Securing best value for NHS patients: requirements for commissioners to adhere to good procurement practice and protect patient choice

Thank you for the opportunity to comment on this consultation.

By way of introduction, it is worth re-stating that the Optical Confederation and the wider optical sector have always supported, endorsed and abided by the *Principles and Rules of Co-operation and Competition*[1] and the *Procurement Guide for commissioners of NHS Funded Services*[2].

We therefore fully support the proposals in this consultation document, which are based on these helpful pre-existing frameworks and the principle of best value (rather than lowest cost on which these frameworks are founded) (paragraphs 1.7, 1.19, 2.1).

Patient-Centred Care

It is worth also stating that, as a sector and well in advance of the mainstream NHS, community optical practice has always "placed patients at the heart of care, providing information, offering patient involvement and choice, developing responsive service and delivering high safety, quality and value for money" (paragraph 1.1). We have been held up as an exemplar service for the rest of the NHS in all of these regards by commentators ranging from Professor John Spiers[3] to Professor Nick Bosanquet[4].

It is for this reason that we have supported the Government's NHS reforms in this regard. We look forward to using our experience and commissioning skills to support the NHS Commissioning Board and Clinical Commissioning Groups in achieving these ends more widely through the proposed Local Eye Health Professional Networks in partnership with hospital and Health and Well-being Board colleagues.

Efficiency and Outcomes

In terms of efficiency and outcomes, it is also worth noting the exemplary results that our sector delivers in both these areas.

Although accounting for only 0.4% of the overall NHS budget, community optical practices provide an extremely efficient public health screening and primary eye care intervention service seeing some 20 million patients (a third of the UK population) each year.

Best Value Commissioning

The College of Optometrists and the Royal College of Ophthalmologists are working together to develop best value commissioning guidance in eye care for Clinical

[1] *Principles and Rules of Cooperation and Competition*, Department of Health, July 2010
[2] *Procurement Guide for commissioners of NHS Funded Services*, Department of Health, July 2010
[3] Spiers, J. *Patients, Power and Responsibility – the first principle of consumer-driven reform,* Oxford, 2003
[4] Bosanquet, N. Liberating the NHS: Eye Care – Making a reality of equity and excellence, December 2012

Commissioning Groups. It will be published this year and cover the main areas of eye care commissioning: age related macular degeneration, glaucoma, cataract, urgent eye care, oculoplastics and low vision services.

Working with Monitor

Although the proposal is that primary ophthalmic services (POS) provision should not be subject to Monitor regulation (because we are already subject to equivalent parallel regulation)[5], we look forward very much to collaborating as a sector with Monitor to ensure that both commissioning and provision work as efficiently as possible in the interests of patients. With this in mind, we would be very happy to comment on drafts, e.g. "Choice and Competition Frameworks" which Monitor will be developing to inform commissioners' decisions (paragraph 1.26).

It is against this background of strong support that we respond to the consultation questions below.

Q1. Do you agree that we should establish broad principles for good procedure practice in the regulations, rather than setting more prescriptive procedural rules?

A1. Yes.

Q2. Do we need to introduce any additional safeguards to ensure the commissioners comply with good procurement practice?

A2. Yes. There are several points we would like to make here about transparency and commissioning for best value outcomes for the NHS and patients.

Absolute Transparency

The first is that the requirement should be absolute on all GPs and Clinical Commissioning Groups to declare any interest at all that they may have in potential contractors or the bidding process, however remote or indirect. It is far better in our view, for this to be open and transparent and for everyone to err on the side of caution.

For an example, any contractor bidding for a contract which has - as shareholders or other beneficiaries - any GPs or others who are members of the practices of the Clinical Commissioning Group, consortium or practices carrying out the commissioning (or members of any other CCGs who may similarly have a beneficial interest) should declare these at the very outset of a tendering process.

This duty should be on both commissioners and bidders. Should it come to light that such an interest had not been declared, the commissioning process should automatically be declared null and void and re-commenced from scratch.

Declaring Investigations and Findings

Secondly, in the interests of good commissioning and as part of the commissioning process, there should be a duty on any bidders for NHS services to declare any current investigations

[5] P*rotecting and promoting patients' interests – licensing providers of NHS services – a consultation on proposals*, Department of Health, August 2012

by, or adverse findings against, them by any NHS commissioner, regulatory or other body under commissioning rules or the Bribery Act.

