NHS Standard Contract 2014/15: NHS England consultation

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 Opticians (FODO). As a Confederation, we work with others to improve eye health for the public good.

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.

Background:

Patients benefit from the commissioning of NHS Community Eye Care Services in England through

- improved access to high quality care closer to home
- reduced waiting times compared to hospital eye services
- weekend and evening appointments at times chosen as convenient for patients, families and carers

Community optical practices are keen to expand these services and support commissioners and NHS England to develop better and more innovative ways of contracting for services.

We support national, evidence-based pathways for community eye care services that deliver world-class care and where access is based on clinical need, not a patient's postcode. Therefore we support: competition that is based on quality, services that are cost-effective and sustainable, and a health system that is responsive to patient needs.

To deliver these desirable goals, commissioners and providers have to work towards more pragmatic and proportionate contracts. For example, current Any Qualified Provider (AQP) and competitive tender contracting for community eye care services involves complex and disproportionate processes and quality assurance requirements that are not risk-based. These divert resources away from patient care

and in our experience are bureaucratic rather than patient-centric frameworks. We feel a more proportionate approach to contracting for community eye care services would allow for greater investment in patient care and allow more patients to access these services.

We believe that NHS England should embrace national pathways and service specifications for community eye care services, underpinned by a proportionate and tailored standard national contract. A national standard for each community eye care service based on the national pathways developed by LOCSU[1] would be welcomed. We strongly believe that this would deliver proportionate and workable incentives and significantly reduce the high transaction costs for all sides in the current arrangements, without any negative impact on patient safety.

LOCSU and the Optical Confederation are pleased to contribute to this consultation and below we set out our view on how local commissioning and contracting can be improved and extended – so that people across England have access to the same high quality and accessible services based on need, not location. We would also be very happy to discuss any of the points in further detail and face-to-face with NHS England.

Questions:

Question 1: Do you support our intention to retain the current three-part structure for the Contract for 2014/15?

Yes. There are however significant concerns that need to be addressed in the short to medium term.

In the 'Particulars' section of the contract we have seen significant local variation for similar community eye care services, as well as a number of unclear service specifications. This has led to unjustified variation across England and risks creating a postcode lottery.

An area for innovation in contracting would be to differentiate high and low risk health interventions. This can generate efficiency savings and increase access to care without any safety risks to patients. We suggest developing the standard contract so that unnecessary clauses could be removed more easily for small contracts to allow separation of contracts for complex services, such as, regional ambulance services and surgical interventions from small, low risk community eyecare services. Low risk services that that can be delivered in a uniform way nationally are ideal services to be commissioned through a national standard contract – reducing transaction costs, consuming less commissioning resources and avoiding a postcode lottery.

It is for these reasons we feel there should be national pathways and service specifications for community eye care services, underpinned by a proportionate and tailored standard national contract. A national standard for each community eye care

[1] http://www.locsu.co.uk/enhanced-services-pathways/

service based on the national pathways developed by LOCSU[2] would be welcomed. LOCSU and the Optical Confederation would be willing to support NHS England in reviewing the current system and working on a more innovative and cost-effective approach to contracting for community eye care services in England.

Question 2: Do you support our intention not to make material changes for 2014/15 to the clauses of the Contract dealing with contract management processes?

Yes, however

i. we would seek assurance that NHS England will consult in line with Cabinet Office and NHS England guidelines if changes are proposed in the future

ii. we agree that commissioners need more support to become fully familiar with the current contract management processes. Our experience is that local commissioners are struggling to establish robust and reliable performance management mechanisms. Therefore we feel more support is needed to help commissioners apply the standard contract in the areas of contract management, disputes resolution and managing activity and referrals. We are willing to help with this for the benefit of all especially patients and the public.

Question 3: Do you support our intention to provide a Contract with greater flexibility in terms of duration, as outlined above, and do you have any comments on the specific details of the approach?

