Freedom to speak up in Primary Care:
Guidance to primary care providers on supporting whistleblowing in the NHS

Optical Confederation, [College of Optometrists and Local Optical Committee Support Unit] Response

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 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.

The Local Optical Committee Support Unit (LOCSU) provides quality, practical support to Local and Regional Optical Committees (LOCs) in England to help them to develop, negotiate and implement local objectives in respect of primary ophthalmic services.

The Optical Confederation and Local Optical Committee Support Unit (LOCSU) welcomes this draft as an exemplar of how NHS England can and should adapt its guidance to reflect the way that primary care is provided in the community. Clear and proportionate guidance for primary care enables the wide variety of providers of NHS-funded services to meet NHS England's goals without introducing excessive bureaucracy or imposing unnecessary burdens on independent businesses, which often do not benefit patients as intended.

We applaud NHS England's decision to address Speaking Up through guidance rather than contractual mechanisms because we believe that the contractual route would be unduly bureaucratic and prescriptive.

Section 4.1 lists external organisations where concerns can be raised, and in our view should include representative bodies such as ABDO, AOP and FODO as the first port of call. As insurers of optical practitioners and businesses such organisations are used to operating Chinese walls when staff need to raise a concern outside their organisation but are hesitant – or it is unnecessary – to escalate to NHS England or the GOC. Local Optical Committees (LOCs) might also be able to take on this role, for example, in circumstances where staff work in a small organisation and must raise concerns externally but the concerns are not serious enough to merit referral to the regulator or if staff are reluctant to become involved in Fitness to Practice proceedings. This intermediate level of escalation

should form the first stage of raising a concern externally and should be highlighted in the annex under 'Raising your concern with an outside body'.

Clear processes for staff will be essential given the range of options for raising concerns to different prescribed persons, including CCGs in due course. We fully agree that this must be reflected in local policies and procedures and will support providers of community optical services with template materials. The proposed March 2017 date for full compliance gives adequate time to ensure that this is carried out across the sector. The finalised guidance should, however, make clear that an accused party has a right of response and include information on how they should respond.

We welcome the recognition that the Freedom to Speak Up Guardian role cannot be implemented as a one-size-fits-all across primary care. Again, this is a role that could be taken on by a nominated person within a representative body or LOC. LOCs may also be able to provide local investigation leads, particularly for small providers where staff resource, time and range of competencies are limited.

Our main area of concern arising from the draft is how local networks of guardians and investigators will be funded, both in terms of training and time.

Training

Many staff in the community optical sector, as elsewhere in primary care, are employed through small and medium sized independent providers of NHS-funded services. Given that such providers operate outside Trust and wider NHS development networks – and have less business across which to spread costs – NHS England must ensure appropriate training is made available for all primary care staff.

Time

Small and medium sized providers may struggle to allocate staff with sufficient time and expertise to investigate disclosures according to the timescales set out in this guidance. As suggested above, LOCs and representative bodies may be able to provide assistance with investigating disclosures. However, where dedicated investigators are required as part of the LOC structure – or indeed within larger providers – this will represent an additional cost burden on these organisations. This will undoubtedly be an issue for other primary care providers, and we would be keen to know NHS England's thoughts on how these costs might be mitigated so that the duties of Freedom to Speak Up are met without imposing undue burdens on independent businesses.

We also have several technical comments on the guidance and policy. First, we appreciate that this is a draft copy and every effort was made to share it with providers as early as possible. However, we note that there are a number of typos, grammatical errors or random words that would benefit from more rigorous proofreading. In particular, the guidance alternates between referring to "your concern" and "your concerns". For clarity, we suggest using the former throughout.

We are content with the draft policy, in principle, but it needs to be able to be adapted/edited to be suitable for primary care providers of different sizes and types. This is particularly the case for single small practices with only a few staff; for example, p.18 refers to an "immediate supervisor," and

then a hierarchy of other staff, and p.20 refers to senior management being informed. In reality the supervisor and "senior management" are likely to be one and the same person in a small practice. Similarly, on p.18 the section on confidentiality needs to separate out – perhaps in two paragraphs – the option for confidentiality/anonymity and the issue of how that is managed in practice. Although the observation that "confidentiality may be difficult to maintain in very small organisations" is correct, it would not make sense in a document coming from the small organisation for the use of its staff. In reality, confidentiality or anonymity are often impossible if you raise a concern internally within a very small organisation. The final policy should recognise this by stating something to the effect of, "because we are a small organisation it may be difficult for you to raise a concern confidentially or anonymously. In those circumstances you may prefer to raise your concern outside the organisation, for example with the local Freedom to Speak Up Guardian, the Local Optical Committee or your representative body."

The list of outside bodies where a concern can be raised (p.20) should be tailored for optical practices, for example by removing the references to the CQC and HEE, which do not play a role in the optical sector, and by limiting the regulators to the GOC.

Finally, a minor point but on p.19 'Advice and Support' refers to the intranet. Many practices will not have one, so the final text will need to include other options such as attachments.

The Optical Confederation would be happy to work in partnership with NHS England to adapt the policy to ensure it is appropriate to the various setting in which community optical care is practiced.