NHS England

Eye Health Policy Book

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Eye Health Policy Book

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The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the National Health Service Commissioning Board has used the name NHS England for operational purposes.

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Contents

Executive summary

This policy and guidance manual has been updated to reflect the changing landscape in primary care co-commissioning.

In January 2016, the ‘Eye Health Policy Book’ for Primary Ophthalmic Services was published (Gateway Ref 04170), which provided commissioners of optometry services with the context, information and tools to commission and manage GOS contracts.

NHS England commissions General Ophthalmic Services. Recognising the need to strengthen guidance for commissioners, NHS England has reviewed its Policy Book and the feedback received since its first publication and has made a number of revisions published here. Chapters included remain the same but the templates for contract assurance and the assessment of new contracts have been updated along with some minor detail changes and the consolidation of the numerous annexes.

NHS England recognises the pace and scale of change in Primary Ophthalmic Services commissioning, service delivery and redesign. As such it is committed to reviewing this policy and guidance regularly, to ensure it supports the commitments set out in the General Practice Forward View, the Five Year Forward View and with changes in legislation and regulation.

Part A – Excellent Commissioning and Partner Working

1 Excellent Commissioning and Partnership Working

1.1 Introduction

NHS England became responsible for direct commissioning of primary care services on 1 April 2013 and at that time published a suite of policies underpinning its single operating model.

Those policies have been reviewed and refined in light of:

- feedback from users;
- engagement with stakeholders;
- the introduction of different models of co-commissioning;
- the changing organisational structure of NHS England under the organisational alignment and capability programme; and
- contractual and regulatory changes.

This policy book provides new and revised policies to support a consistent and compliant approach to primary care commissioning across England.

1.2 Structure

The policies have been arranged into a single policy book. Chapters 2 and 3 provide introductory information on co-commissioning and the general duties of NHS England. Each subsequent chapter contains a policy on a discrete matter with cross references indicating where other policies may be relevant.

It is NHS England's intention to update the policies periodically and users of this policy book are encouraged to ensure that the most up to date policy book is used at all times.

1.3 Transitional Arrangement

This policy book replaces the previous policies. The processes and procedures set out in this policy book must be followed where matters arise after the date of publication of this policy book.

Where a matter arose prior to the publication of this policy book and parties are following a previous policy, the parties should continue to follow that previous policy as this would have been the expectation of the parties.

Parties following a previous policy should consider switching to the relevant policy set out in this policy book if there is a natural transitional point in the matter and provided all parties agree.

1.4 Abbreviations and Acronyms

The following abbreviations and acronyms are used in the Eye Health policies:

CQC	Care Quality Commission
DBS	Disclosure and Barring Service
FHSAU	Family Health Services Appeal Unit
GOC	General Optical Council
GOS	General Ophthalmic Services
GOS Regulations	The General Ophthalmic Services Contracts Regulations 2008
LLP	Limited Liability Partnership
NHS ACT	National Health Service Act 2006
PoS	Point of Service

2 Co-commissioning

2.1 Introduction

This chapter provides an overview of the models of co-commissioning and how the medical services policies reflect the involvement of Clinical Commissioning Groups (CCGs) under different co-commissioning models.

For 2017/18, the scope of primary care co-commissioning was primary medical services only. This information is provided for background to persons involved in dental and eye health services.

2.2 Background

In May 2014, NHS England invited CCGs to come forward with expressions of interest to take on an increased role in the commissioning of primary care services. The intention was to empower and enable CCGs to improve primary care services locally for the benefit of patients and local communities.

CCGs could choose which form of co-commissioning they would like to adopt:

- greater involvement in primary care decision-making;
- joint commissioning arrangements; or
- delegated commissioning arrangements.

In April 2018, over 90 percent of CCGs have fully delegated commissioning arrangements for primary medical services.

2.3 Co-commissioning Models

2.3.1 Greater involvement in primary care co-commissioning

Greater involvement in primary care co-commissioning is an invitation to CCGs to collaborate more closely with NHS England to ensure that decisions taken about healthcare services are strategically aligned across the local health economy.

CCGs who wish to have greater involvement in primary care decision making could participate in discussions about all areas of primary care including primary medical care, eye health, dental and community pharmacy services, provided that NHS England retains its statutory decision-making responsibilities and there is appropriate involvement of local professional networks.

2.3.2 Joint commissioning arrangements

A joint commissioning model enables one or more CCGs to assume responsibility for jointly commissioning primary medical services with NHS England, either through a joint committee or “committees in common”. Joint commissioning arrangements give CCGs and NHS England an opportunity to more effectively plan and improve the provision of out of hospital services for the benefit of patients and local populations.

The functions that joint committees cover include:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
- newly designed enhanced services ("Local Enhanced Services (LES)" and "Directed Enhanced Services (DES)");
- design of local incentive schemes as an alternative to the Quality and Outcomes Framework (QOF);
- the ability to establish new GP practices in an area;
- approving practice mergers; and
- making decisions on 'discretionary' payments (e.g. returner/retainer schemes).

Joint commissioning arrangements exclude individual GP performance management (medical performers' list for GPs, appraisal and revalidation). NHS England is also responsible for the administration of payments and list management.

CCGs have the opportunity to discuss dental, eye health and community pharmacy commissioning with NHS England and local professional networks but have no decision-making role.

2.3.3 Delegated commissioning arrangements

Delegated commissioning is an opportunity for CCGs to assume full responsibility for commissioning general practice services. Legally, NHS England retains the residual liability for the performance of primary medical care commissioning. Therefore, NHS England will require robust assurance that its statutory functions are being discharged effectively. CCGs continue to remain responsible for discharging their own statutory duties, for instance, in relation to quality, financial resources and public participation.

The following primary care functions are included in delegated arrangements:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action, such as issuing branch/remedial notices, and removing a contract);
- newly designed enhanced services ("Local Enhanced Services (LES)" and "Directed Enhanced Services (DES)");
- design of local incentive schemes as an alternative to the Quality and Outcomes Framework (QOF);
- the ability to establish new GP practices in an area;
- approving practice mergers; and
- making decisions on 'discretionary' payments (e.g., returner/retainer schemes).

Delegated commissioning arrangements exclude individual GP performance management (medical performers' list for GPs, appraisal and revalidation). NHS England is also responsible for the administration of payments and list management.

CCGs have the opportunity to discuss dental, eye health and community pharmacy commissioning with NHS England and local professional networks but have no decision making role.

2.4 Co-Commissioning and Primary Care Policies

For the purposes of the primary care policies, the commissioner of the primary care service is not referred to by name but simply as the "Commissioner". This is to reflect the fact that for primary medical services, the identity of the commissioner in an area will depend on the model of co-commissioning that the CCG has adopted:

- where a CCG has adopted greater involvement in primary care co-commissioning, the Commissioner will usually be NHS England;
- where a CCG has adopted joint commissioning arrangements, the Commissioner will usually be NHS England and the CCG acting under the governance of the joint committee; and
- where a CCG has adopted delegated commissioning arrangements, the Commissioner will usually be the CCG.

Although CCGs may assume the role of the Commissioner for the purposes of the policies, legally NHS England retains the residual liability for the performance of primary medical care commissioning. There will be matters which have not been delegated to CCGs or are not able to be carried out by a CCG in which case the Commissioner will be NHS England.

The primary care policies that cover dental, eye health and pharmacy services retain the reference to Commissioner but for 2015/16 this is NHS England.

Where a CCG is operating under the joint commissioning arrangements, the CCG and NHS England should review the governance arrangements to ensure each is aware of its responsibilities as Commissioner.

Under delegated commissioning arrangements, a CCG will have agreed a delegation agreement with NHS England. This document will set out for what matters the CCG has decision-making responsibilities. Where the delegation agreement sets out obligations on the CCG, e.g. liaising with NHS England in relation to managing disputes, the relevant primary medical policy refers to the delegation agreement and highlights relevant points.

2.5 Equality and Health Inequalities

Clinical Commissioning Groups (CCGs) and NHS England have legal duties in respect of equality and health inequalities. Supporting guidance has been issued within the 2015-16 Planning Guidance . In the commissioning and operational implementation of primary dental services due regard should be given to these duties. Further detail is also provided in the next section.

3 General Duties of NHS England

This chapter outlines the general duties that NHS England must comply with that are likely to affect the decisions it takes regarding the provision of primary care.

There are many general duties on NHS England. It is important that decision-makers are familiar with all of these because if a duty has not been complied with when a decision is taken, that decision can be challenged in the courts on the grounds that it is unlawful.

This guidance looks at the general duties that NHS England is required to comply that are most applicable to primary care, providing examples to illustrate how they might affect decision-making.

Below is a summary of the duties that are covered by this guidance. The full wording from the legislation is provided at Annex 3.1. The guidance goes on to look at each of the duties in more detail.

3.1 Equality and Health Inequalities Duties

3.1.1 Equality Duties

The Equality Act 2010 prohibits unlawful discrimination in the provision of services on the grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. These are the "protected characteristics".

As well as these prohibitions against unlawful discrimination the Equality Act 2010 requires NHS England to have "due regard" to the need to:

- eliminate discrimination that is unlawful under the Equality Act;
- advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it; and
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

This can require NHS England to take positive steps to reduce inequalities. The duty is known as the public sector equality duty or PSED (see section 149 of the Equality Act).

3.1.2 The “Regard Duties”

The "Regard Duties" are:

- the duty to have regard to the need to reduce health inequalities (see section 13G of the NHS Act 2006)
- the duty to have regard to the desirability of allowing others in the healthcare system to act with autonomy and avoid imposing unnecessary burdens upon them, so far as this is consistent with the interests of the health service (see section 13F of the NHS Act 2006)

- the duty to have regard to the need to promote education and training of those working within (or intending to work within) the health service (see section 13M of the NHS Act 2006)
- the duty to have regard to the likely impact of commissioning decisions on healthcare delivered in areas of Wales or Scotland close to the border with England (see section 13O of the NHS Act 2006).

3.1.3 The “View To Duties”

The "View To Duties" are:

- the duty to act with a view to delivering services in a way that promotes the NHS constitution (see section 13C(1)(a) of the NHS Act 2006)
- the duty to act with a view to securing continuous improvement in the quality of services in health and public health services (see section 13E of the NHS Act 2006)
- the duty to act with a view to enabling patients to make choices about their care (see section 13I of the NHS Act 2006)
- the duty to act with a view to securing integration, including between health and other public services that impact on health, where this would improve health services (see section 13N of the NHS Act 2006).

