Protecting Patients' Interests – Ensuring Continuity of NHS Services

Department of Health Consultation on Proposals for Health Special Administation Procedure for Companies

Thank you for inviting our comments on this consultation. The Optical Confederation represents the 12,000 optometrists, the 6,000 dispensing opticians and 7,000 optical businesses in the UK who provide high quality and accessible eye care services to the whole population. The Confederation is a coalition of the 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 Opticians (FODO). As a Confederation, we work with others to improve eye health for the public good.

Introduction

As we have explained in previous responses to Monitor consultations, community optical providers are regulated by an optics-specific regulator, the General Optical Council, and under the terms of our primary ophthalmic services contracts with the NHS.

Subject to these parallel forms of regulation, uniquely amongst NHS providers, community optical providers operate in a highly competitive, commercial, open market– on an any qualified provider model where funding genuinely follows each and every patient and which is proven to deliver precisely the benefits of economic, efficient, effective and integrated services which the Monitor regime seeks to replicate amongst more traditional NHS providers.

In our sector, 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, falling prices for product for both patients and the NHS and hence better value through supply chain efficiencies and technological and manufacturing improvements.

Market Entry and Exit – Continuity of Service

As a sector, we already have considerable and successful experience of an open and functioning market with appropriate entries and exits (as noted above largely driven by patient choice and evolving business models) without 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.

Primary eye care has never experienced any of the major failures demonstrated by traditional NHS providers, major hospitals or other private sector providers, nor would this be possible 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 Local Area Team until the patients choose or are transferred to another optical practice.

Moreover, optical practices provide a limited range of services which makes them different in nature, scale and complexity from most other NHS providers and contractors. Given the efficient functioning of the market, they are highly unlikely ever to be designated "protected services" by commissioners or to be taken into special NHS administration or re-structuring.

By definition all optical practices are small-scale and local, even when owned by major retailer or supermarket chains. They operate on the same principles and with the same protections for patients. We would not therefore see the need in our sector (as others have suggested there might be in their disciplines) for any differentiation of regulation between types of community optical providers irrespective of ownership models or operational arrangements.

Financial Management

A recurring theme of the 'Ensuring Continuity of NHS 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 to avoid such calamities. Those that are not able to do so are either taken over by another provider or can exit the market and their patients move to another care provider without interruption of care.

Exemption for Community Optical Providers from Monitor Licensing

We are pleased to support the Government's proposal that primary ophthalmic services providers should be exempt from Monitor licensing. For the above reasons and are equally please to note that they will also be exempted from the licensing continuity arrangements and the proposed 'health service administration (HSA) procedures on the same basis.

Our responses to the consultation questions below reflect this position. Please do not hesitate to contact us if you would like any further information or detail.

Consultation Questions

Question (1): Could the proposals have any perceived or potential impact on equality including people sharing protected characteristics under the Equality Act 2010?
A: Not that we are aware of.

Question (2): Should the regulations include a time limit for commissioners to make a decision on which services must be secured? If so, what sort of time limit would be appropriate; for example 7 or 14 days? Should Monitor be able to extend that time limit in large or complex cases?

A: As community optical providers are to be exempt from these requirements, we have no view.

Question (3): Do you think that it is appropriate to apply the restrictions in regulations 6 to 10 on commencing ordinary insolvency and enforcing security to 'relevant providers'? What would be the impact on cost of capital? Do you think any alternative safeguards might be required?

A: N/A

Question (4): Should a members' voluntary liquidation be excluded from the restrictions on voluntary winding set out in regulation 7? If so, do you think safeguards should be included where it is proposed to move a company from a members' to a creditors' voluntary liquidation?

A: N/A

Question (5): Is regulation 9 fit for purpose or are changes needed to make this more compatible with the steps required to appoint an administrator? Assuming there is a problem, would it be sensible to require a 'notice of intention to appoint' an administrator to be given to Monitor or is there a better solution?

A: N/A

Question (6): Do you think that the indemnity provisions are sufficient? If not, what changes would you like to see?

A: N/A

Question (7): Is it sensible to include an exit route from HSA to 'ordinary' administration by allowing a health special administrator to apply to the court for the making of an administration order? If so, what would be the costs and benefits of an exit route to 'ordinary' administration?

A: N/A

Question (8): Apart from basic details to enable a company to be identified as a 'relevant provider', should any further information be set out in the register?

A: N/A

Question (9): Should HSA only start where the company is insolvent or should there be any other grounds for starting the procedure?
A: N/A

Question (10): Do you think that the general definition of 'business document' should be adjusted for health care providers, for example to specifically exclude prescriptions or other items? To help inform our analysis, we would be grateful for any evidence of costs and benefits of any exemptions.

A: N/A

Question (11): Is 8 weeks enough time for the health special administrator to develop and agree proposals? Is it a sufficient safeguard to provide for this to be varied on a case-by-case basis by Monitor or the court?

A: N/A

Question (12): Should service continuity plans be subject to public consultation? If so, should this be a requirement in all cases or only those which would involve a significant change in the provision of, or access to, NHS services?

A: N/A

Question (13): What sort of criteria should be included in the regulations to determine whether or not public consultation is required? Would it be preferable to base this on a 'significant variation' in services or a 'substantial reduction in access to services'? Do you have any other suggestions?

A: N/A

Question (14): Do you think it would be better to allow a decision on whether public consultation is required to be made on a case-by-case basis? If so, should that decision be made by Monitor or should this be agreed between Monitor and commissioners?
A: Both proposals would seem to be sensible, based on clear and publicly available guidance.

Question (15): Are the provisions of Schedule 2 appropriate to enable the transfer of services and associated assets as a going concern to one or more alternative providers to secure continuity of NHS services?

A: N/A

Question (16): Are any of the provisions of Schedule 2 unnecessary or likely to cause difficulties?

A: N/A

Question (17): Should any other areas be covered in the transfer scheme arrangements?

A: N/A

Submitted by Jenny Gowen on behalf of the Optical Confederation