



## **NHS England Review of incentives, rewards and sanctions**

### **Summary**

This is a joint response from the Local Optical Committee Support Unit (LOCSU) and the Optical Confederation.

We support NHS England's aims to enhance quality and efficiency in the NHS and welcome the opportunity comment on this review of incentives, rewards and sanctions.

We are pleased to support NHS England in its attempts to replicate positive market forces within the quasi-market that most NHS providers still operate in. However, we would urge caution if applying such policies uniformly across *all* health care providers. Community eye care providers already operate in a competitive market and ideally NHS policies should complement, rather than distort the existing, positive market forces.

We also feel that any sanctions should not duplicate existing regulation – e.g. community eye care already operates under a range of possible sanctions: optometrists and opticians are regulated by the General Optical Council, the sector's regulator; providers are regulated through their NHS General and Additional Ophthalmic Services Contracts and are also required to comply with a comprehensive body of consumer regulation (e.g., advertising standards, provisions relating to the sale of goods and services, etc). Therefore, additional NHS sanctions on our sector should be considered with caution, as they are likely to duplicate existing requirements and may distort the playing field between primary and secondary care providers.

We do, however, support the use of proportionate mechanisms designed to drive efficiency and enhance the quality of care, including initiatives which

- improve patient access to care in the community and increase patient choice and convenience where weekend and, for some practices, late evening appointments are available;
- ensure compliance requirements that are proportional to complexity and risk involved (which we believe is low for our sector);
- decrease the complexity of entry so that competition can work optimally for the benefit of patients;

We are pleased to have had the opportunity to share our thoughts and be a part of this important consultation that will go towards designing a package of incentives for 2014/15 and be an integral part of future strategy for NHS England. We are also available to discuss any of the points raised with NHS England, if that would help.

It is against this background that we are pleased to respond to the consultation questions below and we are happy for this response to be made public.

## **Response to Questions:**

### **Which incentives are best used for what?**

#### ***Q1: Do you support these design principles?***

In our view, the design principles are an accurate summary of the current arrangement operating in the NHS. We would caution that what seems sensible for areas of complex medicine, may not work so well in low risk services, such as, eye care in the community. In our view, resources should not be unnecessarily diverted to the pursuit of overly complex metrics, which fail to improve clinical outcomes for patients.

Therefore we welcome the recognition that proportionality is central for incentives, but feel this should also apply to sanctions:

*“We also believe that the overall package of national incentives needs to be at a workable level of complexity, based on evidence whenever possible, and with a balance of risk and reward for providers and commissioners” (Page 5).*

As above, we would be delighted to meet with NHS England to discuss how the proposed framework might apply to the community eye care sector.

### **NHS Standard Contract (General Terms and Conditions)**

#### ***Q2: Do you support general proposals set out above?***

We support the need for greater flexibility in contract duration.

We support the principle of mandated national service specifications that provide patients and the public across England with access to consistent, effective and quality services. However we cannot support blanket provisions for mandated standards without further details about how these would be developed and applied. A national standard for each community eye care service based on the national pathways developed by the Local Optical Committee Support Unit<sup>1</sup> would be welcomed. We would like to add that community eye care services do not require complex or costly monitoring mechanisms and systems must be tailored to the type of care provided and associated risks.

We would support quality standards for our sector that are outcome focussed – both from a clinical and patient experience perspective – as we believe these are highly effective in incentivising providers to offer responsive, efficient and high quality services. However, we would not support quality standards that relate only to mandatory compliance with NHS systems, because in our experience they tend to

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<sup>1</sup> <http://www.locsu.co.uk/enhanced-services-pathways/>

be overly bureaucratic, divert resources from patient care and offer poor incentives by shifting provider focus from delivering excellent care to compliance with complex administrative processes. Overall we favour and support patient-centric quality standards.

In order to achieve these goals any mandated or best practice templates should be developed through active engagement with *all* stakeholders – in particular providers. Existing national frameworks<sup>2</sup> should be used as a basis for such templates for eye care services.

Top-down frameworks can have unintended consequences and divert resources away from investment in patient care – for example, we believe that some current AQP requirements are disproportionate to the clinical or service risks involved in community eye care services. This results in inefficient use of resources for both the NHS and providers.

