

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

## **Shorter-form NHS Standard Contract 2016/2017**

### **Consultation Response**

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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, LOCSU has wide-ranging experience of the issues that arise for commissioners and providers who have to work with the NHS Standard Contract.

#### **Consultation question 1: Do you support our overall objective?**

Yes, we very much support NHS England's overall objective of reducing the complexity and burden for small healthcare providers, while at the same time maintaining a robust contract. We have consistently requested that NHS England address the issue of the disproportionately large Standard Contract to encourage smaller health care providers to enter into a Standard Contract to provide community services in order to help meet the Government's objective of increasing out-of-hospital care, as outlined in the Five Year Forward View<sup>1</sup> and NHS England Business Plan 2015-2016.<sup>2</sup>

We are pleased to see that this has now been put into effect with the shorter-form Contract and consider this to be an important step in the right direction.

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<sup>1</sup> 'Five Year Forward View': <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

<sup>2</sup> 'NHS England Business Plan 2015-16': <https://www.england.nhs.uk/wp-content/uploads/2015/03/business-plan-mar15.pdf>

## **Consultation question 2: Do you agree with the criteria we have suggested above for when to use the shorter-form Contract?**

We strongly believe that rather than simply allowing commissioners, the 'option to use' the shorter-form Contract when commissioning community services provided by primary care providers i.e. general practices, pharmacies and optometrists and opticians, NHS England should mandate its use. Similarly, we feel that to 'strongly encourage commissioners to use the shorter-form for contracts with lower annual values' does not go far enough and that this should also be mandated.

Our concern is that there may be some commissioners who, whether intentionally or merely through force of habit, will continue to insist on using the cumbersome longer-form Contract. In the event of this, NHS England's commendable initiative to reduce complexity and burden for smaller providers through the deployment of this shorter-form Contract would be wasted, as well as unnecessarily burdening smaller providers of community services. We appreciate the point that the shorter-form Contract cannot be exclusively reserved for specific areas of health provision but we do not see why particular areas of health provision, such as community services provided by primary care, cannot have this contract assigned for their use by all commissioners of these services.

As such, in order to ensure that commissioners understand why NHS England has developed the shorter-form Contract, we think that the user guide for commissioners and providers should make this mandating clear. As it stands, the user guide says 'The commissioner must decide which version is appropriate for the specific package of services it is commissioning,' which does not explicitly encourage the use of the shorter-form Contract and gives too much flexibility. As we have said above, we would suggest the document say that commissioners 'must' use the shorter-form Contract in the circumstances outlined.

We agree that the shorter-form Contract must not be used for particular types of health providers such as cancer and A&E and/or providers of services covered by National Prices under the National Tariff in order to reduce the detailed requirements that are present in the longer-form Contract.

## **Consultation question 3: Is the content we have proposed for the shorter-form Contract reasonable? What should we add, remove or amend?**

### **Overview**

We are supportive of the three-fold reduction in the overall size of the shorter-form Contract against the longer-form version. Retaining the three section format for the shorter-form Contract is sensible, as is denoting 'Intentionally Omitted' in places where the longer-form requirement will no longer apply.

### **General Conditions**

The General Conditions benefit from brevity. For example, we note that GC5.2 has removed/simplified a number of existing sub-clauses which did not reflect the fact that the service provided under the contract represents only a small part of the clinical care delivered by an optical practice in any given week. As another example, the removal of the requirement for Remedial Action Plans (GC9.7) and simplification of Assignment and Sub-Contracting (GC12) and Dispute Resolution (GC14) is positive. The change of phrasing from provider 'must' to 'must consider whether the Commissioner's request can be met by providing anonymised or aggregated data which does not contain Personal Data' (GC21.12) is another example of NHS England's recognition of provider burdens.

However, unfortunately there are a number of new impositions on providers which we list below:

#### **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. GC12.2 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**

#### GC5.7

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.

### **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.

### **Service Conditions**

The Service Conditions are also reduced in size which is welcome. We would point to the removal of the requirements relating to NHS Choices (SC6.3); personalised care plans (SC10.1); Equality audit and review (SC13.2); Infection Control/HCAI plan (SC21.3); Organisation Crime Profile (SC24); and Prevent Guidance/WRAP (SC32) as positive steps, in addition to the simplification of Managing Activity and Referrals (SC29), and Emergency Preparedness, Resilience and Response (SC30). We note the inclusion of commissioners 'having regard to the burden' in SC28.3 as an example of NHS recognition of provider compliance requirements.

We support the removal of the Death of Service User requirement: something highly unlikely in an optical setting (SC34). In addition we welcome the removal of many of the Payment Terms clauses in the shorter-form Contract which are designed for larger providers (SC36).

However, the Service Conditions, like the General Conditions, also feature new inclusions:

SC12.1

Accessible Information Standard: A significant undertaking for providers.

SC8

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.

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.

SC28.5

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.

SC36.28

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**

### 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.

### SC36.16

Payment timings: The draft user guide states 'Whatever approach is taken, payment under the shorter-form Contract will be on a quarterly basis.' However, SC36.16 provides details on monthly payments where the parties have not agreed an expected annual contract value. Please could we request some clarity regarding this.

## **Particulars**

We welcome the significant reduction in the Particulars, noting the removal of a variety of requirements across most Schedules. Schedule 4 A under E.B.4 should give an option for 'not applicable' as not all standards would be diagnostic. There should be an option to state not applicable in the new TUPE Schedule 8 as this will not apply in most cases.

## **Formerly 'Small Providers'**

We question the extent to which burdens have been minimised for providers previously classified as 'small providers', where NHS annual revenues are below £200,000. The previous Standard Contract removed particular requirements for these providers: the shorter-form Contract removes this distinction having made it redundant. For example, while it is of course welcome for larger providers that there will no longer be a requirement for Staff Surveys, the National Workforce Race Equality Standard, and Sustainable Development Plans, these would not have been required of small providers previously in any case.

## **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 subcontract 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.

### **Tailored contracts**

We welcome the fact that developing tailored contracts and new contracting models that are needed to deliver new models of care is a priority for NHS England for the 2016/17 contract, although we note that the draft shorter-form Contract does not feature the same scope for tailoring as the full-length version. Encouraging and incentivising providers across a pathway of care and/or geography to collaborate and commit to shared objectives is a key enabler of integrated care.

### **Conclusion**

There is much to welcome in this shorter-form Contract and we believe that in order for it to have the greatest impact, NHS England should mandate its use by all commissioners of community services provided by primary care providers, and for contracts with lower annual values, notwithstanding the serious concern that we have with regards to mandatory subcontractor IGT, and others raised.

We would be very pleased to work with NHS England further in this implementation.