NHS Provider Selection Regime Consultation

About us

FODO is the leading national association for eye care providers working in primary and community care settings. Each year our members provide over 18 million eye examinations and offer a wide range of other eye care services across the UK.

Our members provide the majority of NHS sight tests in England and offer a wide range of NHS extended primary eye care services. We welcome the opportunity to share our views on the proposed Provider Selection Regime (PSR).

Our response

Application

1. Should it be possible for decision-making bodies (e.g. the clinical commissioning group (CCG), or, subject to legislation, statutory ICS) to decide to continue with an existing provider (e.g. an NHS community trust) without having to go through a competitive procurement process?
(Required)

☐ Strongly disagree

☐ Disagree

☐ Neutral

☒ **Agree**

☐ Strongly agree

☐ Don't know

Please explain your answer below:

Subject to the conditions set out in paragraphs 5.5 to 5.6 and 8.2, we agree with this proposal. Nobody supports short-termism and unnecessary churn of contracts without patient benefit.

We also agree that when existing providers are delivering high quality, responsive and cost-effective services, and where patient choice rights are preserved, it is sensible for an ICS to continue with existing providers.

It is important however that primary care services are protected (see our response to question nine) and enhanced (see our response to question three and eight) if the NHS is to deliver the goals in the NHS Long Term Plan (LTP) and Eye Care Restoration and Outpatients Transformation Programme.

It would be helpful if the statutory guidance that will follow (paragraph 9.2) sets out more detail on how an ICS will safeguard patients' existing interests, and how all NHS primary care provider sectors will have a voice at both the ICS and 'place' level.

2. Should it be possible for decision-making bodies (eg the CCG or, subject to legislation, the statutory ICS) to be able to make arrangements where there is a single most suitable provider (eg an NHS trust) without having to go through a competitive procurement process?

(Required)

☐ Strongly disagree

☐ Disagree

☐ Neutral

☒ **Agree**

☐ Strongly agree

☐ Don't know

Please explain your answer below:

This can be both logical and cost-effective if the process is transparent, focused on ensuring "all decisions about how care is arranged are made in the best interests of patients, taxpayers and the population" (paragraph 1.5), and is not used to support unsustainable models of care (as has happened in the past).

To deliver the vision set out in the Long Term Plan (LTP), DHSC White Paper and the Provider Selection Regime (PSR) consultation, it is important for the system to recognise that the most suitable single provider might be the network of NHS primary care providers, operating 'at place' and 'system' rather than a single fixed-site provider.

PSR reforms focus on elective care and removing the unhelpful aspects of National Health Service and Community Act 1990 and the Health and Social Care Act 2012. As the LTP makes clear, this is necessary because the NHS needs to transform how care is delivered, including providing more care out of hospital and in primary care settings. We fully support this stronger role for primary care (which we interpret as pharmacy, general dentistry, primary eye care and hearing care, as well as GPs) at 'system' and 'place'.

Restoring and transforming hospital eye care to meet need is now an NHS top priority and NHS primary eye care providers are the natural partner for expanding capacity, delivering more elective care outside hospital, closer to home and all the

benefits for patients [1,2] (also see our response to question three, eight and nine). NHS England has already laid the foundations for this through:

- the National Pathway Improvement Programme[3]
- recent investment in IT connectivity between primary eye care and the rest of the NHS (in particular the hospital eye service at 'system' level and opticians and GPs 'at place'), which will support the transfer of diagnostic imaging, remote consultant triage and advice, shared care and discharge to primary care.[4]

Helpfully, statutory Local Optical Committees correspond to ICS footprints and already have a not-for-profit provider arm (on the NHS standard contract model) in place. This delivers patient choice, local provider selection, service assurance and delivery (KPIs), integration and clinical, financial and information governance. This model also has a proven track record of delivering high-quality extended primary care services to NHS patients at place and at system level.

Using these vehicles as a single 'most suitable provider' across most ICSs will deliver the aims of the reforms in the most integrated, cost-effective and collaborative way.

Benefits for patients, the NHS and taxpayer

Using such models will also help deliver the LTP goal of transforming "outdated and unsustainable" models of outpatient care" (Paragraph 1.48, LTP).

To drive this change, it would be sensible to strengthen patient choice by extending the mandatory choice regime to include

- options for elective (including diagnostic) referrals to primary eye care services, which might otherwise have been channelled to hospital outpatients
- referrals from primary care other than GPs (e.g. optometrists), so that not all referrals are automatically channelled to traditional outpatients which are already overburdened and struggling to cope (see our response to question eight).