**Q 3: Are there specific changes NHS England could make to the NHS Standard Contract general terms and conditions that could improve or safeguard quality?**

Yes.

In our experience, AQP contracts for community eye care services often contain excessive quality requirements and standards that are NHS-focussed and overlook the greater market forces that exist in the community setting when compared to secondary care. In particular, the normally extensive choice of community eye care providers means that patients can more easily choose an alternative provider if they are unhappy. This is a powerful incentive to providers to deliver a quality and efficient service. Setting inappropriate standards has a net effect of creating an unnecessary burden for community eye care providers and is inconsistent with other NHS policies – e.g. creating a level playing field.

We believe that patients should be put at the heart of service design and contractual terms and conditions should reflect this. Incentives, rewards and sanctions should be used to deliver positive outcomes for patients and not simply to police providers. In our view co-production between the NHS, providers and patients should be able to deliver a quality framework that is achievable, proportionate and cost-effective. This would not remove the legal or ethical obligations that providers would be rightly required to meet however it would limit unnecessary bureaucracy.

**Q 4: Would mandated specifications, over and above those for prescribed services, be welcomed?**

We support the principle of mandated national service specifications that provide people across England with access to consistent, effective and quality services. However we cannot support blanket provisions for mandated standards without further details about how these would be developed and applied. A national standard for each community eye care service based on the national pathways developed by

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the Local Optical Committee Support Unit<sup>3</sup> would be welcomed. We would like to add that community eye care services do not require complex or costly monitoring mechanisms and systems must be tailored to the type of care provided and associated risks.

**Q5: *Would greater flexibility in contract duration have an impact on quality? If so, how?***

We believe it would be in everyone's interests to extend the duration of community eye care contracts for three reasons.

1. Our members work in the community and invest their own capital in the provision of community eye care. Investment in infrastructure and staff training are much easier to plan when contract duration is greater than one year.
2. Annual contracting consumes considerable resources as organisations prepare for re-tendering. These resources could instead be invested directly in patient care if contract duration were extended.
3. Annual contracting similarly consumes considerable commissioner resources who could otherwise focus on higher value activities – e.g. improving quality in a targeted and patient need led system.

**Business rules (rules governing the flexibilities permitted with pricing and contracts)**

**Q 6: *Do you agree there should be consistency between the rules on the level of local flexibility within the national tariff (Local Payment Variations) and the rules on local flexibility with other national incentives?***

In our view reimbursement and other incentives should be structured so that patients have access to high quality and efficient services irrespective of where they live in England. We believe that this can best be ensured by consistent application of proportionate frameworks, which are co-produced nationally. Local decision makers should have clear guidance on when it is and is not appropriate to deviate from nationally agreed frameworks. The guidance should also be agreed nationally with the representative bodies for the services in question.

**Q 7: *What support could NHS England provide to build capacity and capability?***

We would like to see NHS England:

- Supporting the delivery of proportionate and evidence based commissioning of community eye care services by CCGs
- Developing national service specifications for community eye care services in co-production with key stakeholders, based on the national pathways developed by the Local Optical Committee Support Unit<sup>4</sup> and that provide

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<sup>3</sup> <http://www.locsu.co.uk/enhanced-services-pathways/>

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people across England with access to consistent, effective and quality services.

- Producing guidance on when CCGs can deviate from national protocols (must be evidence based and add value), agreed with the relevant optical bodies
- Providing for contracts of longer duration
- Ensuring that community eye care providers of all sizes are in a position to tender for services.

### **CQUIN**

**Q 8: Are there reasons why the current level of funding for CQUIN (2.5%) should change for 14/15?**

**Q 9: Should CQUIN payments apply to i) pass-through payments (for example, for high-cost drugs and devices), ii) small contracts or iii) non-contracted activity? (Please give a reason for your answer)**

**Q 10: Would gain share arrangements on pass-through payments be a better incentive than a CQUIN?**

**Q 11: What do you understand 'pass-through' payments to mean?**

**Q 12: Should CQUIN goals be set at provider or contract level? Which of the following options is most likely to secure higher quality and why:**

**Q 13: Are the mandated national CQUINs (dementia, CQUIN, NHS Safety Thermometer, VTE) delivering improved quality? Which should be retained for 2014/15, which amended and which removed?**

**Q 14: Are there other strong candidates for a national CQUIN? How would it be constructed?**

**Q 15: Would you support a national CQUIN in any of the following areas: staff satisfaction and clinical engagement; improvements in clinical audit; learning disabilities?**

No. We would not support CQUIN for staff satisfaction or clinical engagement or clinical audit and feel these are already part of HR policies and clinical obligations of registered staff and should remain so.