3.1.4 The “Promote Duties”

The "Promote Duties" are:

- the duty to promote awareness of the NHS Constitution among patients, staff and members of the public (see section 13C(1)(b) of the NHS Act 2006)
- the duty to promote the involvement of patients and carers in decisions about their own care (see section 13H of the NHS Act 2006)
- the duty to promote innovation in the health service (see section 13K of the NHS Act 2006)
- the duty to promote research and the use of research on matters relevant to the health service (see section 13L of the NHS Act 2006).

3.1.5 The “Involvement Duty”

NHS England has a duty to make arrangements to secure that service users and potential service users are involved in:

- the planning of commissioning arrangements by NHS England;
- NHS England's development and consideration of proposals for changes to commissioning arrangements, if the implementation of the proposals would impact on the range of health services available to service users or the manner in which they are delivered; and
- NHSE England decisions affecting the operation of commissioning arrangements, if those decisions would have such an impact.

3.1.6 Duty to act fairly and reasonably

NHS England has a duty to act fairly and reasonably when making its decisions. These duties come from case law that applies to all public bodies.

3.1.7 Duty to obtain advice

NHS England has a duty to "obtain appropriate advice" from persons with a broad range of professional expertise (see section 13J of the NHS Act 2006).

3.1.8 Duty to exercise function effectively

NHS England has a duty to exercise its functions effectively, efficiently and economically (see section 13D of the NHS Act 2006).

3.1.9 Duty as to reduce inequalities

The Board must, in the exercise of its functions, have regard to the need to:-

- reduce inequalities between patients with respect to their ability to access health services, and
- reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services.

3.1.10 Duty not to prefer one type of provider

NHS England must not try to vary the proportion of services delivered by providers according to whether the provider is in the public or private sector, or some other aspect of their status.

3.2 Summary of Equality and Health Inequalities Duties

3.2.1 The protected characteristics

The Equality Act 2010 prohibits unlawful discrimination in the provision of services (including healthcare services) on the basis of "protected characteristics". The protected characteristics are:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief (which can include an absence of belief)
- sex
- sexual orientation.

Unlawful discrimination can also occur if a person is put at a disadvantage because of a combination of these factors.

3.2.2 Unlawful discrimination

There are broadly four types of discrimination in the provision of services that are unlawful under the Equality Act:

- Direct discrimination services are not available to someone because they are e.g. not married, over 35, a woman. Apart from a few limited exceptions, direct discrimination will always be unlawful, unless it is on the grounds of age and the discrimination is a proportionate means of achieving a legitimate aim.

- Indirect discrimination occurs when NHS England apply a policy, criterion or practice equally to everybody but which has a disproportionate negative impact on one of the groups of people sharing a protected characteristic, and where the complainant cannot themselves comply. The classic example is a height requirement, which is likely to exclude a much greater proportion of women than men because women are on average significantly shorter. Requirements that require people to behave in a certain way will amount to indirect discrimination if compliance is not consistent with reasonable expectations of behaviour. For example, a requirement not to wear a head covering would be indirectly discriminatory on the grounds of religion, even though followers of religions which require a head covering are physically able to remove it. Indirect discrimination is not unlawful if it is a proportionate means of achieving a legitimate aim.

- Disability discrimination occurs if a person is treated unfavourably because of something "arising in consequence of their disability". This captures discrimination that occurs not because of a person's disability per se (e.g. a person has multiple sclerosis) but because of the behaviour caused by the disability (e.g. use of a wheelchair). So an inability of someone with multiple sclerosis to access services when using their wheelchair could be an instance of disability discrimination. Disability discrimination is not unlawful if it is a proportionate means of achieving a legitimate end.

- A failure to make "reasonable adjustments" for people with disabilities who are put at a substantial disadvantage by a practice or physical feature. The duty also requires bodies to put an "auxiliary aid" in place where this would remove a substantial disadvantage e.g. a hearing aid induction loop. The duty to make reasonable adjustments might e.g. require NHS England to make consultation materials available in braille. However some care is needed here. People with disabilities have a right to access services in broadly the same way as people without disabilities, so far as is reasonable. Offering a telephone consultation to a wheelchair-using patient who is prevented from accessing a clinic by steps may in fact be unlawful discrimination rather than a reasonable adjustment. The wheelchair user should be able to access services in broadly the same way as others i.e. by attending practice premises for a consultation.

(Unlawful discrimination is also prohibited in the field of employment and other areas but these are not covered in this guidance.)

3.2.3 Public sector equality duty

As well as these prohibitions against unlawful discrimination the Equality Act 2010 requires NHS England to have "due regard" to the need to:

- eliminate discrimination that is unlawful under the Act;
- advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it; and
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

This can require NHS England to take positive steps to reduce inequalities. In this regard the Act permits treating some people more favourably than others but not if this amounts to unlawful discrimination. The duty is known as the public sector equality duty or PSED (see section 149 of the Act). The PSED has been used successfully on many occasions to challenge changes to services.

This means that NHS England has a duty to help eliminate any unlawful discrimination practised by the providers of primary care e.g. through requiring premises to be accessible. Failing to use its negotiating power to secure such changes could be seen as a breach by NHS England of the PSED, as well as a breach of the non-discrimination rules by the service provider.

Example

After a site visit NHS England becomes aware that consulting rooms in an optometrist are no longer accessible to those with limited mobility as they have been moved upstairs. NHS England decides that as there are no downstairs consulting rooms and there is no lift or stair lift, this is a breach of the practice's duty to make reasonable adjustments under the Equality Act. This in turn is a breach of the practice's duty under its contract with NHS England to comply with legislation. In order to comply with the PSED NHS England takes steps to ensure that the practice complies with its Equality Act duties by raising the issue informally and issuing a breach notice if the problem is not remedied.

Example

A hearing impaired patient complains to NHS England about their experience with a local (NHS commissioned) optometrist. The patient was unable to communicate effectively with the optometrist because of their hearing impairment. When the patient suggested that the optometrist obtain a sign language interpreter to translate for them this was refused.

It is likely that the provider will be in breach of their obligations under the Equality Act 2010 to make reasonable adjustments. In order to comply with the PSED NHS England takes steps to investigate and enforcement action if needed.

Carrying out appropriate equality impact assessments is usually critical to proving discharge of the PSED, although they are not as such a legal requirement. This is because if there is no assessment of the impact of a possible change on groups with protected characteristics, it is very difficult to argue that NHS England had the impact properly in mind when it made its decision. This is the case even if the impact on protected groups is minimal.

It is not always easy to assess equality impact. A robust service user involvement exercise will help NHS England identify any issues. It is advisable to ask question(s) directly aimed at equalities issues. In many cases it is advisable to take special steps to reach hard to reach groups affected by the decisions (e.g. by making involvement materials available in languages other than English). The more likely a decision is to disproportionately affect a protected group, the more important it is to get feedback from that group about the decision.

The PSED means that NHS England must consider equalities issues when making decisions. In some cases there may be a solution that causes less disadvantage to a protected group but for other reasons is undesirable. In these situations it is important to acknowledge the disadvantage caused and be clear about why the decision was taken. This may include outlining costs concerns. It also makes sense to monitor the situation e.g. does the demographic of service users change as a result of the decision and timetable a formal review in e.g. a year's time.

There are a few themes arising from the cases we have seen so far on the application of the PSED (and similar duties in previous legislation):

- A need to explicitly recognise that the PSED applies and equalities issues need to be considered
- The duty is an ongoing one – to be considered at all stages of decision-making not just at the end
- A need to be clear about the factors driving a decision, even if these are unpalatable e.g. budgetary pressures
- A need to analyse in some detail the impact of a proposed policy or decision so that the public authority has a clear idea of who is affected and how. Statements of impact need to be supported by evidence where possible.
- If a decision is made that will impact negatively on a protected group, that should be acknowledged and the rationale explained
- There should be a detailed consideration as to how any negative impact of the decision could be mitigated. If the steps identified are not practicable, this should be explained
- The duty must be complied with at the time of the decision. After the event reasoning is rarely allowed.

3.3 The Regard Duties

The "Have regard", "act with a view to" or "promote" duties. These form a loose hierarchy of duties:

- The duty to have regard means that when taking actions, a certain thing must be considered
- The duty to promote means action must be taken that actually achieves an outcome. Additionally, it is possible to promote something by encouraging others to do it
- The duty to act with a view to means that action must be taken with a purpose in mind.

In contrast to the Promotion Duties and the View To Duties, the Regard Duties apply to every action of NHS England where it is carrying out its primary care functions. (Pausing there, the duty will not normally apply to "private law" decisions that would be taken by any private sector organisation – making HR decisions, leasing estate etc.)

The PSED cases are the best guide that we have to how a court would interpret NHS England's Regard Duties. We can learn from these that:

- Those in NHS England who have to take decisions must be made aware of their duty to have regard to the various issues outlined in the duties. Failure to do so will render the decision unlawful
- The Regard Duties must be fulfilled before and at the time that a particular decision is being considered. If they are not, any attempts to retrospectively justify a decision as consistent with the Regard Duties will not be enough to discharge them
- Officers need to engage with the Regard Duties with rigour and with an open mind
- It is good practice for the decision maker to make reference to the Regard Duties
- It is not possible for NHS England to delegate the duties down to another organisation to comply with. They will always remain with NHS England. If NHS England acts through contractors it must ensure as necessary that they act consistently with the duties
- The Regard Duties are continuing ones that apply throughout decision-making. It is not enough to only "rubber stamp" a decision by reference to the Regard Duties at the end of a decision-making process. The Regard Duties need to be borne in mind throughout
- It is crucial to keep an adequate record of how the Regard Duties are considered. If records are not kept it will make it more difficult, evidentially, for NHS England to persuade a court that it has fulfilled the duties imposed.

One key point to understand is that there is no obligation to achieve the object of the Regard Duties e.g. it is not unlawful not to eliminate health inequalities (although equally, if health inequalities persist and widen, that fact would need to inform consideration of the regard duty). Nor does NHS England have the luxury of "pausing" the health service while it investigates health inequality or any other matter.

The duties are to have regard, not to achieve perfection, and this is a practical rather than an academic exercise.

