Fair Playing Field Review - for the benefit of patients: Discussion Paper

The Optical Confederation represents the 12,000 optometrists, the 6,000 dispensing opticians and 7,000 optical businesses in the UK provide high quality and accessible eye care services to the whole population. The Confederation is a coalition of the five optical 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.

The Local Optical Committee Support Unit (LOCSU) is part of the Optical Confederation and supports Local Optical Committees (LOCs) across England in developing local eye health services. It helps community optometrists and opticians work with local commissioners to make community eye care services accessible for patients and cost effective for the NHS.

As a sector we have welcomed the Government's proposals - rightly - to exempt the community optical practices from registration by the Care Quality Commission (CQC) and regulation by Monitor, on the grounds that alternative regulation is already in place, operates effectively and that to impose further, duplicatory regulation would not be in the public interest. We have also welcomed the Government's commitment to preserve NHS sight testing as a nationally commissioned service by the NHS Commissioning Board to minimise unnecessary transaction costs.

Nevertheless, we very much welcome the opportunity to comment on 'matters that may be affecting the ability of providers of NHS services to participate fully in improving patient care' where we believe optical providers could play a wider role in delivering effective services in the community, achieving the Quality, Innovation, Productivity and Prevention (QIPP) goals and improving ophthalmic public health by case finding disease and abnormality in the eye and elsewhere, and refining referral to secondary care.

As a sector, we deliver approximately 12 million NHS eye examinations annually through a highly competitive market that is effectively regulated. Through this environment the sector delivers nationwide access to high-quality services with few clinical errors, very low levels of complaints and strong cost containment (evidenced by the General Ophthalmic Services fees paid).

We welcome Monitor's approach of evidence gathering, analysis and development of recommendations with stakeholders (Sections 3 and 6) and agree that any proposals should be realistic, capable of implementation and consistent with work already under way (Section 6).

We also welcome the recognition that competition driving up quality is inherently about difference and competitive advantages. These benefits are then spread through competition to all ensuring that the right care is provided to patients in the right place, at the right time and at best value, and that what Monitor is seeking to remove is distorting factors inhibiting competition rather than making the playing field so level that there is no competition (which is sometimes the NHS view).

We respond from the primary care perspective and would like to raise four specific areas of concerns and what we believe are imbalances in current commissioning, namely

- poor and unimaginative commissioning with muddled tender documents and unclear specifications
- onerous and unnecessary requirements on community practices that are designed for acute hospital providers - in our case CQC registration (which is not required and indeed not legally possible) and NHS N3 connection and unnecessary IG requirements when secure e-mail, e.g. NHS mail more than meets service needs
- failure to engage potential providers in developing service specifications; this automatically introduces bias towards existing providers, prohibiting new small providers from entering the market (especially when combined with requirements for a prior track record of NHS provision)
- community optical practices still not being able to use the NHS logo despite years of requesting this.

These areas of concerns are reflected in our more detailed responses to the specific consultation questions below.

Question 1: Do you believe there is another relevant dimension that should be considered as part of the scope of the review?

Not for our sector.

Question 2: Do you believe that a diverse range of providers is an important lever for helping to improve patient care? Please provide specific examples in either case.

Yes. Just as in the optical sector itself a diverse range of providers will improve patient care, choice, access, convenience and value for money for patients and the NHS.

For example, in East Yorkshire and Hull, local optical practices have been commissioned to provide a primary diagnostic, eye treatment and referral service for patients. This service utilises community optometrists to provide services that have been traditionally provided in the hospital sector, but where capacity is over-stretched. According to an audit by the two commissioning PCTs, the reconfigured service saved £60,000 between April and September 2012.

Similarly, since NHS Stockport introduced an Intraocular Pressure Referral Refinement Pathway in 2010, 77% of patients who would otherwise have been referred to secondary care for raised pressures have been cared for in primary care. As well as providing a convenient service for patients, increasing the diversity of providers has resulted in projected savings for NHS Stockport of around £60,000 a year for this specific pathway.

Question 3: What do you believe is the single most important factor in provider decisions to expand into a new area (whether that "area" is serving a new geography or providing a new service)?