This is particularly important given that new entrant bidders are often adept at designing kick-backs to referring practices in order to get business despite this being a clear breach of NHS procurement rules.

Single Portal

Thirdly, although we welcome very strongly the requirement to publish details of all contracts on "supply2health" we think it should be mandatory to use this site (and not simply an equivalent as suggested at paragraph 2.36). This would ensure that all contracts were nationally notified in the same location and make it easier for potential bidders to see the national picture and be able to bid as appropriate rather than needing constantly to monitor information from different CCGs or other commissioning configurations.

Tendering must always add value

Fourth we agree fully with the principle that "procurement should always be cost beneficial... [i.e.] the potential value-for-money benefits to patients will significantly outweigh the costs incurred by commissioners and providers in participating in procurement processes" (paragraph X).

Widest range of bidders

Fifth we also support the principle of seeking to include the widest number of potential bidders in each tendering exercise, including the private and voluntary sectors (paragraph 2.21).

Clarity, detail and feedback about why contracts are not awarded

Sixth we hope that the regulations will make it very clear that commissioners should keep "appropriate records – the reasons why they have reached their decisions" (as proposed at paragraph 2.23) including reasons about why bidders were rejected, on what grounds and at what stage in the process. Such issues have often in the past been dealt with in a desultory manner which has precluded any serious challenge after contracts have been awarded.

Q3. Could the proposals have any perceived potential impact on equality including people sharing protected characteristics under the Equality Act 2010?

A3. Not so far as we can see.

Q4. Do you agree that the regulations should protect patients' rights to exercise choice as set out in the NHS Constitution?

A4. Yes.

Q5. Are there any further safeguards that should be established through the regulations or elsewhere to protect the extension of choice?

A5. No but we would wish to point out that, almost uniquely in the provision of NHS care, community optical practice offers the widest possible range of choices from major high street providers, through small local independent providers to mobile and domiciliary service for people who cannot leave home unaided.

We operate in a highly competitive, genuine and open market system and, subject to basic entry requirements (concerning premises, equipment, record keeping and staff) market entries and exits are easy and practices open up wherever they see an opportunity to attract patients. Each and every patient has similar value for the optical practice and practices compete vigorously to attract patients on grounds of access (eg opening hours), quality, service, choice and price.

As a result, the 6,000 practices in England already provide wide choices to patients over

- where they are treated
- how they are treated
- choice of clinician (paragraph 3.2).

The highly competitive nature of the market means that practices bend over backwards to meet patients' needs and wishes.

The success of this system depends on the practices operating within a national system, on a nationally negotiated framework of terms and conditions, with national fees and within national regulatory and contact compliance frameworks. Our aim in re-emphasising these points is to urge the NHS Commissioning Board and government not to make any changes in these arrangements which would jeopardise competition, limit choice or reduce quality.

There are also significant opportunities to bring these benefits to other areas of community-based eye care without incurring significant transaction costs for CCGs eg glaucoma referral refinement, cataract referral refinement, and we are very willing as always to discuss these with the NHS Commissioning Board and government.

Anti-competitive conduct

We fully support the government's proposal to retain the "existing prohibitions on anti-competitive conduct by commissioners, as set out in the current Principles and Rules" and to combine them into a single prohibition (paragraphs 4.7 and 4.8).

Q6. Do you agree that we should adopt an effects-based approach to assessing restrictive conduct by Commissioners, rather than assuming that conduct which restricts competition is automatically against patients' interests?

A6. Yes.

Q7. What can the Department of Health, NHS Commissioning Board and Monitor do to ensure that commissioners understand the requirements that they can effectively self-assess whether or not their conduct falls within the rules?

A7. Publish simple guidance as in Figure 8 (page 31) and Figure 9 (p33).

Q8. Are there particularly problematic behaviours which we should address specifically, for example, in the requirements or in Monitor's guidance for commissioners?

