



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

NCHA response

The National Community Hearing Association (NCHA) represents community hearing providers in the UK. NCHA members are committed to good hearing for all and are responsible for the majority of adult community hearing care services in the UK with an excellent record of outcome, safety, and patient satisfaction.

BSHAA is the professional body for hearing aid audiologists providing hearing care to NHS and self-funding clients. They practise in large, medium and small companies and as sole practitioners; and they provide a professional, convenient and local service to people with hearing concerns in every community in the UK.

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

In our view, patient choice should be at the heart of what the NHS offers at local level. Patients make decisions about choosing practices and services for all kinds of

reasons and should have made available to them as much information as they need to make these choices.

The National Community Hearing Association (NCHA) and BSHAA believe in fair access to care and hope NHS England considers how information is delivered in a way to support choice for *all* – for example, research shows that “supported choice” can avoid increasing health inequalities across socioeconomic groups and we believe information should be provided with this in mind. Our view is that information should be

- relevant to the specific health service in question
- easy to understand and meaningful to *all*

In order to deliver these goals, commissioners have a vital role to play:

- quality indicators should be: 1) meaningful to patients, 2) tailored and appropriate to the specific service in question, 3) cost-effective, and 4) comparable nationally rather than locally. This means commissioners need to focus on how to streamline contracting, for example, instead of variation in contracting homogenous services across England – such as adult hearing services – NHS England should consider a national contract whenever possible. This will not only reduce transaction costs but allow national comparative data to be collected and provided to patients locally. It will also allow providers – such as community based adult hearing care audiologists – to work with NHS England to develop service-specific quality frameworks that are proportionate to risk and clinically meaningful to patients and professionals

The NCHA and BSHAA strongly believe in an integrated health service.

Unfortunately, in our view, NHS England has continued to compound systemic (and historical) divisions across the professions and sectors with the framing of this consultation. All primary care consultations should be framed to include all primary care providers. Only through an integrated, proactive and responsive primary care service will a patient-centred NHS - that helps people live active healthy lives - become a reality. Without this reframing it is difficult to envisage how new patient choice models will emerge or how the NHS will meet the much needed integrated model of service delivery.

To encourage new patient choice models, patients (and their families and carers who often share the consequences of illness and disability) should be provided with good information and have the ability to access all primary care services based on clinical need. We agree that each patient's GP should be a central point of contact and oversee care plans. We also understand the vital (and important) role GPs play in the NHS as gatekeeper to higher level services. However, this gatekeeping function

has to move towards an evidence-based approach that delivers high quality health and cost-effective outcomes. For example,

- research by Action on Hearing Loss estimates 45% of people reporting hearing symptoms to GPs are not referred for a hearing test
- a subsequent report – supported by Age UK, Carers UK, Dementia UK, Multiple Sclerosis Society, Royal Voluntary Service, Independent Age, Action on Hearing Loss, Hearing Link, and UK Council on Deafness – clearly highlights why such a traditional gatekeeping approach is harmful. Patients suffering from hearing loss are at risk of social isolation and depression
- hearing screening is cost-effective and community hearing is a feasible option to support all of these patients without referral into hospital
- a new sustainable patient choice model would be to have a National Hearing Plan (including prevention, screening and support for all with hearing loss).

Therefore, the NCHA and BSHAA urge NHS England to rethink the role of General Practice and to support GPs (who struggle to meet demand for preventative care) better to integrate with *all* primary care providers so that a primary care team can assist every person to live an active and healthy life.

The NCHA and BSHAA are keen to work with all stakeholders to improve access to screening, prevention and support services/correction for all people suffering from, or at risk of, hearing loss. We would be happy to work with all our colleagues in primary care to coordinate a National Hearing (or sensory loss) Plan, as part of an active ageing and living well primary care initiative.

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

The National Community Hearing Association (NCHA) and BSHAA support NHS England's focus on

- clinical leadership and innovation
- stretching ambitions for primary care
- supporting integration pioneers in testing new ways of commissioning and contracting for integrated primary and community services for people with physical and mental conditions

In addition we feel more can be done in primary care to support people to live healthy and independent lives regardless of socio-economic status. To achieve these key goals we propose

- Innovation:
CCGs have to share successes with other CCGs so that high quality services can be commissioned across England – especially when not doing so creates a 'postcode lottery' that further widens health inequalities. For example only 44% of CCGs have used AQP to deliver a more integrated primary care service by improving access to adult hearing services in the community – a service that has significant public health benefits. Despite being cost-effective and consistent with the Government's aims of delivering more personalised care, CCGs are struggling to ensure fair access to NHS adult hearing services in the community. Innovation is required to streamline the contracting process for such standard services. In cases such as community-based adult hearing services a national contract and contribution to devices as for sight testing and spectacles might be a more efficient and better solution for NHS patients with lower transaction costs for the NHS and community providers. We would be happy to discuss with NHS England options for how this might be achieved within current parameters.