3.3.1 Reduce health inequalities

Of the Regard Duties, the requirement to have regard to the need to:

- Reduce inequalities between patients with respect to their ability to access health services, and
- Reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services

When making decisions about primary care – particularly about service changes – decision-makers will need to bear in mind the impact on health inequalities. To do this NHS England will need some data around existing health inequalities, and to consider whether its decision can be used to diminish these.

The detail and causes of health inequalities is a highly complex area, ranging from the highest level of generality (male vs female life expectancy, say) down to very granular data taking into account a patients place of residence, age, smoking status etc. NHS England must try to obtain the data needed to understand and address health inequality, but there is a trade-off between making further enquiries and taking decisions and moving the health service on.

The key point is that NHS England can show (through documentation) that the impact a decision will have on health inequalities has been taken into account, and that its decision is based on some relevant data.

3.3.2 Act with autonomy

NHS England has a duty to have regard to the desirability of allowing others in the healthcare system to act with autonomy and avoid imposing unnecessary burdens upon them, so far as this is consistent with the interests of the health service.

3.3.3 Promote education and training

NHS England has a duty to have regard to the need to promote education and training of those working within (or intending to work within) the health service.

3.3.4 Impact in areas of Wales or Scotland

NHS England has a the duty to have regard to the likely impact of commissioning decisions on healthcare delivered in areas of Wales or Scotland close to the border with England. This will clearly be relevant for those working in regional teams that border Wales or Scotland. NHS England will also need to comply with the duty when making national strategic decisions about the delivery of primary care – that affect bordering areas as well as others.

Example

NHS England is considering commissioning new primary care services for a town in England close to the border with Scotland. It is concerned that many of the local residents have difficulty in accessing local primary care services, the nearest practice being based over the border in Scotland. That provider is difficult to access by public transport and in the winter the short route is often impassable. To comply with its duty to have regard to the likely impact of commissioning decisions on healthcare delivered in areas Scotland close to the border with England, the regional team discusses the impact that commissioning services on the English side of the border would have on the Scottish provider. It takes this impact into account when it makes its decision about the commissioning of services.

3.4 The Promote Duties

It is helpful to look next at the Promote Duties. These are:

- the duty to promote awareness of the NHS Constitution among patients, staff and members of the public (see section 13C(1)(b) of the NHS Act 2006)
- the duty to promote the involvement of patients and carers in decisions about their own care (see section 13H of the NHS Act 2006)
- the duty to promote innovation in the health service (see section 13K of the NHS Act 2006)
- the duty to promote research and the use of research on matters relevant to the health service (see section 13L of the NHS Act 2006).

However a decision which is positively contrary to achieving the relevant outcome might breach a promote duty unless there was some compelling reason to adopt it. In this situation please contact the NHS England Legal Team for further guidance.

Additionally, some decisions will be obvious opportunities where e.g. patient involvement could easily be promoted. In such cases the safest course of action is to ensure that this is done.

To meet the duty NHS England does not have to do everything itself – be more innovative, improve its use of research data etc. It can meet the duty by encouraging other people to do things.

3.5 The View To Duties

The "View To Duties" are:

- the duty to act with a view to delivering services in a way that promotes the NHS constitution (see section 13C(1)(a) of the NHS Act 2006)
- the duty to act with a view to securing continuous improvement in the quality of services in health and public health services (see section 13E of the NHS Act 2006)
- the duty to act with a view to enabling patients to make choices about their care (see section 13I of the NHS Act 2006)
- the duty to exercise its functions with a view to securing that health services are provided in an integrated way where it considers that this would:-

    a) improve the quality of those services (including the outcomes that are achieved from their provision)
    b) reduce inequalities between persons with respect to their ability to access those services, or
    c) reduce inequalities between persons with respect to the outcomes achieved for them by the provision of those services.

In many ways the considerations for these duties and the Promote Duties are the same. One difference is that while a Promote Duty can be met by encouraging others to achieve it (e.g. encouraging GP practices to make better use of telehealth devices), with the View To Duties the actions have to be carried out by NHS England.

The View To Duties are less onerous than the Promote Duties because they do not require NHS England to achieve a particular outcome (although that would be desirable) – only to do something that aims to achieve it. This is in contrast to the Promote Duties, which require an outcome to be achieved.

Again, the View To Duties are most likely to affect strategic decisions taken at directorate level. Provided NHS England can show that within the totality of its activities there has been significant action taken with the intention of achieving the outcomes that NHS England is required to have a view to, the duty is discharged.

As with the Promote Duties, decision-makers on the ground should be wary of doing something actively goes against one of the goals set out in the View To duties. In this situation please contact the NHS England Legal Team for further guidance. Also, if there is a clear opportunity to help deliver one of the View To objectives, it is best to take it.

3.6 The Involvement Duty

3.6.1 Overview

Under section 13Q of the NHS Act 2006, NHS England has a statutory duty to ‘make arrangements’ to involve the public in the commissioning services for NHS patients.

Section 13Q applies to:

- the planning of commissioning arrangements
- the development and consideration of any proposals that would impact on the manner in which services are delivered to individuals or the range of services available to them
- decisions that would impact on the manner in which services are delivered to individuals or the range of services available to them.

The section 13Q duty only applies to plans, proposals and decisions about services that are directly commissioned by NHS England. This includes GP, dental, ophthalmic and pharmaceutical services.

3.6.2 NHS England's arrangement for public involvement

The statutory duty to 'make arrangements' under section 13Q of the NHS Act 2006 is essentially a requirement to make plans and preparations for public involvement.

NHS England has set out its plans as to how it intends to involve the public in its Statement of Arrangements and Guidance on Patient and Public Participation in Commissioning'. The document sets out and explains the arrangements NHS England has in place:

- Corporate infrastructure – how public involvement is embedded in the way that NHS England is constituted and carries out its business
- Involvement initiatives – initiatives designed to involve the public in strategic planning and the development of policy or other aspects of NHS England's activities
- Monitoring arrangements – a step-by-step process to help commissioners identify whether the section 13Q applies and decide whether sufficient public involvement activity is already in place or whether additional public involvement is required
- Responsive arrangements – guidance to commissioners on how to make arrangements for public involvement where monitoring has indicated that such arrangements are required.

As well as setting out the above arrangements, which NHS England commissioners should follow, the document is regularly reviewed and updated and contains useful resources for commissioners, including:

- Details of existing corporate infrastructure and involvement initiatives which could be drawn upon by commissioners to involve the public in their commissioning activities
- Reference to NHS England's framework for involving patients and the public in primary care commissioning, which includes resources developed especially for primary care
- Resources to help commissioners identify whether the section 13Q applies, put in place appropriate arrangements for public involvement and avoid legal challenge
- Guidance on a variety of topics that often arise, such as what 'public involvement' means, how to involve the public, who to involve, when

involvement should take place, urgent decisions and joint involvement exercises
- Case studies based upon primary care scenarios
- Summaries of related legal duties
- Details of how to seek further advice if needed.

The document is intended to be used by both NHS England staff (who need to understand and comply with the arrangements when commissioning services) and the public (to understand how NHS England involves the public in it's commissioning of services). It is not intended for CCGs, who are required to make their own arrangements for public involvement under section 14Z2 of the NHS Act 2006.

3.7 Duty to act fairly & reasonably

NHS England has a duty to act fairly and reasonably when making its decisions. These duties come from case law that applies to all public bodies.

3.7.1 Acting fairly

Normally, to act fairly NHS England will need to act in accordance with its own policies. It can depart from guidance if there is good reason to do so. In this scenario NHS England will need to explain the situation fully to the people & organisations affected and give them a chance to provide their views on the procedure to be followed. This will include why it wants to depart from the usual policy and what it will do instead.

NHS England also needs to be careful about keeping to promises made to contractors or the public e.g. that there will be a public consultation before any final decision is made on closing a particular pharmacy. It is sometimes (but not always) possible depart from such promises. Therefore care should be taken about giving any clear commitments to a particular course of action until NHS England is sure that it is what it wants to do. If NHS England is considering depart from a commitment it has given to do a particular thing or follow a particular type of process, please contact the NHS England Legal Team for further guidance.

It is also important to act proportionately, taking into account any adverse impact on patients and/or contractors.

3.7.2 Acting reasonably

NHS England has to take all relevant factors into account when making its decisions and exclude irrelevant factors. It is up to NHS England how much weight it gives competing considerations and may give a factor no weight at all. The key point is that all the relevant factors are identified and documented.

The reasons for NHS England's decisions also need to "stack up". It is important for NHS England to document its reasons for a decision as NHS England needs not only to act reasonably but be able to show that it has acted reasonably by reference to contemporaneous documents. This means that particularly where a controversial decision is being made the thinking behind the decision needs to be carefully documented.

3.8 The duty to obtain advice

NHS England has a duty to "obtain appropriate advice" from persons with a broad range of professional expertise (see section 13J of the NHS Act 2006).

This means that decision-makers need to collect appropriate information before making decisions. If NHS England does not have the information it needs then it should seek out appropriate advice. In many cases it will not be necessary to do this as all the necessary information is to hand. The duty is most relevant to strategic decisions taken at directorate level, where decision-makers will need to document how they obtain advice from those with professional expertise (some of whom may be NHS England employees or secondees).

3.9 The duty to exercise functions effectively

NHS England has a duty to exercise its functions effectively, efficiently and economically (see section 13D of the NHS Act 2006).

This is a statutory reformulation of a duty that has been contained for many years in Managing Public Money and its predecessors. If NHS England has complied with the other duties in this guidance – in particular the duty to act reasonably – it is highly unlikely that it will breach this duty.

3.10 The duty not to prefer one type of provider

NHS England must not try and vary the proportion of services delivered by providers according to whether the provider is in the public or private sector, or some other aspect of their status.

This means that NHS England must focus on the services delivered by an organisation and its sustainability. It should not make choices about contractors based solely on their status as e.g. company, partnership, public sector, private sector, charity or not for profit organisation.

Part B – General Contract Management

4 Characteristics of GOS Contracts

4.1 Characteristics of GOS Contracts

GOS Contract (General Ophthalmic Services - mandatory and/or additional services)	
Who can hold a GOS contract?	Any person or business that is not ineligible under regulations 4(3) – set out in detail in Annex 4.1
Where two or more individuals are practising in partnership, is a GOS contract treated as being made with the partnership?	Yes
Is there a model contract?	Yes – model contracts exist for mandatory and for additional services
Is a GOS contract time limited?	No except in certain circumstances when a temporary contract can be used – see Temporary Contracts below
Can the commissioner terminate at will?	No
Must the contractor provide mandatory services?	No
Do the model contracts contain KPIs?	No
Payment arrangements	GOS Contracts (Payments) Directions

4.2 Temporary Contracts

A GOS contract usually subsists until it is terminated in accordance with its provisions. A GOS contract can, however, be used for a fixed period where the Commissioner has terminated a contract of another provider of primary ophthalmic services, and as a result of that termination, it wishes to enter into a temporary contract for a period specified in the contract for the provision of services.