We hope the statutory guidance that will follow legislative change (paragraph 9.2) will include these options to drive transformation and delivery of the LTP goals of high-quality patient-focused care delivered closer to home wherever possible and wherever this best meets patients' needs and wishes.

3. Do you think there are situations where the regime should not apply/should apply differently, and for which we may need to create specific exemptions?

(Required)

☐ Strongly disagree

☐ Disagree

☐ Neutral

☐ Agree

☒ Strongly agree

☐ Don't know

Please explain your answer below:

The introduction of the three-tiered Primary Ophthalmic Services (POS) framework in 2008 recognised the patient and public health benefits of a national sight testing and case finding service, and the need to commission extended primary eye care services locally (Box 1).

NHS Primary Ophthalmic Services (POS) – three-tiered framework

- **Mandatory eye care services:** NHS must ensure provision of sight testing service. 'Level I'
- **Additional eye care services**: NHS must ensure provision of prescribed services (currently includes domiciliary sight testing and planned to be used for new special schools service). 'Level II'
- **Extended primary eye care services**: commissioned locally to meet need and fit local service patterns. 'Level III'.

Box 1: Summary of the POS framework. References[5]

The national NHS sight testing and case-finding service is commissioned using General Ophthalmic Services (GOS), Levels I and II POS. This has stood the test of time. It has ensured patients have universal access to a high-quality sight testing service matched with high levels of efficacy driven by patient choice and very few complaints, whilst minimising procurement and commissioning systems costs. This is why the Clinical Council for Eye Health Commissioning, College of Optometrists and other optical bodies have all called for GOS to be protected (see also our responses to questions eight and nine). As the representative body for primary eye care providers which deliver the majority of GOS sight tests, we strongly support these calls for GOS to be protected in the best interests of patients (see our response to question nine).

Regrettably, locally commissioned extended primary eye care services, Level III POS, for which CCGs have been responsible, have not been utilised as intended. This has led to serious capacity issues within the hospital eye service and increased risk of avoidable sight loss (see our response to question eight). There is a need for significant expansion of this level of care, which ICSs offer the opportunity of getting right.

Today the eye care sector – including the Royal College of Ophthalmologists and College of Optometrists – is working to ensure more eye care services are commissioned outside hospital in primary eye care settings. If successful, this will ensure that the hospital eye service can focus available acute capacity on meeting patients' complex needs more effectively and safely.[6] However, this will not happen unless patient choice rights are strengthened to include Level III NHS funded primary eye care services where clinically appropriate.

Commissioning Level III POS at ICS rather than CCG level, and offering these as part of the patient choice regime, will enable the NHS collectively to expand capacity to meet growing eye care needs (without overloading hospitals), to reduce waiting

times and backlogs and to cut the risk of avoidable vision impairment owing to delays in care.

We therefore urge NHS England to

- protect the national GOS sight test and case finding service which is at the heart of primary eye care in England (see our responses to question nine)

- use the Level III POS framework to ensure ICSs meet the ageing population's increasing eye health needs – e.g. for cataract, glaucoma, macular degeneration and other eye health problems, in line with the Eye Care Restoration and Outpatients Transformation Programme (see our response to question eight).

The Eye Care Restoration and Transformation Programme estimates that some 25% of current ophthalmology outpatient appointments, 2.3 million appointments per year, can be delivered differently.[7] The PSR offers the opportunity for these services now to be commissioned at ICS level by extending existing contacts over wider footprints, and to include primary eye care practices, without having to go through unnecessary competitive procurement processes.

We would be happy to provide more information to NHS England's consultation team about this if this would be helpful.

4. Do you agree with our proposals for a notice period?

(Required)

☐ Strongly disagree

☐ Disagree

☐ Neutral

☒ Agree

☐ Strongly agree

☐ Don't know

Please explain your answer below:

We support the proposals for a notice period. However, the proposed notice period of four to six weeks looks tight. Extending it to 8-12 weeks would probably be safer and in patients' interests.

It would give all stakeholders time to review notifications and consider whether the ICS would benefit from feedback that could help patients, the wider NHS and taxpayer.

To ensure this happens and to avoid delays or missed opportunities to improve care and value for money:

- there should be an (ideally national) online platform on which notices are published. The notice period should start from when the notice is live on the platform
- there should be clear guidance on how to list all services falling within a proposed contract to enable providers working together to offer innovative solutions.