We believe that the single most important factor in provider decisions to expand into a new area is economic viability, as, for our sector, there is no financial support or subsidies and the entire risk of expanding service provision rests with the provider. As providers we need clarity about the intentions and aspirations of commissioners in an area, including details such as service specifications, in order to be sure that we can ensure financial viability and deliver within the advertised tariff or negotiated tariff.

Question 4: In the responses to our initial call for evidence, effective commissioning was overwhelmingly identified as important to ensuring a range of providers can offer their services. To what extent do you think the main issues relating to commissioning and the fair playing field are being addressed through the current reforms?

Our experience has been that many staff involved in commissioning services on behalf of PCTs have not fully understood the diverse range of providers that may be able to deliver particular services, or the range of services a particular provider may be able to deliver. For example, when commissioning community ophthalmology services, there is often no consideration given to the role that optometrists, ophthalmic nurses or other healthcare professionals can play, or that health improvement programmes, such as Stop Smoking can be delivered from optical practices.

Also, many teams have not understood the procurement options available to them to ensure effective commissioning.

We have seen a number of examples of muddled service specifications that make it difficult for potential providers to understand the service requirements. We hope that clearer guidance on procurement for the emerging CCGs will improve clarity for potential providers and will lead to more effective commissioning.

AQP

We believe that Any Qualified Provider (AQP) procurements have great potential to increase the diversity of providers in a number of areas, including for new community eye care pathways. We have seen evidence of this in Stockport and Cheshire, where the LOCs have bid successfully for AQP services via single provider companies (essentially consortia of local practices). However, we have also seen examples

where AQP has become a barrier to community providers, e.g. procurement teams have not understood that optical practices are exempt from CQC registration, or a procurement team insists on N3 connections without considering the option of secure encrypted software to manage patient data.

Question 5: Are you aware of any specific examples where costs arising from tax differences between NHS, private sector, voluntary and charitable providers have had an impact on provider decisions about whether to bid for contracts (or provide services covered by AQP)?

Not in our sector.

Question 6: Are you aware of any specific examples where costs arising from differences in pension costs between NHS, private sector and VCS providers have had an impact on provider decisions about whether to compete for contracts (or provide services covered by AQP policy) and on provider's ability to attract high quality staff?

Not in our sector.

Question 7: Which of the issues identified in the review do you feel is the most important to your organisation? Are there any important issues that you feel we have missed?

We feel that 'Commissioning and tendering' is the most important area to our sector from the issues identified in the review.

Failure to engage potential providers in the design of a service specification, and issuing poorly defined service specifications make it less likely that new providers will be able to bid for services. The rigid nature of qualification questionnaires often excludes small providers or newly established collaborative bodies from succeeding.

Question 8: Which type(s) of provider do you feel are most disadvantaged by the current NHS playing field and why?

Small providers are particularly disadvantaged due to the onerous nature of procurement processes, and the NHS Community Services Contract. Detailed completion of the qualification questionnaire (when there is rightly no guarantee of success) is onerous and not felt worthwhile by many small providers. There should be a simplified version of the NHS Community Services Contract for utilisation in the procurement of low risk, low cost services.

New providers (or collaborations between groups of different professions) are also regularly disadvantaged as the local questions put forward by the procurement teams are often around giving examples of how you have previously delivered a similar service.

NHS Logo

All optical practices are disadvantaged in the current NHS playing field due to restrictions on their use of the NHS logo.

There is little doubt that the NHS logo has a value and is a very strong brand. However, more importantly it sends a very clear signal to patients of where they can access services commissioned by the NHS. We believe the latter to be most important and have been arguing for use of the logo since this was introduced for our sister profession – dentistry - in 2004. Each time the request is made it seems that the 'Branding Team' is undertaking further review, reorganising and latterly transferring from the Department of Health to the NHS Commissioning Board. It may be that the optical sector is regarded as too small to concern the 'Branding Team' despite the evidence of the NHS health and care benefits we offer. We would very much welcome a discussion with the relevant persons in the NHS Branding team on this point.

By unfairly restricting the use of the NHS logo in the optical sector, patients are unclear that NHS services are being offered locally and may delay attending for care which in turn leads to poorer public health outcomes and greater pressure on A&E, GP and hospital services. It also inhibits community optical providers from bidding for NHS services as they are incorrectly seen as being outside the NHS family and can thus be overlooked as potential providers.

Submitted by Ben Cook on behalf of the Optical Confederation and LOCSU