Monitor – Continuity of Service Tranche 2 – March 2012

The Optical Confederation represents 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. 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 (Ophthalmic and Dispensing) Opticians (FODO). As a Confederation we work with others to improve eye health for the public good.

We welcome the opportunity to contribute to this second consultation.

Condition 8 – Availability of resources

We cannot currently envisage any circumstances in which either sight testing (General Ophthalmic Services) or locally commissioned enhanced services (Primary Ophthalmic Services) would need to be designated as Commissioner Requested Services.

However, if they were, the conditions proposed would be completely disproportionate to the kinds of NHS services community optical providers supply:

- as identified in responses to previous Monitor consultations, there is no risk of service failure in the community optical sector
- NHS income accounts for only a small proportion of sector revenue (less than 20%)
- the services provided although essential and valuable in health terms, are low in cost terms (because of the cost subsidy from the sale of spectacles and contact lenses)
- in extreme cases, there would not be the need for significant working capital for a community optical service to continue.

Moreover, as explained in previous consultation responses, both sight testing and locally commissioned enhanced services are claimed or charged to commissioners in arrears (i.e. after the service is provided) so there is no risk to NHS funds if a provider were to fail.

In the theoretical example that a provider goes out of business before spectacles or contact lenses ordered have arrived and been fitted, in most cases, these are only

paid for on completion, so the patient would not lose out and, in cases where payment had been received in advance, it would be normal for whoever took over the practice (or in extreme cases the administrators) to pass on the product, when it arrived to the patient. Lenses are not transferrable between patients and there would be no advantage in seeking to retain them as they would have minimal value.

As we have explained in previous consultation responses, community eye care is delivered in a highly competitive, open commercial environment where there are low thresholds to both market entry and arguably higher thresholds for exits. This benefits patients and the NHS in that new providers are entering the market all the time driving up competition, quality, access, choice and value; while other providers have merged or been taken over. In community eye care all providers must innovate and deliver what their patients want to survive. For further evidence of the competitive nature of the community optical market, please refer to the attached supplementary paper titled 'Optical Market Benefits March 2012'.

In the past few years, two major optical chains in the UK have changed hands without any loss to patients or the NHS, which has improved their service offering and therefore benefitted patients.

There is no evidence in our view of any need for the kinds of protections set out in Condition 8. Patients, the NHS or the public are already sufficiently well protected without the need for further bureaucracy. Such a burden would be entirely unnecessary and disproportionate.

To impose such an unnecessary and onerous burden on optical providers, all of whom operate on tight margins owing to the highly competitive market in which they operate, would result in practice closures (especially among the independent sector) reducing the very choice and competition on which the sector thrives and, as previously noted, delivers significant benefits to both patients and the NHS.

We have responded to the specific questions, as follows:

Q1. Do you think that this condition is proportionate? Please give reasons for your answer.

A1. This should not apply to community optical practice for the reasons set out above.

Q2. What do you consider would be sufficient evidence to support them at both annual certificates?

A2. Not applicable to community optical practice.

Q3. Should "operational resources" be explicitly listed in this condition to capture important outsourcing arrangements?

A3. Not applicable to community optical practice.

Q4. Are there any reasons why distributions might not be paid within 3 months after they have been declared? Certificates for distributions required under our proposed condition would only be valid if the distribution is made within 3 months of its being issued.

A4. Not applicable to community optical practice.

Q5. What do you estimate to be the likely impact, if any, of this licence condition on your organisation's costs? Please provide details of the assumptions underlying your estimates.

A5. Not applicable to community optical practice.

Q6. Can you suggest more effective ways of achieving the same objectives? What might they involve?

A6. As demonstrated above (and in our response to Pricing Tranche 2), the nature of the optical market means that it already operates with spare capacity, which would provide sufficient cover to ensure continuity of service. There is no need or evidence of need for this requirement for community optical providers.

Condition 9 – Limits on indebtedness

As demonstrated above, it is very unlikely that sight testing or Primary Ophthalmic Services would ever be designated Commissioner Requested Services.

However it should be re-emphasised that the proposed conditions on indebtedness would be completely disproportionate to the nature and scale of the services provided by and commissioned from community optical practices.

For major providers in optics, and we imagine in many cases community pharmacy, the optical services that they provide in England are only a small part of their overall business, which of itself would be unlikely to impact on the financial viability of the larger business.

Imposing bureaucracy which has been developed primarily for NHS trusts and large acute providers would be inappropriate and impose an unacceptable burden. As a result, many might withdraw from providing convenient, highly accessible services because of the unnecessary additional burden of regulation from Monitor, should that be imposed. This would obviously have the opposite effect to the one intended, resulting in reduced choice for providers and employment in the community optical sector.

Similarly, the burden would not be feasible for smaller businesses and independent practices to bear.

Q7-10. are not applicable to the community optical sector.

Condition 10 – Further restrictions in the event of financial distress

The same arguments apply to this condition. The further restrictions proposed would be entirely inappropriate and disproportionate to the level, scale and nature of services provided by community optical providers.

Condition 11 – Restrictions on lending

As demonstrated above, this condition would also be inappropriate and unworkable in community optical practice. The costs associated with credit ratings, etc, would be completely disproportionate and unaffordable for the majority of community optical practices who would no doubt be forced to withdraw from providing services, significantly undermining consumer access and choice, particularly in remote or sparsely populated locations.

Such a condition, obviously designed for large acute providers and high cost services, is simply not at all applicable to community optical providers and would not be feasible in our sector.

In respect of all of the above, we would be strongly opposed to Primary Ophthalmic Services being swept up into a far heavier regulatory regime designed for high-cost health care services.

Community eye care services are high value, but low cost, delivered with minimal risk to patients or NHS commissioners. There is no evidence that such conditions are required for this sector and the imposition of such conditions would have a significant, detrimental effect on provision, as already described.

We are happy for this response to be made public.

This response has been submitted by:
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March 2012