We hope these options will appear in the statutory guidance on how ICSs can promote transparency and constructive challenge using a collaborative and open approach (including sharing information), rather than the more cumbersome, lengthy and costly remedy of judicial review (which is unlikely, for these reasons, to be used).

5. It will be important that trade deals made in future by the UK with other countries support and reinforce this regime, so we propose to work with government to ensure that the arranging of healthcare services by public bodies in England is not in scope of any future trade agreements. Do you agree?

(Required)

☐ Strongly disagree

☐ Disagree

☐ Neutral

☐ Agree

☐ Strongly agree

☒ Don't know

Please explain your answer below:

Numerous consultations have shown the public wants this protection for the NHS to ensure that international companies – particularly costly models of care like those in the USA – do not cause market failure in the UK's health system. We fully understand this view. There have also been well-attested cases where the NHS has been slow to partner breakthrough technologies developed elsewhere.

International trade deals are complex instruments and we would be concerned that any overly rigid caveats might have unintended consequences for the NHS and patient care. For instance, in the future, healthcare could become more dependent on technologies that might not respect traditional borders and trade deals. Hence, we have selected the 'do not know' option. However, we would expect any decision on trade agreements to have included a prior, thorough review of any unintended consequences both on the sustainability of health service provision in the UK and on access for UK citizens to innovative technologies developed outside our borders.

Key criteria

6. Should the criteria for selecting providers cover: quality (safety effectiveness and experience of care) and innovation; integration and collaboration; value; inequalities, access and choice; service sustainability and social value?

(Required)

☐ Strongly disagree

☐ Disagree

☐ Neutral

☐ Agree

☒ Strongly agree

☐ Don't know

Please explain your answer below:

The criteria set out in paragraph 6.3 (and Annex A) will be key to the success of new operating arrangements proposed. However, from our and patients' perspectives two important criteria are missing: patient convenience and amenity. Both would support better outcomes from patient engagement with health care.

We understand the rationale (paragraph 6.4) for NHS England not setting a hierarchy for these domains. It would, nevertheless, be helpful if ICSs could be given clearer guidance on how to run an objective process when weighting the criteria. CCGs have suffered from lack of guidance in this area and, properly supported by guidance, 'systems' and 'places' will have more opportunity to get this right for their populations in the future.

We look forward to seeing the proposed legislation and statutory guidance, which we hope will include more detail on how to apply the criteria effectively, transparently, and validly at all levels in the new NHS structures.

Transparency and scrutiny

7. Should all arrangements under this regime be made transparent on the basis that we propose?

☐ Strongly disagree

☐ Disagree

☐ Neutral

☐ Agree

☒ Strongly agree

☐ Don't know

Please explain your answer below:

We strongly agree with NHS England that it is "important that the outcomes of decision-making bodies' decisions reached under this regime are made public, and that sufficient scrutiny is applied to ensure the regime is being followed" (paragraph 8.1). We also support the key requirements set out in paragraph 8.2(i)-(iv), which are consistent with the NHS Constitution.

However, we have lived the experience of poor decision-making by CCGs based on inaccurate data, unfounded and untested misperceptions, and skewed methodologies. We feel therefore that 8.2(iv) should go further in protecting the public interest by setting out

- what remedial actions an ICS should take when it establishes non-compliance at any time as well as part of an annual audit
- what remedial action will be taken if an ICS does not comply with these transparency requirements. For example, we understand that despite NHS England guidance on conflict of interests, compliance reporting still needs improvement.

We hope these issues will be addressed in the statutory guidance, alongside emphasising transparency in both decision-making and the basis for decision-making. One option for achieving this, which would also align with collaboration principles of the current reforms, might be to align more closely with the Cabinet Office reform proposals for public procurement, especially a single digital platform for all NHS providers, the Open Contacting Data Standard (OCDS) and the principle of actively and appropriately engaging all stakeholders from the very beginning of the planning process.

General questions

8. Beyond what you've outlined above, are there any aspects of this engagement document that might:

- have an adverse impact on groups with protected characteristics as defined by the Equality Act 2010?
- widen health inequalities?

Yes

Free text box:

If the provider selection regime (PSR) misses the opportunity to strengthen patient choice for diagnostic, preventive and elective eye care services in primary care, it is likely to exacerbate the inverse care law and, notwithstanding their protected characteristics, this will have a disproportionate impact on older people who are at greatest risk of sight loss from glaucoma and macular degeneration.

The NHS needs to expand capacity and facilitate earlier intervention and discharge through extended primary eye care services urgently, as this will help avoid sight loss due to delays in hospital care, and help to tackle the widening health inequalities gap.