Where a temporary contract is entered into, the contract is not required to contain the right for the contractor to terminate at will but the parties can agree to include such terms as to termination by notice as they may agree.

5 Contract Application

This policy applies to both mandatory (premises) and additional (mobile) services GOS contract applications.

This policy sets out the general approach to processing applications for new GOS contracts including:

- requesting an application;
- processing new GOS applications;
- the process for approving premises (mandatory contracts only), equipment, record keeping facilities and staffing arrangements for mandatory contracts;
- suitability to hold a contract; and
- preparing a GOS contract.

To ensure that all GOS contracts issued are assured in terms of suitability of contract holder, premises, record keeping and performers within the contract, the Commissioner must follow the contract approval process below.

5.1 Requesting and Receiving an Application

A request for an application will normally start by an applicant telephoning, writing or emailing to the Commissioner.

The Commissioner must ask the applicant whether they are:

- intending to provide mandatory or additional services (or both); and
- applying for a contract as:

    a) an individual;
    b) a partnership; or
    c) a body corporate.

This determines which application form and sections need to be submitted.

Contractor	Description	Documents
Individual	A person carrying on a business.	Individual Application (Sections A and B)
General Partnerships	This is a partnership where two or more persons are carrying out a business purpose. General partners share equal rights and responsibilities and assume full responsibility for all business debts and obligations. General partnerships are governed by the Partnership Act 1890.	Partnership application (Sections A and B)

Contractor	Description	Documents
Limited Partnership	This is a partnership where the limited partners are able to restrict their personal liability to the stake in the business, i.e. their investment. A limited partnership must have at least one general partner taking on the full responsibility for the business debts and obligations. The general partners retain the right to control the business whilst the limited partners do not participate in management decisions. A limited partnership is governed by the Limited Partnership Act 1907, must register with Companies House and its business name must end in LP.	Partnership application (Sections A and B)
Limited Liability Partnership (LLP)	A limited liability partnership offers the advantages of a general partnership but also offers personal liability protection to its participants. Individual partners are not liable for the wrongful acts of other partners or the debts or obligations of the business. These are governed by the Limited Liability Partnership Act 2000. A Limited Liability Partnership must register with Companies House	Body corporate application (Sections A and B)
Company	A company is an association of legal or natural individuals. The company's shareholders or members (depending on the form of the company) are usually liable to a capped amount. Companies are governed by the Companies Act 2006. A company must be registered with Companies House	Body corporate application (Sections A and B)

All the required information is included in the standard application form that all applicants must use:

- Individual or partnership applicants:

    a) mandatory services – Section A (Application) – see Annex 5.1;
    b) additional services – Section A (Application) – see Annex 5.2; and
    c) mandatory and additional services – Section B (Declaration) – see Annex 5.3.

- Corporate body applicants (including LLPs):

    a) mandatory services – Section A (Application) – see Annex 5.4;
    b) additional services – Section A (Application) – see Annex 5.5; and
    c) mandatory and additional services – see Section B (Declaration) – see Annex 5.6.

The Commissioner should obtain a report from Companies House to ensure the company is registered with the same directors as identified in Section A (this is free of charge) and that all the relevant Section B forms are received.

Where a business or “trading as” name includes a protected title, the Commissioner should check that they are entitled to use it (see below). For this reason the business name and/or “trading as” name are required within the application form. A business that is using a protected title in its "trading as" name or company name requires General Optical Council registration to trade. A protected title is any of the following:

- (registered) optometrist;
- (registered) dispensing optician;
- (registered) ophthalmic optician; and
- (registered) optician(s).

The GOC registers can be checked at https://www.optical.org/en/utilities/online-registers.cfm

The standard information that must be provided and is contained within all GOS contract applications is set out in Schedule 3 of the GOS Regulations, extracts of which are set out in Annex 5.7.

Regulation 9 of the GOS Regulations requires that the contract specifies in the case of a partnership the names of the partners and in the case of a limited partnership, their status as a general or limited partner. This information must be provided by the applicant before the Commissioner awards a contract so that the Commissioner knows who in the partnership has full responsibility and accountability for the business.

Where the applicant is applying for a contract as a limited company, the Commissioner must ask the applicant how many company directors there are including the company secretary and chief executive. The applicant should then be provided with the appropriate number of copies of the relevant Section B application forms (one copy for each director, company secretary and chief executive) and the relevant Section A contract application form for either a mandatory or additional services contract or both.

For mandatory services, the premises from which the GOS are being provided need to be within the boundary of the Commissioner processing the application.

For additional services, the Commissioner should note that contractors are not obliged to cover the whole of the Commissioner's area and may provide services across a smaller proportion of the area. This smaller area does not need to be specified in the contract but the Commissioner must be informed of the planned area of coverage by the applicant at the time of application. This is to enable the Commissioner to fulfil its duty to ensure that it has providers covering the whole of the Commissioner's geographical area.

5.2 Processing New Contracts Applications

When the Commissioner receives an application form from an existing contractor who is applying for further premises, this should be handled as variation to an existing contract and not a new contract application (See Chapter 8).

DBS checks may be undertaken on applicants for GOS contracts. Commissioners should be prepared to indicate as to the reasons that they feel a DBS check is appropriate.

When the application form has been completed and returned, a contract file should be set up and a progress sheet should be opened and worked through for one of the following:

- individual and partnership applicants (see Annex 5.8); or
- body corporate applicants (see Annex 5.9).

The application form and enclosures should then be checked for completeness and any inconsistencies or discrepancies clarified with the applicant.

Applications should be fully completed by the applicant and should withstand a common-sense check. They must be accompanied by evidence of appropriate insurance, including clinical negligence insurance or indemnity arrangements (except where the applicant intends to rely upon the clinical negligence insurance of his/her performers in which case there should be evidence of clinical negligence insurance for each proposed performer) and evidence of public liability insurance.

The Commissioner must ask for a CV for individual applicants or company directors, company secretaries or chief executives, to explain any gaps in their careers which are greater than 6 months so these can be investigated further if necessary and to provide evidence in determining suitability to hold a contract. All documentary

evidence submitted should be originals. These should be photocopied, signed by an employee of the Commissioner for the file and the original documents returned to the applicant.

Where applicants (and directors, chief executives and company secretaries) are members of a healthcare profession their professional registration must be checked on the relevant registration body website. The records found should be printed out and added to the file as a confirmation that the checks have been undertaken.

The Commissioner should also check with NHS Protect and the FHSAU to further establish the applicant's suitability to be a contract holder.

5.3 Process for Approving Premises, Equipment, Record-Keeping Facilities and Staffing Arrangement

A mandatory services applicant must be contacted to arrange a practice visit to all of the premises included in the application form.

Where the applicant is applying to provide additional services they must present all appropriate equipment and relevant policy paperwork at a location agreed on by both parties. This will usually be at the Commissioner's office.

Practice visits should normally be undertaken by an appropriately trained member of the Commissioner's primary care team and/or an optometric adviser as appropriate.

A practice visit protocol is available in Annex 5.10, which covers premises, equipment, record-keeping facilities and staffing arrangements for both mandatory and additional services contracts.

Where it causes difficulty for applicants proposing to provide additional services to bring all appropriate mobile equipment into the Commissioner's office for inspection and approval, the Commissioner should agree with the applicant a suitable time and place for inspection and approval such as at a mandatory services contract application premises visit. At this time the applicant can also be asked relevant questions about their record-keeping facilities and staffing arrangements.

In the context of a new application there may be circumstances where the applicant’s proposed premises, equipment, record-keeping facilities or staffing arrangements fall short of those required but not to such a degree as to render the application unsuitable. Relatively minor improvements to the premises, equipment, record-keeping facilities or staffing arrangements can be made which will then allow the application to be approved.

The Commissioner cannot award a contract subject to conditions but should advise an applicant that if they make the necessary improvements a contract may then be awarded within a specified period of time. The Commissioner must not allow an application to remain undetermined for an indefinite period.

If an application is left undetermined for longer than three months without any evidence from the applicant that they intend to make the requested improvements, the applicant should be contacted to ask whether they wish to formally withdraw their contract application without prejudice and then re-apply once they have carried out the required improvements. Applicants should also be advised that any refusal of an application for a contract must be declared in all future applications. Applicants should be given a period of two weeks to respond.

Where the applicant does not respond within a reasonable time or is non-compliant then the Commissioner must formally reject the application and the applicant should be advised of their right of appeal to the Health, Education and Social Care Chamber of the First-Tier Tribunal. The Commissioner should decide what constitutes a reasonable time for a response based on the circumstances relating to the application.

5.4 Consideration of Sustainability to Hold a Contract

Once all the relevant information and evidence has been supplied a desktop assessment should to be made to determine the applicant's suitability to hold a GOS contract.

This assessment should be made by the Commissioner taking into account the detailed application, the insurance certificates (clinical negligence insurance and public liability insurance), the CV checks, the outcome of NHS Protect and FHSAU checks and the practice visit and, if completed, DBS checks. Advice must also be sought from the optometric adviser.

In accordance with Regulation 4 of the GOS Regulations, the Commissioner may refuse an application if it is not satisfied that the applicant:

- has the appropriate premises, equipment or record keeping arrangements;
- will employ or engage, by the date the contract is to start, appropriate staff, to provide the services under the contract; or
- is suitable to provide general ophthalmic services.

In addition, there are certain applicants who the Commissioner must refuse and they are listed in Annex 5.11.

Commissioners should ensure that they follow appropriate internal decision making and reporting processes for their Regional Team so that the relevant persons are aware when a new contract application is approved or where the Commissioner is likely to delay or refuse a contract application. This is because of the risk of challenge should the Commissioner delay or refuse an application. The Commissioner should be aware that when an application is refused, the unsuccessful applicant has the right of appeal and the Commissioner may be required to defend the decision to refuse the application at a hearing before the First-Tier Tribunal.