We would however be keen to explore how services might be improved or specific services commissioned for people with learning disabilities.

### **Local Incentives**

**Q 16: Have you used or are you intending to use the provisions for local incentive and risk sharing schemes? If so, what for?**

**Q 17: Which of the following options is most likely to secure higher quality and why:**

1. *Nationally mandated Quality Premium goals for the full £5*
2. *No change to the current balance of national and local indicators*
3. *No change to the current balance of national and local indicators, but with clearer rules around local indicator development, including a pick-list of potential indicators to be used.*
4. *Fewer nationally mandated Quality Premium goals, with greater local autonomy for negotiating local schemes*

In general, we doubt that QP goals have any great value in incentivising quality, and fear that local autonomy would only lead to further confusion and post-code lottery in service delivery.

***Q 18: What level of oversight is required by NHS England to ensure parity in the level of ambition across local schemes?***

As noted above, we feel that NHE England's role is to provide support and capacity for the delivery of proportionate, responsive and evidence based pathways (see response to Q 7) which would similarly assist in delivering parity of ambition.

***Q 19: Are the mandated national Quality Premium Indicators (HCAs, reduction in mortality, Friends and Family Test, Reducing Avoidable Admissions) delivering improved quality? Which should be retained for 2014/15, which amended and which removed?***

We support sector specific indicators – for example with Community Eye Care Services we would support a Friends and Family Test and consider other indicators provided they were proportional, clinically relevant and improved patient care, and consistently applied across England.

***Q 20: How could the Quality Premium be used to improve outcomes in mental health?***

***Q 21: Should CCGs be able to set local QP measures that duplicate national QP measures but with a greater 'stretch'?***

***Q 22: Should the design of the QP scheme explicitly allow for sharing of the QP earned with partners who contributed to it?***

### **National Sanctions**

***Q 23: Are financial sanctions effective in sustaining quality and performance? Are they particularly effective of or ineffective in some areas over others?***

Sanctions are an important mechanism in any healthcare system to ensure agreed minimum standards are met by all providers. The key is to ensure they are applied judiciously and consistently. Sanctions should not be used as a substitute for effective commissioning.

Many problems or shortcomings that warrant sanctions have an underlying cause that should be understood and tackled with the aim of improving quality and providing lessons to other commissioners.

While sanctions can be effective, the cause of the service failure should be properly understood and tackled before applying sanctions – for example it is known that costing in hospitals is fraught with technical difficulties, which may result in hospital departments underestimating costs of services and being awarded contracts. If these services subsequently are deemed to be failing then new models of care in the community should also be considered.

We would like to highlight a key distinction in community-based eye care in that if community eye care providers do not deliver the service expected then patients will choose to go elsewhere. In effect, patients sanction poor quality and reward good service providers with repeat visits.

***Q 24: What, if any, perverse incentives, does the current system of sanctions create? Are there examples where the application of sanctions has damaged service quality?***

***Q 25: Should there be national rules on how funds withheld through sanctions imposed are used by the commissioner? If so, what should these be?***

Yes, there should be consistent application based on national rules. Those rules should be tailored to the service in question and co-produced with national representative bodies.

***Q 26: Does the timing of sanctions impact on their effectiveness? Is there a case for a range of timings for sanctions or should all be considered to the same timescale (Annual? Quarterly? Monthly? Sanctions to take effect the following contract year?)***

***Q 27: Are sanctions broadly proportionate as currently devised? Where might adjustment be required?***

No. Currently we feel some of the financial sanctions in existence are disproportionate to the value of the service provided.

Any sanction should be proportionate to the risk and harm posed to the patient and the value of the specific contract at local level because the price paid is usually linked to the complexity of the service provided.