A8. As niche providers, we are somewhat concerned by the issue of "bundling" which may be more for the convenience of commissioners than for any benefits, outcomes or efficiency gains for patients (paragraph 2.8). For example, bundling community optical services with

other services that optical practices cannot possibly provide would unfairly exclude these very efficient providers from bidding for contracts.

"Bundling" can also lead to unhealthy forms of vertical integration and anti-competitive market domination. We would therefore be very keen to work with the Department and Monitor on any advice being developed for CCGs to support the government's aims of bringing the benefits of fair competition both to the ophthalmic sector and the wider NHS. Please also see additional comments below about tick box requirements and Local Optical Committee (LOC) bidding.

Q9. Do you agree that the Act and proposed requirements impose sufficient safeguards to ensure that Commissioners manage conflicts of interest appropriately?

A9. Nearly. We welcome the government's proposals

- to provide an appeal to an independent authority where it is believed that decisions have been influenced by an interest in a provider
- to establish requirements specifically prohibiting Commissioners from awarding a contract to a provider where that decision is the result of an interest in the provider
- for commissioners to be required to maintain records of how they have managed conflicts of interest in individual cases.

We do, however, have concerns about remedies.

As noted above (response to Q2), the key element for us is absolute openness and transparency about all conflicts and potential conflicts of interest, however oblique or distant, at the very outset of the tendering process.

- If this is not complied with, it is all too easy for glitches, errors, oversights and slip-ups to disappear into the shifting sands between registers of interests and arrangements for managing conflicts etc; and post-hoc sanction of the provider will be of little comfort to those who have lost out through a bidder's misbehaviour or a commissioner's laxness.

In our view, it should be a clear principle that where any breach has occurred, the tendering process should be opened again and re-started from scratch unless Monitor decides that there is an overriding public interest why this should not happen. Inconvenience or cost to the provider or commissioner, unless the mistake was genuinely and demonstrably human error, should not be such a reason.

Q10. If not, what additional safeguards could we introduce?

Please also see our comments in response to Questions 2 and 9 above.

Additional Comments

<u>Tick Box Commissioning, Excessive Requirements and Local Optical Committee (LOC)</u>

We are particularly pleased that the Future Forum and this consultation paper recognise that commissioners have sometimes imposed excessive requirements which prevent capable providers bidding to run services (paragraph 1.11). Within the community optical sector, many local Optical Committees (LOCs) in England, which are the statutory representative organisations for local NHS contractors and clinicians, have formed local

companies (open to all local optical NHS contractors to participate in, effectively a consortium of providers) to tender for services.

Unfortunately, rather than "intelligent commissioning", some commissioners have taken blanket tick-box approaches which have precluded LOCs from bidding to provide eye care services well within their capacities and which would have widened patient choice. In some cases this has involved inappropriate "bundling" (please see comments above) but in others, the imposition of requirements which are not legally achievable for community optical practices and for companies set up by Local Optical Committees.

For example, primary ophthalmic services are already heavily regulated by the General Optical Council, under the terms of their general ophthalmic services contracts and parallel business regulation and, as such, we are exempt from the requirement for CQC registration and, it is proposed, should also to be exempt from Monitor registration. Yet, despite this, many tender processes start with a tick box approach that requires a yes/no answer to the question about whether or not the bidder is CQC registered, etc. There is no box for "not required" or "not applicable". In such situations, the Local Optical Committee and optical contractors are "damned if they do and damned if they don't". If they tick "no" they are automatically excluded from the bidding. However, if they tick "yes", they are making an untrue statement and are likely to be excluded at the next round when checking shows that they are not in fact CQC registered. There is no room for explanation in these automated processes.

We would strongly urge the government to find some way of dealing with this issue, which may simply require the issuing guidance to all NHS commissioners to make it clear that certain providers who may well wish to tender for community services, particularly community pharmacists and community optical practices, are exempt from the requirements for certain types of registration and regulation which apply only to the less-regulated NHS acute and private hospital sector.

We very much look forward to working with the Department and NHS Commissioning Board on these issues to ensure that the benefits of competitive tendering really do run from top to bottom of the new NHS and deliver the government's anticipated benefits for patients, outcomes and the public purse.

Further Information

We are very happy for this response to be made public. If you have any queries on any of the above or require further information, please do not hesitate to contact us.

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.