5.5 Preparing a Contract

The model mandatory and additional GOS contracts need to be amended to reflect the type of contractor. Contracts that are not amended to reflect the type of contractor are not fit for purpose and may not be legally binding. Annex 5.12 sets out the sections of the model contracts that the Commissioner is required to amend.

Clauses that are not relevant need to be removed and replaced with the text ‘Reserved’, as set out in the example below:

"1.1 Reserved"

Where clauses are deleted that included footnotes, the Commissioner should ensure that the footnotes are retained.

This approach to amendments will ensure that the clause numbering and footnotes throughout the contract are preserved. This is particularly important so that, when variation notices are issued, the numbering in the notices mirrors that in the contracts, reducing the workload on the Commissioner.

6 Contract Assurance

This policy sets out the assurance framework for GOS mandatory (premises) and additional (mobile) contracts. It sets outs the approach that the Commissioner needs to follow to ensure a consistent approach to contract assurance including:

- the timescale for an information request; and
- the process for a practice visit including premises, equipment, record keeping facilities and staffing arrangements for mandatory contracts.

6.1 Timescales for Assurance Process

Paragraph 14 of Schedule 1 of the GOS Regulations obliges a contractor to provide the Commissioner with any information that is reasonably required by the Commissioner for the purposes of, or in connection, with its GOS contracts or any other information which is reasonably required in connection with the Commissioner's functions. This requirement includes access to the contractor's NHS patient records.

The GOS contract assurance procedure is an important part of the Commissioner's duty of assuring high quality GOS to patients.

All GOS contractors are required to comply with the Quality in Optometry ("QiO") Level 1. QiO is a national quality assurance tool website (www.qualityinoptometry.co.uk) used by optical practices to assess their compliance with their GOS contracts and to assure, maintain and improve the services they provide.

The Commissioner should ask all contractors to submit the completed QiO checklist once every three years. Commissioners should seek the agreement of their Local Optical Committee's if they wish to take a phased approach. An example checklist is available in Annex 6.1. While completing the checklist, contractors can make notes beneath each question and these will appear on the final report. The dashboard for the checklist will indicate how many questions remain unanswered, as well as how many are compliant, non-compliant or not applicable. The contractor must also submit a checklist of evidence and a practice declaration (Annex 6.2) to demonstrate its compliance status. The contractor is not required to submit the evidence itself, which should be retained in the practice and can be confirmed at the practice visit if necessary.

The contractor should within eight weeks return the completed checklist to the Commissioner (as determined by NHS England) to allow the Commissioner to identify risks and benchmark all contractors. The current contract assurance cycle commenced in April 2016 and will complete by 31 March 2019.

6.2 Contracting Entity

Where a contractor has submitted its QiO checklist and it is unclear what organisational form the contractor is (individual, partnership, corporate body) or this does not match the known contractual form of the contractor then the Commissioner should either:

- contact the contractor asking them to clarify; and/or
- check the contractor's GOS contract to see what organisational type of contract has been issued. If the QiO does not match the contract or the Commissioner is still unclear, the form should be returned to the contractor for clarification. Any inconsistencies between the contractor and contract type should be clarified and rectified as soon as possible.

The Commissioner should note the responses from the contractor as this may indicate where the wrong contract type has been applied for and/or issued or where changes may have occurred without informing the Commissioner.

6.3 Action Plans for Non-Compliance

Where a contractor identifies sections in the checklist where it is non-compliant it is required to submit an action plan to the Commissioner which addresses each of these areas. The Commissioner should acknowledge the contractor's action plan using the template letter in Annex 6.4.

The plan will set out the section(s) where the contractor is not compliant together with a proposed timescale for ensuring compliance. The contractor should include any evidence to support its action plan. The timescale for completion should usually be 28 days from checklist submission but this can be amended by agreement.

The Commissioner will review the checklist and confirm any action plans. The Commissioner may request further clarification from the contractor if required, for example if further information is required regarding timescale or the content of the declared evidence.

The Commissioner should follow up any outstanding actions if evidence of completion has not been submitted before the deadlines set out in the action plan.

Throughout this process the Commissioner should be mindful of the nature and degree of any non-compliance and consider whether this is sufficiently serious to merit issuing a Breach or Remedial Notice. Please refer to the policy on contract breaches and termination (Chapter 7) for further information on Remedial Notices and Breach Notices.

6.4 Criteria for Visiting an Ophthalmic Practice

During the three year contract assurance cycle the Commissioner should prioritise the following for visits.

- Practices who have not complied with the data submission, submission of an action plan or complied with an action plan.

- Practices where there are concerns about contract delivery as identified by activity concerns, Key Performance Indicators or other information.

The Commissioner should also visit an additional 5% of contractors selected at random.

In accordance with Regulation 19 of the GOS Regulations, the Commissioner must write to the contractor in advance of the visit giving the contractor reasonable notice. A template letter can be found in Annex 7.5. A contract assurance visit should normally last no longer than one to two hours. The visiting team should include a member of the primary care commissioning team and an optometric adviser. Written evidence of the authority of the person seeking entry must be produced on request to the contractor.

If, during a visit, the contractor is unable to produce the necessary documentation and /or demonstrate that a policy or procedure is in place but had included it in their QiO checklist of compliance, the Commissioner will check the reason for this and assess the seriousness of the omission. Depending on that assessment the Commissioner may:

- require the contractor to produce the documentation within seven days
- issue a breach or remedial notice;
- refer for Post Payment Verification (PPV); or
- initiate performance procedures.

Following the practice visit the Commissioner will write to the contractor summarising the visit (see template letter in Annex 6.6). Any actions agreed during the visit will be detailed in an action plan together with timescales (see Annex 6.3 for template action plan). The timescales for completing actions will be agreed between the Commissioner and contractor. All actions should be completed within 28 days unless an alternative timescale is agreed.

The Commissioner should write to the contractor to acknowledge a returned action plan using the template in Annex 7.4.

7 Contract Breaches and Termination

This policy outlines the approach to be taken by the Commissioner when a GOS contract is considered to have been breached. This policy applies to both mandatory (premises) and additional (mobile) services GOS contract applications.

Given that any decision to issue a Breach or Remedial Notice, apply sanctions or terminate a contract or agreement can be challenged by the contract under appeal, it is essential that the Commissioner follows, and can demonstrate that it has followed, due process in investigating, communicating and implementing actions in this respect and that the Commissioner has acted fairly and reasonably throughout.

It is essential that the Commissioner maintains thorough and accurate records of all communications, discussions and decision-making in respect of all notices under this policy.

7.1 Contract Breaches

Where the Commissioner considers that a breach has occurred, there are a number of options on how to proceed. The Commissioner can:

- take no action;
- agree an action with the contractor;
- issue a Remedial Notice;
- issue a Breach Notice;
- apply a Contract Sanction; or
- terminate the contract.

Doing nothing and agreeing an action with the contractor are options that are always available to the Commissioner. The remaining options may only be applied in specific situations as envisaged by the contract.

The following paragraphs set out the relevant processes that the Commissioner must follow relating to:

- the issue of a Remedial Notice or a Breach Notice;
- the application of a Contract Sanction; and
- the termination of the contract.

The Commissioner must ensure that when undertaking these matters, it follows the proper internal processes, complies with any standing orders and considers all relevant factors.

7.1.1 Remedial Notice

Where a contractor has breached the contract and the breach is determined to be capable of remedy the Commissioner may issue a Remedial Notice to the contractor setting out the actions that must be taken to remedy the breach.

A flowchart highlighting the main steps that the Commissioner should take when issuing a Remedial Notice is set out in Annex 7.1.

The Commissioner must issue a Remedial Notice before it takes any other action it is entitled to take under the contract, except where the breach relates to the rights of termination set out below:

- contractor's inability to perform services;
- provision of untrue information;
- suitability;
- patient safety;
- material financial loss; or
- significant breach.

The Commissioner has a right to terminate the contract immediately for a breach of any of these conditions but must behave reasonably. These rights of termination are explained in more detail in section 7.3

A breach capable of remedy is where the breach continues but the contractor could take action to stop the breach. Examples of breaches that may be capable of remedy include:

- lack of sufficiently trained practice staff to deliver PoS checks; or
- failure to provide relevant information to the Commissioner.

Where the breach creates a serious risk to patient safety, the Commissioner can take more immediate action, regardless of whether the breach is capable of remedy or not. For further information on this, please refer to paragraph 7.5.8 of this policy.

Where the Commissioner has determined that a breach is capable of remedy the Commissioner must take the following steps:

- Initially the Commissioner should contact the contractor to discuss the breach and the action that they may be entitled to take, i.e. the issue of a Remedial Notice
- The contractor should be afforded the opportunity to provide an explanation as to the circumstances that led to the breach and this discussion should be recorded accurately in writing
- The Commissioner should then investigate the breach including any details recorded during the contractor discussion which are pertinent to the matter and examine any evidence in relation to the breach
- If the Commissioner is satisfied that the matter is a breach which is capable of remedy, then the Commissioner may issue a Remedial Notice to the contractor, requiring the contractor to remedy the breach
- It is important that when the steps above are undertaken, this is completed as quickly as is reasonably possible as long delays between the breach occurring, or the Commissioner becoming aware of the breach, and the Remedial Notice being issued could lead to an argument that the Commissioner has accepted the breach and waived its right to take action.

A Remedial Notice must specify:

- details of the breach, which led to the Remedial Notice being issued and any evidence gathered in respect of the breach;
- the steps the contractor must take in order to remedy the breach to the Commissioner's satisfaction;
- the period in which the steps must be taken;
- any arrangements for reviewing the matter to ensure that the requirements of the Remedial Notice have been met; and
- the actions that the Commissioner shall take if the contractor fails to satisfactorily remedy the breach.

The Commissioner may wish to include in the Remedial Notice how the Contractor may appeal against the decision to issue a Remedial Notice.

A template Remedial Notice is provided in Annex 7. 2.

The period during which the steps to remedy the breach must be taken must not be less than 28 days from the date that notice is given, unless the Commissioner is satisfied that a shorter period is necessary to protect the safety of the contractor's patients or protect NHS England from material financial loss.

The Remedial Notice must be delivered to the contractor in accordance with the notice provisions of the contract. This usually requires hand delivery or postal delivery (first class or registered post). Delivery of a notice by fax or email may be permissible. The Commissioner should review the relevant provisions to the contract to ensure proper delivery. Where the notice is hand delivered, the template Receipt Notice in Annex 7.3 can be used.