Yes. We welcome this approach and feel it will allow the community eye care sector to invest in patient care initiatives that are otherwise difficult with an annual contract – e.g. investment in innovative technologies.

We support quality led competition and feel that, when contracting for community eye care services, commissioners should be encouraged to award longer term contracts (greater than three years) because

- community eye care care providers still have no guaranteed values on their contracts and this leaves them with considerable financial risks without being able to plan long-term
- providers are committed to delivering high quality services to the NHS at a fixed price.

However we would look for contracts with a duration of greater than one year to have an annual pricing review.

Question 4: Do you agree that the current Contract can support innovative commissioning models such as the 'prime contractor' approach? If not, what changes do you think are needed?

We support innovative commissioning models that deliver cost-effective and high quality services for patients.

[2] http://www.locsu.co.uk/enhanced-services-pathways/

LOCSU has developed a Local Optical Committee (LOC) company model to act as a vehicle to enable a LOC to put together a consortium of local contractors so that they can all participate in an AQP or competitive tender contract.

In this model the LOC Company can be regarded as the 'prime contractor' and individual community optical practices are sub-contractors to the LOC company.

This model has distinct advantages for commissioners:

1. Extending patient choice of provider - the LOC company model encourages local optical practices to get involved in providing community eye care services, which the bureaucracy and work involved to develop and submit individual bids for small scale services without guaranteed activity would be considered too onerous by most practices.

2. A fully managed service - the model is underpinned by an IT platform and infrastructure that enables the LOC Company to deliver a fully managed service with reporting as agreed with the commissioner, and managing payment disbursement to sub-contractors. This has the benefit of significantly reducing administration and demands on the commissioner's resources.

3. Robust performance data – electronic data capture means the LOC company can provide robust performance and outcomes reports as specified by the commissioner. This has the benefit of making it easier for the LOC company and the commissioner to monitor the quality of the service and to act swiftly on any areas of concern.

The main problem encountered is that the local variation in service specifications for similar services mentioned throughout this response requires significant time to be spent on both the commissioner and provider sides to develop and agree the 'prime contractor' contract and associated sub-contractor agreements. This adds to the cost of delivering care without any meaningful benefit for patients. Such local variation also creates problems for clinicians who must ensure they are fully conversant with different specifications, again diverting resources from delivering care

We suggest the following would help improve the current arrangements:

Develop a 'reduced' version of the contract for small scale services that is service specific. Low risk services that that can be delivered in a uniform way nationally, such as community eye care services, are ideal services to be commissioned through a national standard contract – reducing transaction costs, consuming less commissioning resources, minimising clinician confusion and avoiding a postcode lottery. We would be prepared to develop a standard sub-contract between LOC companies and optical practices based on an agreed national contract described above. This would allow providers to invest more resources in delivering care and eye health outcomes than in dealing with the complexities of local variations.

Question 5: Can you suggest additional quality or service standards for community, mental health and other non-acute services which could be reflected in, and possibly incentivised through, the Contract in 2014/15?

We support the development of national quality or service standards designed in conjunction with key stakeholders that are: in line with national service specifications for community eye care services, based on the national pathways developed by LOCSU[3] and that provide people across England with access to consistent, effective and quality services.

Community optical practices already have to comply with national quality standards related to the General Ophthalmic Services contract and the Quality in Optometry framework[4] which was developed in conjunction with NHS England to support this.

We feel that quality standards should be

- designed to improve or maintain the quality of service a patient actually receives
- proportionate to the specific health service in question
- cost-effective (so the system is sustainable and does not divert resources unnecessarily from the front line).

We feel the development of national quality or service standards for community eye care services designed in conjunction with key stakeholders would benefit patients, reduce transaction costs and result in better use of NHS and commissioner resources. For example, such an approach would allow national comparisons to be made and assist commissioners in analysing local pathways.

