

**Optical Confederation and Local Optical Committee Support Unit**  
**Longer-Form NHS Standard Contract 2016/2017**  
**Consultation Response**

**Optical Confederation and Local Optical Committee Support Unit**

The Optical Confederation represents the 13,000 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 Optical Confederation also represents manufacturers, distributors and importers.

The Local Optical Committee Support Unit (LOCSU) supports contract negotiations between local optical committees (or provider companies known as local optical committee companies) and CCGs or CSUs in the commissioning of community eye services across England. As a result, we have wide-ranging experience of the issues that arise for commissioners and providers who have to work with the NHS Standard Contract.

**Response Overview**

We strongly feel that the proposed longer-form Contract will be potentially prohibitive for community services providers, such as general practices, pharmacies and optometrists and opticians due to its size and detail, and that this version is more suitable for major providers such as Trusts with far greater resources. We believe this is also NHS England's view: as we have said in our response to the shorter-form Contract consultation, we very much welcome NHS England's decision to recognise the realities of community service provision and develop the more proportionate shorter-form contract. In order to ensure this laudable initiative is successful, we feel that it is vital to ensure that no CCG disregards or overlooks NHS England's strong recommendation that the shorter-form be used for community services and issue this longer-form Contract. Many of the changes outlined in the longer-form consultation document are not relevant to community service providers—for example the requirements for published local access policies (SC6) and procurement in respect of high-cost devices (SC36)—and their omission from the shorter-form Contract is illustrative of NHS England's recognition of proportionality.

Please see below for specific comments on the Standard Contract:

### **Responsibility when engaging Sub-Contractors**

#### GC 21.14

We have a major concern with regard to the statement 'the Provider must impose on its Sub-Contractor obligations that are no less onerous than the obligations imposed on the Provider by this GC21.' We are concerned that this in effect means that all subcontractors working under a Prime Provider model will be required to complete the Information Governance Toolkit (IGT) in 2016-17. We consider this to be a disproportionate imposition and burdensome requirement that, together with the lack of funding to implement, will act as a disincentive for small healthcare providers to become subcontractors to Prime Providers. This will reduce patient choice and will limit the expansion of out of hospital care and community services. GC12.7 makes it clear that providers will be responsible for acts and/or omissions of all subcontractors 'as though they were its own'. We feel that it should be the responsibility of the Provider to determine how they assure themselves that subcontractors meet statutory compliance requirements.

### **Further new requirements**

#### GC5.8

Freedom to Speak Up Guardian: While we support the whistleblowing agenda, we consider the requirement to appoint a Guardian to be disproportionate for small providers. The Optical Confederation is currently working with NHS England to develop Freedom to Speak Up for Primary Care guidance and we do not think the Contract should mandate any greater a responsibility than will be in that.

#### GC21 (throughout)

Environmental Information Regulation: We appreciate this reflects legislation but we point to it as a new burden over and beyond the existing.

#### GC21.4

Providers will be expected to implement the Caldicott Review into data security pending the final report.

#### GC21.11.14

We note that Providers will be required to agree protocols to govern sharing of Personal Data with partner organisations.

#### GC23.1

NHS Identity Guidelines: Providers must now comply with NHS Identity Guidelines, rather than branding guidelines and we would query whether this is also an added burden.

#### GC27

Transparency on gifts and hospitality: this is a further requirement for small providers that adds to the compliance burden.

#### SC8

Unmet Needs and Making Every Contact Count: We note that there is a new requirement to produce a Making Every Contact Count organisational plan (SC8) which adds unnecessary bureaucracy for small providers.

#### SC10

Patient Decision Aids: We would like clarity on Patient Decision Aids and how they are to be funded.

#### SC12.2

Accessible Information Standard: A significant undertaking for providers.

#### SC23.5

NHS Numbers: The requirement for referrers to use NHS Numbers cannot apply for optical providers as, due to an absence of connectivity to NHS IT infrastructure, optometrists and opticians do not have access to the Patient Demographic service/NHS Numbers.

#### SC28.6

Commissioner Assignment Methodology Guidance and Who Pays?: This is a further new requirement that parties must have regard to.

### SC32.2.2

Child Sexual Exploitation Lead: This is another named role that providers must make.

### SC36.49

e-Invoicing Platform: While we recognise that the e-Invoicing Platform, Tradeshift, is designed for faster settlement and that it is free to use and setup, any new platform poses implementation challenges and we would ask that NHS England/Tradeshift fully consider these from the perspective of the small provider. Will an alternative invoicing method be available for community service providers who are not easily able to use the e-invoicing platform?

### **Points of Clarification**

There are a number of points of clarification that we would like made please:

GC4.1 should make it clear that if both parties agree then longstop dates can be moved.

GC8.1 should outline that alternatives to physical meetings such as conference calls are acceptable.

GC20 appears to place the onus on both parties to maintain confidentiality rather than refusing the receiving party the right to use information; if so, this is also welcome.

GC21.3.2 should include clinical leads as part of 'governing bodies': note that in many smaller providers, the governing body will often be comprised of a small number of individuals.

### SC36

Payment terms: With regard to payment terms, we are concerned by the apparent removal of reference to payment during serious incidents or force majeure and would like clarification regarding this.

## **Other comments**

We are not clear how the new discharge summaries would affect optical providers, but note these are not included in the shorter-form Contract (SC11). Supplying medication for discharges from inpatient or day case care would not be relevant to the optical setting (SC11). In terms of organising the steps in a care pathway, this is something that community eye health services supported by LOCSU already feature (SC12).

## **eContract**

We have worked with numerous CCG and CSU colleagues who have struggled with the paper contract and the eContract, and would stress that a system which works reliably is essential. Although some teams have used the 2015/16 eContract, many have continued with the paper version and we feel that the only way to ensure that the eContract is used by all CCGs and CSUs is to make its use mandatory. Training for users is vital.

## **Standard Contract Training**

We also recommend that further training for CSUs and CCGs on the content of the NHS Standard Contract, and its relevance to different types of services and providers, is crucial to significantly reduce the time and costs being wasted due to the current lack of experience and expertise. This must be prioritised to bring efficiency to the commissioning process both for commissioners and providers.

## **LOC Company subcontract**

A standard sub-contract agreement for use between the LOC company and individual practices has been developed and we would like to discuss endorsement of this agreement by NHS England so that individual CCGs do not have to waste their time and resources and those of the LOC companies exploring whether the agreement is robust enough.

## **Conclusion**

While the shorter-form Contract is welcome (albeit with a number of new requirements in itself) this longer-form version includes all of these new requirements but without the reduction in length and scope. As we have consistently said, for community eye health providers, a contract of this magnitude is disproportionate and acts as a barrier to service

provision. We would therefore please request that NHS England make it clear to CCGs that this longer-form Contract is unsuitable for community services providers, such as optometrists and opticians.