The Commissioner should ensure that arrangements are in place to follow up a Remedial Notice appropriately and in a timely fashion.

Where the Commissioner is satisfied that the contractor has taken the required steps to remedy the breach within the required period, a letter should be issued to the contractor informing them that the terms of the Remedial Notice have been satisfied and that no further action will be taken at this stage. A template Remedial Notice Satisfaction letter is provided in Annex 7.4.

Where the Commissioner is satisfied that the contractor has not taken the required steps to remedy the breach by the end of the required notice period, the Commissioner may inform the contractor that they have failed to meet the terms of the Remedial Notice and that the Commissioner may terminate the contract with effect from such date as the Commissioner may specify in a further notice to the contractor.

Where the Commissioner intends to terminate the contract, please refer to sections 7.5 to 7.7 of this chapter.

If, following the issue of a Remedial Notice, a contractor either repeats a breach that was the subject of a Remedial Notice or otherwise breaches the contract that results in a further Remedial Notice or a Breach Notice, and then the Commissioner has the right to terminate the contract by serving notice on the contractor.

The right to terminate in paragraph 7.1.1 above must only be used where the Commissioner is satisfied that the cumulative effect of the breaches is such that the Commissioner considers that to allow the contract to continue would be prejudicial to the efficiency of the services to be provided under the contract. Where the Commissioner intends to terminate the contract under this right, please refer to paragraph 7.3.

If the contractor is in breach of any obligation and a Remedial Notice in respect of that default has been given to the contractor, the Commissioner may withhold or deduct monies which would otherwise be payable under the contract in respect of that obligation which is the subject of the default.

7.1.2 Breach Notice

Where the contractor has breached the contract and that breach is not capable of remedy, the Commissioner may serve a Breach Notice on the contractor requiring the contractor not to repeat the breach.

A flowchart highlighting the main steps that the Commissioner should take when issuing a Breach Notice is set out in Annex 7.5.

Breach Notices cannot be issued where the breach relates to the rights of termination set out in section 7.1 For further information on these rights of termination; please refer to section 7.3 of this policy.

A breach that is not capable of remedy is where a breach occurs but either does not continue prior to a notice being issued or there is no action that can be taken to remedy the breach.

Examples of breaches that are not capable of remedy include:

- failure to maintain patient records; or
- failure to ensure GOC registration for a performer.

Where the breach creates a serious risk to patient safety, the Commissioner can take more immediate action, regardless of whether the breach is capable of remedy or not. For further information on this, please refer to paragraph 7.5.8 of this policy.

Where the Commissioner has determined that a breach is not capable of remedy, the Commissioner must take the following steps:

- Initially the Commissioner should contact the contractor to discuss the breach and the action that they may be entitled to take, i.e. the issue of a Breach Notice
- The contractor should be afforded the opportunity to provide an explanation as to the circumstances that led to the breach and this discussion should be recorded accurately in writing
- The Commissioner should then investigate the breach including any details recorded during the contractor discussion which are pertinent to the matter and examine any evidence in relation to the breach
- If the Commissioner is satisfied that the matter is a breach which is not capable of remedy, then the Commissioner may issue a Breach Notice to the contractor, requiring the contractor not to repeat the breach.

The Breach Notice must specify:

- Details of the breach and the requirement that the contractor must not repeat the breach again; and
- The consequences of the contractor further breaching their agreement;

A template Breach Notice is provided in Annex 7.6.

The Breach Notice must be delivered to the contractor in accordance with the notice provisions of the contract. This usually requires hand delivery or postal delivery (first class or registered post). The Commissioner should review the relevant provisions to the contract to ensure proper delivery. Where the notice is hand delivered, the template Receipt Notice in Annex 7.3 can be used.

If, following the issue of a Breach Notice, a contractor either repeats a breach that was the subject of a Breach Notice or otherwise breaches the contract that results in a further Remedial Notice or a Breach Notice, and then the Commissioner has the right to terminate the contract by serving notice on the contractor.

This right to terminate can only be used where the Commissioner is satisfied that the cumulative effect of the breaches is such that the Commissioner considers that to allow the contract to continue would be prejudicial to the efficiency of the services to be provided under the contract. Where the Commissioner intends to terminate the contract under this right, please refer to paragraph 7.5.11 of this policy.

If the contractor is in breach of any obligation and a Breach Notice has been issued, the Commissioner may withhold or deduct monies which would otherwise be payable under the contract in respect of that obligation.

7.2 Contract Sanctions

Contract Sanctions must not be applied to a contract unless the Commissioner is in a position to move to terminate. Where Contract Sanctions are applied, this is an alternative to terminating the contract. The Commissioner cannot apply Contract Sanctions and later decide to terminate the contract on the grounds of the same contract breach.

The circumstances in which the Commissioner may apply Contract Sanctions are those circumstances set out below where a right of termination arises. Please refer to the relevant right of termination in section 7.3 for further information on how these rights of termination arise:

- death of a contractor;
- contractor's inability to perform services;
- provision of untrue information;
- suitability;
- safety of the contractor's patients is at risk;
- NHS England is at risk of material financial loss;
- significant breach by the contractor;
- where the Commissioner is satisfied that the contractor has not taken the steps required by a Remedial Notice to remedy a breach within the required period;
- where, after a Remedial Notice or Breach Notice has been issued, the contractor:
    a) repeats a breach that was the subject of a Remedial Notice or a Breach Notice; or
    b) otherwise breaches the contract resulting in a further Remedial Notice or Breach Notice.

- where the contractor carries on business detrimental to the contract;
- where a person connected with the contractor is the subject of a direction under section 13F of the Opticians Act 1989 or an order under section 13H of the same Act;
- where changes in membership of the partnership is likely to have a serious adverse impact on the ability of the contractor or the Commissioner to perform obligations under the contract.

Such sanctions may involve:

- termination of specified reciprocal obligations;
- suspension of specified reciprocal obligations for a period of up to six months; or
- withholding or deducting monies otherwise payable under the contract.

The choice of which Contract Sanction to use would ordinarily depend on the nature of the breach, or cumulative effect, and what is felt to be the most appropriate and proportionate action in those circumstances.

Where the Commissioner decides that the most appropriate sanction would be to withhold or deduct monies, this must be calculated in accordance with set criteria in order to establish a consistent, fair and measured approach. Annex 7.7 provides further information on calculating a financial Contract Sanction.

Where the Commissioner decides to impose a Contract Sanction, the Commissioner must issue a notice of its intent to apply a sanction to the contractor which must include:

- the reason for the sanction to be applied;
- the nature of the sanction;
- if withholding or deducting monies, how this has been calculated and the duration of any such sanction;
- if services are to be terminated, which services and from what date;
- if suspension of specified reciprocal obligations under the contract or agreement, the period of that suspension and its end date;
- an explanation of the effect of the imposition of the Contract Sanction; and
- the contractor's right to appeal the decision to apply a Contract Sanction.

A template Contract Sanctions notice is provided in Annex 7.8.

The date that the Contract Sanction takes effect must not be until at least 28 days after the notice was served unless the Commissioner is satisfied that it is necessary to impose the Contract Sanction earlier to protect the safety of patients or protect NHS England from material financial loss.

Where a Contract Sanction is imposed, the Commissioner can charge the contractor reasonable administration costs of imposing the Contract Sanction.

If the contractor disputes the imposition of a Contract Sanction, the Commissioner must not impose the Contract Sanction until the dispute has been determined unless the Contract Sanction is necessary to protect the safety of patients or protect NHS England from material financial loss.

Where a dispute arises in relation to the imposition of a Contract Sanction, please refer to the policy on managing disputes (Chapter 10).

The Commissioner should ensure that arrangements are in place to monitor the contractor's compliance with a Contract Sanction notice.

7.3 Termination

Termination is a very significant action to take both on the part of the Commissioner and the contractor and is an area of high risk for both parties in respect of financial impact and continuity of services. It is essential that the Commissioner maintains thorough and accurate records of all communications, discussions and decision-making in respect of all notices.

Contractors have the right to appeal so it is essential that the Commissioner follows and can demonstrate that they have followed, due process in investigating, deciding on, communicating and implementing actions leading to termination.

It is essential that prior to moving to terminate a contract, the Commissioner is satisfied that they are fully within their rights to do so.

Legislation sets out certain rights of termination that are required to be in a GOS contract. These mandatory termination rights are set out below and explained more fully in section 7.3. Where the termination relates to a matter that is contained within an alternative policy, this is highlighted.

The contract may contain additional termination rights. The Commissioner should consider the relevant contract to ensure it is fully aware of all termination rights.

The following circumstances relating to rights of termination are required to be in a GOS contract:

- agreement of the parties;
- death of a contractor;
- contractor serving notice;
- late payment by the Commissioner;
- contractor's inability to perform services;
- provision of untrue information;
- suitability;
- patient safety;
- material financial loss;
- significant breach by the contractor;
- remedial Notices and Breach Notices;
- carrying on business detrimental to the contract;
- where a person connected with the contractor is the subject of a direction under section 13F of the Opticians Act 1989 or an order under section 13H of the same Act; and
- where changes in membership of the partnership is likely to have a serious adverse impact on the ability of the contractor or the Commissioner to perform obligations under the contract.

Contracts may also terminate by reaching their natural end dates, if relevant.

Where the Commissioner has considered all the relevant factors and has decided to proceed with termination, it must send a Termination Notice to the contractor.

A template Termination Notice is provided in Annex 7.9.

Where the Commissioner serves notice to terminate, the notice must specify a date on which the contract terminates that is not less than 28 days after the date on which the Commissioner has served the notice on the contractor. The Commissioner may state a date less than 28 days where this is necessary to protect the safety of the contractor's patients or protect NHS England from material financial loss.

Where the contractor disputes the Commissioner's decision to terminate the contract, the contractor may invoke the NHS dispute resolution procedure. In such circumstances, the Commissioner should follow the policy on managing disputes (Chapter 10).

7.4 Key Considerations on Termination

The Commissioner must establish that grounds exist under the terms of the contract to terminate. The Commissioner must follow due process and investigation of the facts and provide the contactor with the opportunity to provide a response to allegations, wherever possible.

The Commissioner must consider all relevant information available and decide on the appropriate course of action and whether the contract should be terminated.

Apart from considerations regarding whether the right to terminate arises, there are a number of common factors that the Commissioner should consider when termination is a proposed course of action. These factors are set out below.