- Clinical Leadership:

With an ageing population the NHS has to move quickly to ensure it has a sustainable model for sensory impairment – including prevention, detection, correction, amelioration and support. More work is needed to support all people at risk of, or suffering from, sensory loss. The NCHA and our colleagues in primary eye care, are keen to work with NHS England to develop an integrated primary care service that supports GPs to deliver a world-class 'whole person care'.

Effective communication is at the heart of good health care. Therefore it is essential that health care professionals become more aware of sensory impairment - such as hearing loss –and adapt communication with this growing cohort of patients and understand where to refer for further support

and advice. Unfortunately, this is not the case today and it is highly probable many patients have worse health outcomes as a result.

The NCHA and BSHAA urge NHS England to do more to raise awareness of hearing loss and its impact on patients' well-being – including social isolation and depression. For example, we support a screening service for hearing loss in high risk groups and feel that this should be part of an integrated and sustainable primary care service.

The NCHA joins the voice of many charities – including Age UK, Carers UK, Dementia UK, Multiple Sclerosis Society, Royal Voluntary Service, Independent Age, Action on Hearing Loss, Hearing Link, and UK Council on Deafness – in the call for hearing health to be recognised for the significant public health issue it is.

More work on public health needs to be done in the community and a National Hearing Plan is an integral part of this. The NCHA supports a community based NHS that is active in public health and is keen to work alongside all stakeholders and NHS England to deliver a national hearing care service that both prevents unnecessary hearing loss and helps those who need help.

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

The National Community Hearing Association (NCHA) and BSHAA support the need to better utilise GP time and resources. We support an integrated primary care service where GPs are supported by allied primary care professions to reduce

demand on their practices. For example a National Hearing Plan that supports access to hearing services in the community can help reduce the negative consequences of unaided/unsupported hearing loss – e.g. social isolation, depression and cognitive decline – and therefore reduce demand for GP services.

We fully support a move away from tick-box culture and towards a more patient-centred and outcomes-focused model for all NHS services – not just primary care. We feel commissioners have a vital role to play in this and that quality indicators must be

- readily available but
- relevant to the specific health service in question
- easy to understand and meaningful to *all*

For example, in the case of adult community hearing services, AQP and the quality system IQIPS have been helpful in getting the process started but, having been developed for the hospital sector, are unnecessarily cumbersome to operate easily in primary care and dissuade providers, especially smaller providers, from offering care to NHS patients.

The NHS has to move towards patient outcomes that matter, and indicators that are tailored for and reflect the risk of specific services. We welcome that NHS England acknowledge the current system risks creating a tick-box culture and wants to take action to avoid this. As a sector, we would be keen to work with NHS England, CCGs and government to design a better contracting and quality framework for community hearing services with a clearer focus on outcomes, patient satisfaction, access, quality and value.

We would also like to highlight the important role commissioners can play in freeing up GP time and resources. For example, access to adult hearing services in the community currently requires a GP referral. This means that a patient with symptoms of hearing loss has to visit their GP, and then the GP - who often has no access to equipment to measure hearing - refers the patient on to a community hearing care provider. This process is not cost-effective and creates unnecessary steps in the care pathway and barriers to care.

We feel commissioners should, whenever possible, facilitate patient choice in a way that reduces the strain on General Practice. Adult hearing services in the community provides an opportunity to pilot a model that could achieve both of these objectives.

As community hearing providers, we are keen to work with general medical practice to ensure that hearing care, which can play such an important role in preserving independence and well-being, reducing the incidence of mental health and mental illness, is available to all patients who need it in the community on the basis of access, choice, quality and value.

In our view patients should be able to access adult community hearing services as easily as they can NHS eye health services - i.e. from any practice of their choice with the need for hearing correction and any device supplied being notified to the GP as the co-ordinator of care as for any other health intervention. It is a waste of resources, however, for all referrals to community hearing practices to need to pass via a GP and, indeed, many GPs in our experience – and backed by research by Action on Hearing Loss - fail to pick up on hearing issues or make appropriate referrals to the hearing sector.

As the Community Hearing Sector we would be very keen to pilot self-referral to adult community hearing services in partnership with NHS England, CCGs and government to develop a framework within which such services could be rolled out nationwide with improved outcomes and cost benefits for the NHS. We believe this will provide a new model of patient choice that improves quality of life, is cost-effective and helps reduce referrals to hospital and demand for GP services.