We would also like to raise concerns about proportionality. Contracts and reporting requirements should reflect risks posed by a specific service. We do not feel that community providers working in low risk areas should be subject to reporting mechanisms designed for medium to high risk services. We feel this creates an un-level playing field, distorts local health economies and discourages innovative service development. Examples of current issues include:

- Commissioning for Quality and Innovation (CQUIN), which is difficult to apply in a meaningful way to community eye care services and tends to be ignored
- Local quality indicators that rely on data from other sources, e.g. reduction in ophthalmology outpatient attendances.

Question 6: Is the current guidance on collaborative contracting sufficiently comprehensive, detailed and clear? If not, which specific areas and issues require further clarification?

We appreciate that Clinical Commissioning Groups (CCGs) are still in their infancy, but, to date, we have seen very little evidence of collaborative contracting. We would welcome a more collaborative approach on the basis of a set of agreed national service specifications for Community Eye Care Services. We believe this would make the process more efficient allowing the limited resources CCGs have to be

[3] http://www.locsu.co.uk/enhanced-services-pathways/
[4] http://www.qualityinoptometry.co.uk/

dedicated to other commissioning projects that require more specialised contracting. This would also free up local commissioners to focus more on the assessment of needs and service planning to meet those needs.

Question 7: If an improved, more reliable and responsive eContract system is made available for 2014/15, will your organisation plan to make use of it for the majority of its contracts?

Yes, provided the eContract system is reliable.

Currently community eye care service providers have reported mixed experience with the eContract system with some commissioners appearing unable to utilise eContract and others pushing the eContract as the "only option".

In principle, provided the eContract is readily accessible and in a format that allows local information to be easily inserted, then we would support its use.

Question 8: Are there types of contract or provider for which use of the NHS Standard Contract is proving particularly problematic? How can these problems best be overcome?

Yes. The NHS standard contract is problematic for providers of small scale community eye care services.

The problems experienced by our members are largely due to a lack of understanding among commissioning support teams as to how to use the NHS Standard Contract appropriately and effectively, and inflexibility of the contract in that changes to certain sections are not permitted. As a consequence, a number of inappropriate sections and clauses remain in the contracts that our members are asked to sign.

The main problems are Schedules 2 and 4 of the Particulars section of the contract:

1. Certain domains of the NHS Outcomes Framework are not relevant to community eye care services e.g. Domain 1 'Preventing people from dying prematurely' yet have remained in the contract
2. Expected annual contract value and risk share agreements are not applicable for AQP services or other services with no guaranteed activity
3. The majority of the Operational Standards in 4A and the National Quality Requirements in 4B are not applicable to community eye care standards yet commissioners have not removed them from contracts
4. In Local Quality Requirements in 4C only the relevant Domains should be included
5. The Never Events in 4E are not relevant to community eye care services and should not be included
6. CQUINs are not applied to community eye care services, so this section is not relevant
7. The 18 weeks and Clostridium Difficile targets are not relevant to community eye care services and should be removed from contracts for such services.

In Schedule 5 of the Particulars section of the contract:
We would like to point out that community optical practices already have to comply with governance standards related to the General Ophthalmic Services contract and the Quality in Optometry framework[5] has been developed in conjunction with NHS England to support this. We suggest that this establish framework should be embedded into any contract for community eye care services. We are willing to work with NHS England on this.

In Schedule 6C of the Particulars section of the contract:
The reporting requirements for community eye care services need to be adjusted to reflect the fact that the majority of the Quality Requirements, 'never events', etc. do not apply to such services.

In 6.2.3 of the Service Conditions section of the contract:
'the commissioner must use their best endeavours to ensure all referrals are made through the 'choose and book system' distorts the level playing field as community optical practices did not have access to the choose and book system'.

We are also concerned about local variations in service specifications significantly complicating administrative processes for providers operating across regions and adding to the cost of delivering care without any meaningful benefit for patients. Such local variation also creates problems for clinicians who must ensure they are fully conversant with different specifications, again diverting resources from delivering care.