This list is not exhaustive and there are likely to be other issues that need due consideration under these provisions. These considerations will also apply following the sudden death of a contractor (please refer to the policy on the death of a contractor (Chapter 11).

7.4.1 Continuity of service provision

NHS England has a statutory duty to ensure continuity of provision of primary care services. Termination of existing service provision may result in some persons not being able to access primary care services. The Commissioner must therefore consider how this duty will be discharged if it decides to terminate the contract.

If the Commissioner envisages that a new contract will be entered into with a provider, the Commissioner must consider how to procure that contract and to ensure it is in accordance with procurement law and any procurement protocol issued by NHS England.

7.4.2 General Duties of NHS England

NHS England has a number of statutory duties relating to the exercise of its functions including reducing health inequalities and patient involvement. The Commissioner must ensure that its actions in terminating a contract and any consequential actions ensure compliance with its general duties. Please refer to the Chapter 3 (General duties of NHS England) for more information on the scope of the duties.

7.4.3 Patient Records

GOS contractors will hold records about NHS patients in either paper or electronic form. When a contract is terminated these are normally passed securely to the new contractor(s) and the patients informed. Where the contact is being terminated and services are not transferring or being terminated, and the patient records have not already been passed to another practice of the patient's choice, the contractor will hand over the records to the Commissioner.

7.5 Rights of Termination

7.5.1 Termination with agreement of the parties

GOS agreements are required to contain a provision stating that both parties may agree to terminate a contract.

Where the parties agree to terminate, the parties must agree the date from which termination will take place and any further terms relating to the termination. Before agreeing the termination date, the Commissioner should ensure any proposed timescale allows the Commissioner to consider any other factors or actions that may be required prior to termination.

The contractor party may be composed of more than one person. The Commissioner must agree the same termination arrangements with all persons that constitute the contractor.

7.5.2 Termination due to death of a contractor

Please refer to the policy on the death of a contractor (Chapter 11) for further information.

7.5.3 Termination due to the contractor serving notice

GOS contracts can be terminated by the contractor by serving notice in writing at any time.

Where a contractor serves notice to terminate, it shall terminate three months after the date on which the notice is served.

If the date on which the contract will terminate is not the last calendar day of a month, the contract shall instead terminate on the last calendar day of the month in which the termination date falls.

7.5.4 Termination due to late payment

The contractor may give notice in writing to the Commissioner if the Commissioner has failed to make any payment due to the contractor under the contract. If the Commissioner has failed to make any such payment within 28 days of the notice, the contractor may terminate the contract by a further written notice.

Where the NHS dispute resolution procedure has been invoked by the Commissioner, within 28 days of the initial notice, the contractor may not terminate

the contract until either the NHS dispute resolution determination allows termination or the Commissioner ceases to pursue the NHS dispute resolution process.

For further information on the NHS dispute resolution process, please refer to the policy on managing disputes (Chapter 10).

7.5.5 Termination due to the contractor's inability to perform services

The Commissioner must terminate the contract where the contractor is an individual who is an ophthalmic practitioner and is suspended by the licensing body or suspended from an ophthalmic performers list.

The requirement to terminate only arises where the suspension leads to the contractor ceasing to be able to perform as an ophthalmic practitioner.

The requirement to terminate will not apply where:

- the contractor can satisfy the Commissioner that adequate arrangements are in place for the provision of services under the contract for as long as the suspension lasts; or
- the Commissioner is satisfied that the circumstances of the suspension are such that if the contract is not terminated immediately, the safety of the patients is not at serious risk and/or NHS England is not at risk of material financial loss.

7.5.6 Termination due to the contractor's provision of untrue information

The Commissioner may serve notice to terminate the contract immediately (or from any date set out in the notice) if, after the contract has been entered into, it comes to the attention of the Commissioner that written information:

- provided to the Commissioner before the contract was entered into; or
- provided to the Commissioner pursuant to paragraph 17(2) or 18(2) of Schedule 1 of the GOS Regulations; or
- which should have been notified under paragraphs 16 to 18 of Schedule 1 of the GOS Regulations,

in relation to:

- regulation 4 of the GOS Regulation; or
- suitability information in Schedule 3 of the GOS Regulations; or
- compliance with those conditions or that information,

was, when given, untrue or inaccurate in a material respect.

An additional right of immediate termination arises where the information that was not notified but should have been notified under paragraphs 16 to 18 of Schedule 1 of the GOS Regulations was material.

7.5.7 Termination due to the contractor's unsuitability

The Commissioner may serve notice in writing on the contractor terminating the contract immediately (or from any date set out in the notice) where a person or body connected with the contract (such as an individual, a partnership, a corporate body or a director) falls within any circumstances set out in the GOS Regulations. Those circumstances include where the person or body:

- is disqualified from practising by a licensing body;
- has been convicted of certain offences;
- has been adjudged bankrupt or insolvent (for more information on the consequences of termination due to insolvency, please refer to paragraph 8; or
- has been subject to a disqualification under the Company Director Disqualification Act 1986;

The full list of circumstances is set out in Annex 7.10.

7.5.8 Termination due to patient safety

The Commissioner may serve notice in writing on the contractor terminating the contract immediately (or from such date set out in the notice) where the contractor has breached the contract and, as a result of that breach, the safety of the contractor's patients is at risk if the contract is not terminated.

7.5.9 Termination due to material financial loss

The Commissioner may serve notice in writing on the contractor terminating the contract immediately (or from such date set out in the notice) where the contractor's financial situation is such that the Commissioner considers that NHS England is at risk of material financial loss.

7.5.10 Termination due significant breach by the contractor

The Commissioner may service notice in writing on the contractor terminating the contract immediately (or from such date set out in the notice) where the contractor has breached the contract and, in the Commissioner's judgement, that breach is so significant that it is inappropriate that the contract should continue.

7.5.11 Termination due to Remedial Notices and Breach Notices

The Commissioner has a right to terminate the contract where the Commissioner is satisfied that the contractor has not taken the required steps to remedy the breach by the end of the required period as stated in the Remedial Notice.

The Commissioner has a further right of termination where, following the issue of a Remedial Notice or Breach Notice, a contractor:

- repeats a breach that was the subject of a Remedial Notice or Breach Notice; or
- otherwise breaches the contract that results in a Remedial Notice or Breach Notice.

The further breach must have occurred after the breach which was the subject of the Remedial Notice or Breach Notice. The Commissioner may intend to issue a further Remedial Notice or Breach Notice for a breach that occurred prior to the original breach with the need to investigate or gather information delaying the issue of the notice. In these circumstances, the Commissioner cannot then rely on this right of termination as the further breach did not occur following the issue of the original Remedial Notice or Breach Notice.

This further right to terminate can only be used where the Commissioner is satisfied that the cumulative effect of the breaches is such that the Commissioner considers that to allow the contract to continue would be prejudicial to the efficiency of the services to be provided under the contract.

7.5.12 Termination due to the contractor carrying on business detrimental to the contract

Where the contractor is carrying on business which the Commissioner considers is detrimental to the contractor's performance of the contract, the Commissioner may give notice to the contractor requiring that it ceases carrying on the relevant business within a specified period (which must not be less than 28 days from the date the notice was given).

Where the contractor has not satisfied the Commissioner that it has ceased carrying on the business by the end of the notice period, the Commissioner may by further written notice terminate the contract immediately (or from such date set out in the notice).

7.5.13 Termination where a person connected with the contractor is the subject of a direction under section 13F of the Opticians Act 1989 or an order under section 13H of the same Act

Where the contractor is either:

- an individual who is a registered optometrist;
- a partnership and one of the partners is a registered optometrist; or
- a corporate body and it or a director, chief executive or the secretary of that body is a registered optometrist,

who is the subject of a direction under section 13F of the Opticians Act 1989 or an order under section 13H of the same Act, the Commissioner may service notice in writing on the contractor terminating the contract if the Commissioner considers that as a consequence, the contractor is no longer suitable to be a contractor.

7.5.14 Termination where changes in membership of the partnership is likely to have a serious adverse impact on the ability of the contractor or the Commissioner to perform obligations under the contract

A Commissioner has a right to terminate a GOS contract:

- where the contractor is two or more persons practising in partnership;
- where one or more partners have left the practice during the contract; and
- if the Commissioner reasonably considers that the changes in membership of the partnership is likely to have a serious adverse impact on the ability of the contractor or the Commissioner to perform its obligations under the contract.

Where this occurs, the Commissioner may terminate the contract by notice in writing on such date as is set out in the notice. The notice must contain the Commissioner's reasons for considering that the change in the membership of the partnership is likely to have a serious adverse impact on the ability of the contractor or the Commissioner to perform its obligations under the Contract.

7.6 Termination of Contracts Following Insolvency

Where an individual or company ceases to trade and where the individual or company is a GOS contractor they are likely not to satisfy the conditions imposed by Regulation 4 of the GOS Regulations. In such circumstances, the Commissioner must service notice on the contractor, terminating the contract forthwith.

The Commissioner may not be informed about the insolvency until it has happened.

Any residual payments due to the contractor in relation to the period before the contract was terminated should be made as instructed by the administrator or receiver.

7.6.1 Sale of viable practices

The administrator or receiver of an insolvent company may attempt to keep the company trading and to seek a buyer for some or all of the optical practices. The administrator or receiver may be unaware that, depending on circumstance, NHS England may be unwilling to continue the GOS contract while the company remains in administration or receivership.

Where a viable practice is sold to a company or individual that does not already hold a GOS contract, the new provider will be required to make a new GOS contract application. Such a new contract application will be subject to the usual requirements (please refer to the policy on contract applications (Chapter 5) for further information).

Where the application is successful, there may be a period during which the practice does not have a GOS contract meaning it may not treat NHS patients either by carrying out GOS sight tests or by issuing NHS optical vouchers.

These practices may however continue to trade in the private sector.

7.6.2 Winding up arrangements

Insolvency practitioners have as a primary duty to maximise the pay-out to creditors. The winding-up processes are likely to concern the supply of uncollected glasses and arranging the safe storage of patient records or their transfer to another local contractor. The Commissioner may need to work closely with the administrator or receiver to ensure that the winding-up arrangements are carried out appropriately and in the best interests of the former NHS patients of the insolvent contractor before making any remaining payments due under the contract.

7.6.3 Introduction to voluntary strike off and dissolution of companies

An application for voluntary striking off can only be made by a company and must be made on the company's behalf by its directors or a majority of them.

