Response form for *Developing the Continuity of Services Licence Conditions: Stakeholder Engagement Document*

If you would like any part of the content of your response (as distinct from your identity) to be kept confidential, you may say so in a covering letter.

We would ask you to indicate clearly which part or parts of your response you regard as confidential. We will endeavour to give effect to your request, but as a public body which is subject to the provisions of the Freedom of Information legislation, we cannot guarantee confidentiality.

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Please write your answers to the following questions below. Please expand the boxes or continue on further sheets if necessary. Then follow the instructions at the end of this form to return your response to Monitor.

Monitor consultation 3: continuity of services

As the Optical Confederation, we speak for the 12,000 optometrists, 6,000 dispensing opticians, 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 through a highly competitive, open market system.

This consultation, more than any we have seen, reinforces our view - as set out in our response to Framework Document in December 2011 - that community optical providers should be exempted from the Monitor licensing regime.

As previously explained, uniquely amongst NHS providers, the commercial, open market in which we operate – on an Any Qualified Provider basis and where money genuinely follows each and every patient - has already been proven to deliver precisely the benefits of economic, “efficient and effective” services which “maintain or improve the quality of services” that Monitor is now seeking to achieve in respect of others services through the proposed licensing regime.

Unlike other NHS providers, the optical market is already subject to two levels of regulation

- normal business regulation through the Companies Act 2006, consumer protection and product guarantees, professional indemnity protection, the Office of Fair Trading, Advertising Standards etc and
- optics-specific regulation by the General Optical Council.

Over the past 20 years, this highly competitive open-entry market has delivered significant benefits to patients including easy access in every community, ever improving clinical standards driven by competition, failing prices for product for both patients and the NHS and hence better value through supply chain efficiencies and technological and manufacturing improvements.

To continue to deliver these benefits, all optical practices (from large corporate to small independents) operate on tight margins and many could not survive the burden of "an additional layer of protection", which, in our view, would be both unnecessary and duplicatory.

Market Entry and Exit – Continuity of Service

As a sector, we already have considerable and successful experience of an open and functioning market with notable entries and exits (as noted above largely driven by patient choice and evolving business models) without any evidence of disruption to continuity or quality of care.

Both patients and the NHS pay for

- the professional services they receive at the point of delivery
- and spectacles and contact lenses at the time of purchase.

This means that there is no risk to patients' health care from continuity of service issues and, as a consequence primary eye care has never experienced any of the major failures demonstrated by traditional NHS providers, major hospitals or other private sector providers, nor could we because of the way our sector is structured.

Invariably when an optical practice closes, either another practice takes over the patients' care and records (with the patients' agreement) or the patient's records are transferred to a new practice of their choice, and therefore continuity of care is maintained.

For extreme cases where this is not possible (e.g. in an unviable location) we have agreed with the Department of Health that the patient records will transfer temporarily, and with the patients' permission, to the NHS Commissioning Board until they can be re-allocated to another optical practice.

Moreover, optical practices provide a limited range of services which makes them different in nature and scale from most other NHS providers and contractors. Given the

efficient functioning of the market, they are unlikely ever to be designated "protected services" by commissioners or to be taken into special NHS administration or re-structuring.

Financial Management

One recurring theme of the Continuity of Service consultation is the threat to patients and continuity of care from poor management and financial performance of providers. As stated above, providers in the optical sector are accustomed to operating in an open market and managing their financial affairs as private businesses. Those that do not exit the market and their patients move to another care provider.

In our view, therefore, it is imperative that community optical practices are exempted from the Monitor licensing regime (under Clause 82 of the Health and Social Care Bill when enacted). For them not to be exempted would risk destroying the genuine, competitive and successful market, which has long delivered significant benefits for both patients and the NHS.

It is against this background that we respond to the individual consultation questions below where we have experience we think might help.

We are happy, as ever, for this response to be made public.

Mark Nevin
Director of Policy and Regulation

Question 1: Do you think there are mandatory services currently provided by foundation trusts which should not become Commissioner Requested Services? If yes, which services and why? How might we identify those services?

This is not a matter for us. However, we would point out there is scope for confusion here in that sight testing services in England are legally referred to as 'General Ophthalmic Mandatory Services' with, in this case, "mandatory" meaning it is mandatory for Commissioners to commission them as well as for providers (who wish to be NHS providers) to provide them.

We would ask that guidance issued by Monitor make very clear that Primary Ophthalmic Mandatory Services are not included within this area of regulation.

Question 2: Which types of evidence should be taken into account when determining whether a particular service should be added to or removed from Commissioner Requested Services?

N/A

Question 3: What grounds do you consider would provide a legitimate reason for licensees to withhold their consent from having services added to Commissioner Requested Services?

N/A

Question 4: Should commissioners who have contracted for a particular service from a licensee in the past, but who do not have current contracts with the licensee for that service, be consulted if that service is being removed from the licensee's Commissioner Requested Services? If so, how far into the past should we look?

N/A

Question 5: Do you think there are mandatory services currently provided by foundation trusts that require substantial alteration? If so, which services and why?

N/A

Question 6: Do you think our proposed condition would allow licensees to alter Commissioner Requested Services in ways that would benefit patients? Please give reasons for your answer.