Whilst providers are responsible for their staff, it would not be in the best interest of the NHS or public to take action that may put an entire service provider into question when in fact an individual or specific area of operations is responsible for failure. The service provider would need to demonstrate that its procedures were sufficiently robust.

As these are detailed and complex contractual matters, we would be happy to meet with NHS England to discuss the commissioning of community eye care services for

England, incentives and sanctions, and national guidelines to which they should operate.

***Q 28: Is the range of existing sanctions manageable for commissioners and providers?***

No. We feel that financial penalties that can result in 20% loss in contract income are unmanageable for providers in AQP contracts where there is no guaranteed activity.

***Q 29: Are there any national sanctions that are no longer necessary?***

***Q 30: Would assessment of composite performance on specific areas (e.g. waiting times) be more helpful?***

We feel this depends on the type of service being commissioned. We would support careful use of area wide waiting times as an indicator for service delivery in a particular CCG.

***Q 31: Could a balanced scorecard approach work?***

We do not believe this has been adequately explained in the consultation document, however we would caution against diverting resources into the production of scorecards.

***Q 32: Should there be more national sanctions for non-acute contracts? If so, in which areas?***

No. We do not believe this is necessary for community eye care.

An effective sanctions system should be tailored to the service being delivered and requires a detailed understanding of how it should work, coupled with robust data. This is resource intensive, complex and costly, and therefore as stated above we believe that the overarching principles and guidance should be co-produced nationally, recognising that community eye care providers operate in an open market with minimum standards of service provision.

***Q 33: Is there a case for financial compensation to be offered by providers direct to affected service users, rather than (or as well as) to commissioners?***

We do not agree that financial compensation should be offered by providers direct to service users or commissioners.

Furthermore, there must be transparency to ensure that a level playing field is maintained – for example, imposing financial compensation on a hospital provider can result in a payment from outside the departmental budget, whereas community eye care providers would suffer the full burden of cost.

If such a system was to be put in place, then we would also argue that it should be reciprocal, i.e., providers should be entitled to seek compensation where commissioners break contractual agreements.

## **Locally Agreed Sanctions**

**Q 34: Does the 1% ceiling on local sanctions provide any benefits or disadvantages? Is there a case for a combined cap across nationally-mandated and locally-agreed sanctions?**

**Q 35: Which of the following options is most likely to secure higher quality and why:**

1. No locally agreed sanctions
2. Requirement for locally agreed sanctions to a specific % of contract value, with clear supporting guidance.
3. No change to the current rules.

We favour option 1.

Local variation in sanctions can create confusion and add a layer of unnecessary complexity to the contracting process.

## **Long-term direction of travel on incentives, rewards and sanctions**

**Q 36: Is this a direction of travel you would support?**

We support

- a range of service providers for patients to choose from – a key driver of quality
- patients ultimately choosing their provider based on service quality and accessibility
- transparent and sustainable community eye care services. Contracts should be awarded on realistic pricing and quality standards
- contracts of longer duration that allow providers to invest in eye care over a longer period than current annual contracts allow.

**Q 37: In designing the package of incentives, rewards and sanctions for the future, what balance should we strike between national mandation and oversight on the one hand and flexibility, local autonomy and freedom to innovate on the other?**

We feel duplication should be avoided as it creates added layers of complexity and as a result increases risks. More importantly duplication diverts resources away from patients without any benefit (in particular for low risk services).

Any final package should be proportionate to the service involved and co-produced with the relevant stakeholders. NHS England should avoid a “one size fits” all system for all services as this cannot deliver the quality and efficiency gains required

to meet the anticipated growth in demand for health care services. The correct balance is not necessarily that between national and local, but more specific to the nature of the service and to the profession providing it.

### **About Us:**

The Optical Confederation represents the 12,000 optometrists, the 6,000 dispensing opticians, and 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. For more details, please visit: <http://www.opticalconfederation.org.uk/>

LOCSU provides quality, practical support to Local and Regional Optical Committees (LOCs/ROCs) in England and Wales to help them to develop, negotiate and implement local objectives in respect of primary ophthalmic services. It is a key interface between the optical, representative bodies and the LOCs/ROCs, facilitating robust lines of communication between the national organisations and the grass roots of the professions. For more details, please visit: <http://www.locsu.co.uk/>

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