We suggest the following would help improve the current arrangements:
Develop a 'reduced' version of the contract for small scale services that is service specific. Low risk services that that can be delivered in a uniform way nationally are ideal services to be commissioned through a national standard contract – reducing transaction costs, consuming less commissioning resources, minimising clinician confusion and avoiding a postcode lottery. This would allow patients to access the same high quality service regardless of where they live and allow providers to invest more resources in delivering care and eye health outcomes than in dealing with the complexities of local variations.

Question 9: Do you agree that it would be appropriate to amend the Payment Terms clause, so that providers issue monthly reconciliation accounts, which each commissioner can then accept or contest?

This would be sensible as currently providers typically report per CCG, on a monthly basis.

The contract sets out a process for financial reconciliation between commissioners and the provider in clause 36 of the Service Conditions (Payment Terms). This process places the onus on the Co-ordinating Commissioner to provide a separate reconciliation account for itself and each commissioner for each month, based on

[5] http://www.qualityinoptometry.co.uk/

information provided by the provider. The provider then either accepts or contests the reconciliation account in respect of each commissioner

Our understanding is that the approach set out in the Contract is often not what is implemented locally across the NHS. Rather, current practice is typically for the provider to issue the reconciliation account, split by commissioner, with each commissioner then accepting or contesting its element. We accept that this is probably a more logical approach, and would welcome a Contract amendment to reflect this for 2014/15.

Question 10: Do you have suggestions for specific changes to the Reporting Requirements schedule of the Contract, with a view to safely reducing the information collection burden?

Yes. As we have highlighted above, we feel that local variation is resulting in bespoke reporting requirements at a local level. We strongly feel this is inefficient and not in the best interests of patients, for example:

1. it means there can be no national benchmarking
2. it unnecessarily diverts resources away from delivering care to management processes and makes the system more bureaucratic

In our view these provide good reasons to reduce the information burden and rethink reporting requirements in terms of how patients will benefit from the information collected.

We support reporting requirements that are evidence-based, proportionate and patient- not system -focused. Again we are willing to work with NHS England to develop acceptable solutions to these problems.

Question 11: In terms of practical completion of the Contract documentation, can you suggest ways in which this could be streamlined, eliminating any current requirements which are not seen as adding value locally? And do you have suggestions for the type of support you would like in understanding and using the Contract?

Yes. In terms of local requirements we would state they often fail to add value and do so at a considerable opportunity cost to patients. These are resource intensive and providers would prefer to invest these resources in enhancing the patient journey.

Local service requirements risk creating a post-code lottery and NHS England should encourage commissioning of care based on need not location. This further highlights the importance of a more evidence-based, cost-effective and sustainable approach to commissioning.

We would suggest the following solutions

1. A consistent approach to contracting community eye care services nationally
2. Community eye care services to be delivered using the same framework nationally

In addition, we have noted some CCGs have limited knowledge of contract terms and might benefit from support services such as a "central helpline" so that local commissioners and providers can better understand the national picture and lessons can be learned from peers across England.

Question 12: Do you think that the Contract gets the balance right, in terms of the extent to which existing guidance on specific policy areas is re-stated within it? Should specific content be removed, or additional areas added?

No. Our main concern is that of proportionality. We feel that guidance on specific policy areas is not sensitive enough, and often broader NHS policies – for example those designed for complex areas of medicine – are superimposed disproportionately into lower risk services such as community eye care services.

This creates an unnecessary level of complexity and increases the cost of providing care without returning any benefit to patients. We feel that to achieve the right balance, the Contract has to reflect the specific service and more appropriately reflect clinical and outcome risk.

Community eye care services are low risk and the community optometrists who provide them under are registered with and regulated by the General Optical Council. We recommend that the balance of the contract should reflect this and not be biased towards medium to high risk services where additional levels of guidance on specific policy areas are required.

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