As explained above, the concept of extended primary eye care services was designed to fill this gap and ICSs should be encouraged to expand services at scale across whole ICS areas to meet the ageing population's increasing eye health needs – in line with the Eye Care Restoration and Outpatients Transformation Programme (see our response to question three).

NHS England's 2021/22 planning guidelines gives impetus to this, but given ICSs' other priorities, the pilot status of transformation locations and the fact that eye care is only one of four equivalent programmes, this may not be enough. If that proves to be the case, and avoidable sight loss through lack of capacity continues, as well as facilitating change and better planning through this provider selection regime and guidance, NHS England may need to consider a more directive approach for transformation priorities in the future.

Supporting evidence

- "NHS Patients are suffering preventable harm due to health service initiated delay leading to permanently reduced vision." Royal College of Ophthalmologists[8]
- "Harmful delays to treatment in the hospital eye service (HES) have already been recognised before the pandemic. In eye care, the current measures in place to protect people from acquiring Covid-19 will undoubtedly lead to vision loss that in normal circumstances would have been preventable, as additional safety measures will further reduce capacity." Royal College of Ophthalmologists and College of Optometrists[9]

In England people are losing their sight due to delays in traditional hospital-based treatment and follow-up. This is now a chronic problem which has been highlighted in several reports, most recently in 2020 by the Healthcare Safety Investigation Branch.[2,10,11]

NHS England reports ophthalmology is already one of the "busiest specialties in the NHS, providing over 7.5 million outpatient appointments a year (representing the highest volume outpatient specialty in England) and more than half a million surgical procedures – including the most common operation offered on the NHS, cataract surgery".[12]

The Royal College of Ophthalmologists has also highlighted that there is a severe shortage of eye doctors in the UK[13], although this is in part at least offset by the higher levels of registered optometrists in England (compared with international comparators) the flexibilities which would make that resource available to expand capacity on a risk stratified basis have not been utilised by CCGs.

Put simply, the current model of ophthalmology outpatients is unsustainable even with more ophthalmologists. Extended eye care pathways delivered by NHS primary eye care providers need to be in place across all ICSs. We set how this could be done in our response to question three and hope the final provider selection regime and supporting guidance will facilitate and encourage this.

9. Do you have any other comments or feedback on the regime?

Yes.

Free text box:

Maintaining the national sight-testing and case-finding service (GOS) and related NHS community infrastructure will be key in delivering the Long Term Plan (LTP) and Eye Care Restoration and Outpatients Transformation Programme (see our responses to question three and eight).

We note that legislative recommendation five anticipates GOS contracts in future being held at ICS level as NHS England becomes more streamlined.[14] This causes us some concern as having a more efficient approach was one of the benefits of the contracts moving from PCTs to NHS England in 2013. However, now that claims and payments processing have moved to Primary Care Services England (PSCE) and are online, and more contract administration is moving to NHS Business Services Authority (NHSBSA), it should be possible to avoid the unnecessary and costly variation of the past. We were therefore reassured to see that NHS England plans to:

- "maintain a national role in agreeing and maintaining contracts, and managing back office functions (such as transactional payments for eye tests or dental check-ups) and performers lists"
- "for all services (regardless of who the commissioner is), […] continue to have a role in setting national standards and service specifications, and maintaining nationally mandated contracts to ensure continuing national consistency, alongside any other appropriate safeguards NHSE/I and stakeholders identify as essential to preserving the safe and effective commissioning of these services (e.g. an appropriate assurance and oversight framework)"[15]

We also note that NHS England has reaffirmed its commitment to safeguards for all primary care contractor professions:

- "We reaffirm our continued commitment to national contractual arrangements across the primary care contractor professions and also to the primary and community services funding guarantee – alongside the mental health investment standard – in the NHS Long Term Plan."[16]

This, combined with transparency, using the provider selection regime to support POS Level III services at ICS level and extending the elective care mandatory choice regime to include primary care-based options (see our response to question three), will be major steps forward in the prevention of blindness, better services and earlier intervention at both 'system' and 'place' levels and better outcomes for individuals and populations.

FODO, together with our sector partners the Association of British Dispensing Opticians, the Association of Optometrists, and the British Medical Association makes up the Optometric Fees Negotiating Committee (OFNC) – the national negotiating body for eye care in England with the Department of Health and Social Care and NHS England. Along with sector partners, including the College of Optometrists and LOCSU, we would be happy to discuss these issues further with the Department and NHS England to ensure the best possible outcomes for patients and populations are achieved on a sustainable basis.