N/A

Question 7: Do you anticipate any financial or other difficulties arising as a result of a refusal of a request to materially alter a Commissioner Requested Service? Please give reasons for your answer.

N/A

Question 8: Do you think that it is necessary to place a restriction on the disposal of all assets? If not, what changes would you make to the licence condition we are proposing in order to strike a better balance between patient and licensee interests?

N/A

Question 9: Do you think we should introduce a threshold value for assets to which our restriction on disposals would apply? What would be an appropriate value at which to set the threshold and why?

N/A

Question 10: How much notice should we require from providers before assets can be disposed of and why?

N/A

Question 11: Do you think that there are existing providers of NHS-funded services who would not be able to obtain an investment grade credit rating? If yes, how long might it take them to reach a position at which they could obtain one? Please give reasons for your answer.

Yes.

These are not applicable to the community optical sector but, from our experience, we would caution again against over-regulation and costs in the system. Every penny taken in obtaining credit ratings and reporting on them, etc. is money removed from patient care. Clearly this should only apply to monopoly or major providers and not to Small and Medium-sized Enterprises (SMEs).

Question 12: How difficult do you anticipate licensees will find maintaining an investment grade credit rating? Please give reasons for your answer.

Please see answer to Question 11.

Question 13: Do you think we should introduce a threshold size for licensees to which our risk rating requirements would apply?

Please see answer to Question 11.

Question 14: Are there any reasons why licensees would not be able to obtain legally-binding undertakings with their ultimate controllers? Please provide reasons for your answer.

Yes

Notwithstanding our belief, stated above, that the optical sector should be exempted from the Monitor licensing regime, such a system would not be workable for community optical practices. Even where owned by larger businesses and corporations, they

remain essentially small businesses operating at local level. They provide a limited range of services and cannot be in contract with the NHS unless they have in place (and the NHS Commissioning Board is and continues to be satisfied with) appropriate premises, equipment, registered staff and record-keeping. A legally enforceable contract with an ultimate controller would be meaningless therefore and simply add to costs. As described above the highly competitive market in which community eye care is provided ensures that any gap in the market (due to exit or failure) is immediately filled and adequate systems are already in place to ensure continuity of patient care.

Question 15: Do you foresee any unintended consequences of the condition we are proposing? For example, conflicts of interest between licensees and ultimate controllers. Please provide reasons for your answer.

Please see answer to Question 14.

Question 16: How do you think licensees' contributions to the risk pool should be determined? For example, contributions could be adjusted to reflect risk profiles or revenues. Please give reasons for your answer.

Notwithstanding our belief, stated above, that the optical sector should be exempted from the Monitor licensing regime, we understand that risk pooling will only apply to protected, designated services. Nevertheless, for the record, we would be strongly opposed to risk pool levy conditions being applied to community optical practices. As a sector, we have never experienced the problems or caused patients the difficulties that these conditions are intended to protect against. As explained above, the open market system within which we operate is specifically structured so that these sorts of eventualities cannot happen.

Imposing such a levy would have very serious consequences for community optical providers, a proportion of whom (who may well be providing essential services and access in remote locations) could be forced out of business reducing patient access and choice. This would be a serious unintended and unnecessary consequence and demonstrates again very clearly why community optical practices should be exempted from the licensing regime.

From our wider experience however, where we have experience of operating risk pooling regimes, including captive insurance models for professional indemnity and clinical liability, we would query whether such a fund is necessary to be established in advance rather than each provider having a commitment to contribute if necessary on the lines of the ABTA model for travel services.

We are also fearful that the risk pool might be seen to encourage commissioners to be less than diligent in checking that they are commissioning appropriately from reliable

providers. With clinicians in the driving seat and greater clinician-to-clinician contact across the commissioning divide, this should improve but our experience, to date, is that some NHS commissioners do not have the necessary skill mix and might be easily persuaded by promises and glossy brochures without feeling it necessary to carry out due diligence in relation to their potential partners.

We hope that Monitor will consider seriously whether these proposals might not undermine the drive for genuinely effective commissioning, which we understood to be the Government's aim.

Question 17: How would you like to be involved in our consultation on the methodology for calculating the risk pool levies?

Please see answer to Question 16.

Question 18: What do you think the pre-failure planning team's roles and responsibilities should be?

These are not matters for us but seem a logical consequence of the "continuity of services" regime proposed.

Question 19: How would you like to be involved in our consultation on the roles and responsibilities of the pre-failure planning team?

Please see answer to Question 18.

Engagement process

Thank you for responding to this engagement document. Please save this document and email it to licensing@monitor-nhsft.gov.uk with 'Continuity of Services Licensing Conditions' in the subject line.

Alternatively, you can fax your response to 020 7340 2401, or post it to:

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This document *Developing the Continuity of Service Licence Conditions: Stakeholder Engagement Document* was issued on 16 December 2011. Please submit your responses to

the questions and any other comments that you have by 5pm on 23 January 2012. There will also be subsequent opportunities to respond to our licensing engagement documents.

If you wish to do so, you can request that your name and/or organisation be kept confidential and excluded from the published summary of responses. Please tick this box to ensure confidentiality. ☐