) which are designed to be the point of contact for most anterior eye presentations, in our opinion it would be prudent to also engage earlier with the primary care professions who could potentially face an increased burden from these proposals.

Engaging the system: systematic, multi-channel communication and engagement with clinicians, patients and commissioners

Question 11: What further suggestions do you have to enable effective communication and engagement to support with implementation?

A multidisciplinary approach is needed, there is no point in optical practices following this guidance if patients are inappropriately redirected by GPs or other healthcare practitioners. This potentially creates unrealistic expectations from the patient that places extra pressure on optical practices.

Engaging the system: Demonstrator Communities to test proposals before December 2018 and provide peer-to-peer support to other systems

Question 12: Are you aware of any particular communities making good progress in implementing any of the clinical recommendations on the 17 interventions, which might like to be part of this before December 2018 ?

No, in fact the application of the 2017 applications seems to vary by region, this is difficult for practitioners working in different areas, or where patients are seen on the borders of areas.

Require Individual Funding Requests for Category 1 interventions and Prior Approvals for Category 2 interventions

Question 13: Do you agree that with our proposals for IFR for Category 1 interventions?

Yes, we think it is important that there is a mechanism to allow interventions that are in the best interest of the patient.

Question 14: Do you agree that with our proposals for prior approval for Category 2 interventions?

Yes

Introduce zero payment for Category 1 interventions without IFRs

Question 15: Do you agree with our intention to mandate through the National Tariff by introducing arrangements so that providers should not be paid for delivering the four Category 1 interventions, unless a successful IFR is made?

Yes

Question 16: Do you agree that this change should apply from 2019?

Yes

Amend the NHS Standard Contract for Category 1 and 2 interventions

Question 17: Do you support our intention to mandate compliance with the Evidence Based Interventions Policy through the NHS Standard Contract?

Yes

Question 18: In relation to the proposed wording for the NHS Standard Contract, as set out in Appendix 5:

Do you support our proposed wording for the new Contract requirements?

Yes

Do you have any specific suggestions for how the Contract wording could be improved?

No

Applying a rigorous approach to assess implementation

Question 19: Given the mixed record of applying research-based evidence to decommission ineffective treatment, do you agree that we should introduce the range of performance management measures proposed above?

Yes, we are strong advocates of evidence-based practice.