10. In what capacity are you responding?

Professional representative body

11. Are you responding on behalf of an organisation?

(Required)

☒Yes

☐ No

If yes, please give organisation name:

FODO – The Association for Eye Care Providers

Email address

healthpolicy@fodo.com

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[1] NHS England, 2021, NHS Operational Planning and Contracting Guidance https://www.england.nhs.uk/operational-planning-and-contracting/
[2] NHS, 2020, Eye Care and Restoration and Transformation Programme https://vimeo.com/479014448
[3] NHS England, 2021, 2021/22 priorities and operational planning guidance https://www.england.nhs.uk/operational-planning-and-contracting/
[4] NHSX, 2020-21, Dynamic Purchasing System (DPS) for Electronic Eyecare Referral Systems (EeRS) https://www.nhsx.nhs.uk/key-tools-and-info/procurement-frameworks/dynamic-purchasing-system-electronic-eyecare-referral-systems/
[5] NHS England, 2021,NHS Standard Contract Technical Guidance, Section 7, paragraph 7.4; General Ophthalmic Services Contracts Regulations 2008 (S.I.2008/1185); Department of Health and Social Care, 2007, Commissioning toolkit for community based eye care services; Section 115(1)(a) of the NHS Act 2006; Section 115(1)(b) of the NHS Act 2006
[6] Royal College of Ophthalmologists and College of Optometrists, 2020, Ophthalmology and Optometry, Our vision for safe and sustainable patient eye care services in England during and beyond COVID-19 https://www.rcophth.ac.uk/wp-content/uploads/2020/08/CoO-RCOphth-Our-vision-for-safe-and-sustainable-patient-eye-care-services-in-England-during-and-beyond-COVID-19-13-08-20-1.pdf
[7] NHS, 2020, Eye Care and Restoration and Transformation Programme https://vimeo.com/479014448
[8] Royal College of Ophthalmologists, 2016, Surveillance of Sight Loss due to delay in ophthalmic review in the UK: Frequency, cause and outcome https://www.rcophth.ac.uk/standards-publications-research/audit-and-data/the-british-ophthalmological-surveillance-unit-bosu/abstract-surveillance-of-sight-loss-due-to-delay-in-ophthalmic-review-in-the-uk/
[9] Royal College of Ophthalmologists and College of Optometrists, 2020, Ophthalmology and Optometry, Our vision for safe and sustainable patient eye care services in England during and beyond COVID-19 https://www.rcophth.ac.uk/wp-content/uploads/2020/08/CoO-RCOphth-Our-vision-for-safe-and-sustainable-patient-eye-care-services-in-England-during-and-beyond-COVID-19-13-08-20-1.pdf
[10] HSIB, 2020, Latest HSIB report highlights 'devastating' impact of delays and pressure on national glaucoma services https://www.hsib.org.uk/news/latest-hsib-

report-highlights-devastating-impact-of-delays-and-pressure-on-national-glaucoma-services/

[11] Royal College of Ophthalmologists, 2017, BOSU report shows patients losing sight to follow-up appointment delays https://www.rcophth.ac.uk/2017/02/bosu-report-shows-patients-coming-to-harm-due-to-delays-in-treatment-and-follow-up-appointments/

[12] NHS, 2019, Ophthalmology GIRFT Programme National Specialty Report https://gettingitrightfirsttime.co.uk/wp-content/uploads/2019/12/OphthalmologyReportGIRFT19P-FINAL.pdf

[13] Royal College of Ophthalmologists, 2019, New RCOphth Workforce Census illustrates the severe shortage of eye doctors in the UK https://www.rcophth.ac.uk/2019/01/new-rcophth-workforce-census-illustrates-the-severe-shortage-of-eye-doctors-in-the-uk/

[14] NHS England, 2021, Legislating for Integrated Care Systems: five recommendations to Government and Parliament page 6 https://www.england.nhs.uk/wp-content/uploads/2021/02/legislating-for-integrated-care-systems-five-recommendations.pdf.

[15] NHS England, 2021, Legislating for Integrated Care Systems: five recommendations to Government and Parliament. Page 22 https://www.england.nhs.uk/wp-content/uploads/2021/02/legislating-for-integrated-care-systems-five-recommendations.pdf

[16] NHS England, 2021, Legislating for Integrated Care Systems: five recommendations to Government and Parliament Paragraph 17 https://www.england.nhs.uk/wp-content/uploads/2021/02/legislating-for-integrated-care-systems-five-recommendations.pdf