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

As a sector, we are more than happy to work alongside our general medical practice colleagues to provide more integrated care out-of-hospitals with the GP co-ordinating care where necessary.

It is axiomatic for us that GPs should always be informed about patients' hearing care needs and correction and the possible effects these might have on patients' wider health and wellbeing such as balance, falls, isolation, loss of independence and mental health.

We would also be very willing to work with the government, NHS England and CCGs to improve this. For example establishing better IT links will facilitate more effective communication across the professions and improve health outcomes. With the government aiming to take the paper out of the system by 2018 we feel this is the ideal opportunity to use IT to raise awareness about hearing (and other sensory) impairment. In order to deliver a more integrated out-of-hospital service a new approach to delivering health care is needed; one that focusses on reducing the risk of comorbidities and hospitalisation. At the heart of this is effective communication and the NHS has to innovate in this area to avoid an ageist health system that ignores the needs of vulnerable older people with sensory loss. We are happy to offer support and guidance on areas for improvement and how to adapt to a changing demographic.

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

We are concerned that the initial authorisation process for CCGs in 2012-13 undervalued (and accepted scant evidence of) collaboration with other primary care and community providers. In our view, this sort of collaborative and integrated care is only just beginning and progress has been inadequate, even in areas where Local Professional Networks have been established to accelerate the process. CCGs, in our view, need to be helped to engage far more effectively with 'partner providers' of care in the community to develop integrated, holistic solutions for all patients.

This should be based on genuine partnerships and mutual respect and should in future be assessed as a critical success factor in CCG performance and for the government's NHS reforms and in far greater depth and breadth than has been the case to date.

Again, we would be willing to work with all interested parties to develop a framework for adult hearing care. This need not require a lot of time and effort from CCGs but rather a change in culture and more openness on the part of traditional general practice.

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 National Community Hearing Association (NCHA) and BSHAA support a patient-centred NHS that works with local authorities (LAs). NHS England, CCGs and LAs have to avoid duplication and better mitigate risk by working on common goals together.

Here, focussing on the ageing population should be a priority and in particular how to screen, prevent, intervene and support all individuals at risk of or suffering from sensory loss. For example, hearing loss results in social isolation, depression and can make it difficult for individuals to access support they need. Therefore, NHS England, LAs and CCGs should work together to assist the 1 in 6 people affected by hearing loss.

A better framework for commissioning community hearing services and assessing quality and outcome would lead to more effective investment and a better balance in resources across the NHS and LAs. Acting now to move towards a more nationwide service is vital because, left unaddressed, it will result in an ageing population being at greater risk of social isolation, depression and a reduced quality of life which will inevitably place further strains on the NHS and LAs.

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

We feel that local authorities (LAs) need to take urgent action to address sensory loss in an ageing population. A more joined-up approach to assist these, often vulnerable, groups is an essential and unaddressed public health issue. For example, an integrated health and social care service should facilitate inter-professional referral so that all professionals work around patients and patients are not expected to work around the system. The National Community Hearing Association (NCHA) is willing to engage with all stakeholders to deliver a National Hearing Plan that works across all sectors to get individuals at risk of, or suffering from hearing loss, access to appropriate intervention and support.

The NCHA agree that more needs to be done to improve access to care based on clinical need and to reduce health inequalities. National Patient Choice Survey data shows that patients – particularly in lower socio-economic groups – do not and often cannot, travel long distances to access care. NHS England, CCGs and LAs have a vital role to play if we are to avoid increasing already unjustifiable health inequalities. For example, current commissioning of adult hearing services in the community makes it difficult for all providers to enter the market. Economic barriers to entry – created by arbitrary and excessive contractual terms by CCGs – are too high and this means less choice for smaller and vulnerable communities in our view. Patients in these communities should have the same right to choice as larger more affluent communities and therefore we call for a change in the way adult hearing services are commissioned under AQP. Effective and evidence-based commissioning of community services can help improve equity in access to NHS funded services. This can only occur through better engagement between commissioners (NHS England, CCGs and LAs) and providers. Services have to be designed around patient need and with all stakeholders engaged to avoid unintended consequences. The NCHA would be keen to meet with NHS England, CCGs and LAs to address these issues

and deliver a sustainable, equitable and cost-effective community hearing care service.

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

Commenting as community partners, we would like to see those GPs who will become future community leaders inducted into community and professional leadership and partnerships at a far earlier stage in their careers and for this aspect of community medicine to be as well recognised and rewarded as other clinical and academic areas of achievement.

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 Whatever new system is developed, community hearing providers and clinicians would be very happy to work more closely with GP colleagues, recognising their role in co-ordinating care for individual patients, and to improve information sharing in both directions between community medical and hearing practices.

Analytical Pack

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

A.N/A

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