The company directors on the company's behalf will apply to the register at Companies House to be struck off the register and dissolved. They do this by completing a 'striking off application by a company'. Form DS01 is available on the Companies House website.

The reasons a company may wish to do this include:

- the directors wish to retire and there is no one to take over from them;
- the business model has not worked out for the contractor;
- the business is non trading or dormant; or
- the business no longer wishes to keep the company name.

The company is required to meet certain criteria in order to be eligible to apply for voluntary striking off. One of the conditions is that a company must not have traded or otherwise carried on business at any time in the last three months.

7.6.4 Termination of contracts following dissolution of a company

Contractors often are not aware that dissolving a company does not automatically lead to the termination of a GOS contract.

Ideally when a company is planning to apply to be struck off, it would be an ideal time to submit a termination notice to the Commissioner giving three months' notice, although a shorter-timescale may be reached if both parties agree.

Where the individual(s) plan to trade from the same premises to provide NHS services they will need to submit a new contract application.

Further information on processing new contract applications is available in the policy on contract applications (Chapter 5).

Where a Commissioner becomes aware a company is no longer trading, the contract will need to be terminated as set out in this document.

Where the same individuals are providing NHS services from the same premises under a different name, the Commissioner will need to contact them to advise that

they do not have a contract in place to provide NHS services and any claim for payment received will not be authorised.

7.7 Consequences of Termination

Contracts usually contain certain obligations on both parties on termination of the contract. The GOS Regulations do not set out any requirements for contracts to contain such provision but the model GOS Contracts contain a number of obligations including provisions relating to:

- co-operation in dealing with any outstanding matters;
- delivering up property owned by the other party; and
- carrying out a financial reconciliation.

8 Contract Variations

8.1 Introduction

This policy describes the process for making GOS contract variations, whether by mutual agreement or required by regulatory amendments, to ensure that any variation complies with legislation. It applies to both GOS mandatory (fixed premises) and additional (mobile/domiciliary) services contracts.

This policy does not cover all eventualities so a general contract variation notice is included in Annex 8.1. This can be tailored to fit the requirements of the GOS Regulations. The template also contains detailed guidance notes for completion.

Variations to contracts fall broadly within three categories:

- changes due to legislation or regulatory change;
- changes to delivery of the services, e.g. relocation of premises, inclusion of additional premises or removal of premises; and/or
- changes to the contracting party, e.g. partnership changes, 24 hours retirement and body corporate changes.

This policy provides guidance on these types of contract variations and how to amend contracts which may have varied without being properly recorded.

Both commissioners and contractors are reminded that the overriding aims during any contract variation process are to:

- ensure contracts reflect the reality of provision in accordance the GOS regulations
- safeguard continuity of patient care
- minimise bureaucracy for both contractor and commissioner whist ensuring that contracts and variations are up-to-date and properly recorded.

8.2 Amending contracts to reflect previous changes which may not have been recorded

Where the Commissioner needs to vary an existing contract, the Commissioner should take the opportunity to review the contract documentation. All contracts awarded before 1 April 2013 transferred from primary care trusts (PCTs) to NHS England. The Commissioner may therefore be faced with a mix of contract documentation.

Where there are multiple documents, e.g. the original contract and multiple contract variations, the Commissioner should consider whether to consolidate the documentation.

The Commissioner must keep a record of any previous contracts that existed and when and how they were varied. This is because referrals can be made to the NHS dispute resolution up to three years after the event and court proceedings can be

issued six years after the event. It is essential to maintain a clear record of the terms of all contracts as they were at any previous point in time.

Where the Commissioner considers that contract documentation should be consolidated, the Commissioner should normally use the most up to date version of the relevant model GOS contract. This will have been agreed with the Optical Confederation on behalf of all contractors.

This cannot be done unilaterally and will require the agreement of the contractor as:

- a new contract will need to be entered into;
- this will need to be signed by both parties; and
- the old contact will need to be simultaneously terminated.

In such circumstances, the issue of a new contract should not normally require a full new application or a practice visit. A letter from the contractor, accepting NHS England's proposal to replace the old contract and variations with a new contract incorporating the same, and stating that there have been no substantive changes to the detail of the old contract, should suffice

Where the Commissioner proposes to replace a contract with a model GOS contract, the parties should note that the previous contract may have had provisions (other than those provisions required by the GOS Regulations) that differ from the provisions in the model GOS contract.

If a new contract is not to be issued, the contract documentation could be consolidated by the Commissioner by amending the terms of the original contract in accordance with each variation agreed. This would provide a single "at a glance" reference document indicating only those terms that are presently applicable. It should be noted that such a document will be for reference only. The actual contract is the signed original taken together with the signed variations.

8.3 Legislation or regulatory change

Usually both parties to a GOS contract must agree a variation in order for it to take effect. The Commissioner may, however, vary the contract without the contractor's consent where it is reasonably satisfied that it is necessary to do so to comply with the NHS Act, any regulatory changes pursuant to the NHS Act or any direction given by the Secretary of State pursuant to the NHS Act.

The Commissioner must notify the contractor in writing of the wording of the variation and the date it will take effect. Where it is reasonably practicable to do so, the date the variation will take effect must not be less than 14 days after the notice is served.

There is no need for the Commissioner to seek agreement or require a signature of acceptance for this type of variation, as there is no right of refusal or negotiation.

The process for issuing a variation notice due to legislation or regulatory changes is as follows:

- a regulatory amendment is issued with an indication of when the amendment takes effect;
- a centrally issued GOS variation to the model GOS contracts may be issued but if not, the Commissioner should complete the general contract variation notice in Annex 8.1;
- the Commissioner notifies contractors of the contract variation, and advises contractors to keep a copy with their original contract of which it now forms part; and
- the Commissioner updates all electronically held contracts, retains a copy of the variation notice and updates the contract variation log.

8.4 Service Change

8.4.1 Premises

Mandatory GOS contracts are location dependent, i.e. the details of the location from which ophthalmic services are provided are contained within the mandatory services contract. Failure to seek agreement with the Commissioner before a change of premises could constitute a breach of contract and may lead to termination of the contract.

A contract variation is required where a contractor intends to:

- relocate the premises from which services are being provided;
- provide services from additional premises; or
- no longer provide services from a location.

An application form for the contract holder to relocate their premises is provided at Annex 8.13.

Where the contractor intends to relocate the premises from which services are being provided or provide services from additional premises, the Commissioner should complete and send Annex 8.2 to the contractor.

When the contract is to be varied to change the premises or add additional premises the Commissioner has to be satisfied as to the suitability of the premises, equipment, record keeping facilities and staffing arrangements. This should necessitate a visit before the variation is issued. Please refer to the policy on contract applications (Chapter 5) for more information.

If the premises are not found to be suitable but the contractor can carry out actions to make the premises suitable, the Commissioner should complete and send Annex 8.3 to the contractor.

If:

- the premises are found to be suitable; or
- the contractor carries out the actions required to make the premises suitable,
- the Commissioner should complete and send Annex 8.4 to the contractor enclosing two copies of the completed contract notice contained in Annex 8. 1.

If:

- the premises are not found to be suitable and there are no actions that the contractor can take to make the premises suitable; or
- the contractor was required to carry out actions to make the premises suitable but the Commissioner is not satisfied with those actions,
- the Commissioner should complete and send Annex 8.5 to the contractor.

The contractor cannot submit claims from a new premises' address until the contract has been varied.

Where the contractor intends to no longer provide services from particular premises, the reference to the premises will need to be removed from the contract. The Commissioner should complete and send Annex 8.6 enclosing two copies of the contract notice contained in Annex 8.1 completed as required.

8.4.2 Opening hours

Where a contractor requests to change its GOS hours (including those by appointment), this requires a contract variation. The Commissioner should complete the general contract variation notice in Annex 8 1 and send to the contractor with a covering letter.

8.5 Partnership Changes

Changes to the composition of a partnership will require variation to the contract.

Contracts may be varied where:

- an individual contractor changes to a partnership;
- a partnership changes to an individual contractor; or
- there are changes to the composition of partnerships.

8.5.1 Individual to partnership

If a GOS contractor is currently an individual who wishes to enter into partnership with one or more individuals under that contract, the contractor is required to notify the Commissioner in writing and provide the following information:

- the name of the person or persons with whom the contractor proposes to practise in partnership;
- whether the person or persons is an ophthalmic practitioner;

- confirmation that the person or persons satisfies the conditions imposed by regulation 4 of the GOS Regulations (please refer to chapter 5 (Characteristics of a GOS contract) for further information on regulation 4);
- an application form completed in accordance with Schedule 3 of the GOS Regulations;
- whether or not the partnership is to be a limited partnership and if so, who is a limited and who is a general partner; and
- the date on which the contractor wishes to change its status (which shall not be less than 28 days from date on which the notice was served on the Commissioner).

The notice must be signed by the individual contractor and by the person or persons with whom the individual contractor is proposing to practise in partnership.

Where a contractor contacts the Commissioner about changing to a partnership, the Commissioner should send Annex 8.7 to the contractor. The Commissioner should include the relevant application form with this letter. Please refer to the policy on contract applications (Chapter 5) for details of confirmation to be provided in accordance with Schedule 3 of the GOS Regulations.

On receipt of the information, the Commissioner must ensure the accuracy of the information provided. This may be achieved, for example, by checking the professional registration status of the proposed partner(s) with the General Optical or Medical Council (as the case may be) and that the proposed partner(s) meet the eligibility criteria for holding a GOS contract.

If the Commissioner is satisfied that the notice meets the relevant conditions, then the Commissioner should confirm in writing that the contract will continue with the partnership (see Annex 8.8) and issue a contract variation notice (Annex 8.1) accordingly to amend the relevant sections of the contract. The Commissioner must specify in the contract variation notice the date on which the contract will continue as a partnership. Where reasonably practicable this should be the date requested by the contractor in their initial notice, or the nearest date to it.

The contractor would then be required to return a signed copy of the contract variation notice. The Commissioner should ensure that the electronically held contract documentation is amended accordingly.

If the new partner is not accepted as eligible, the Commissioner should advise the contractor in writing of the reasons they believe the proposed partner(s) to be ineligible (see Annex 8.8) and confirm that the contract status will remain single handed until the matter can be resolved or a further notice is provided by the contractor proposing an alternative eligible partner.

8.5.2 Partnership to individual

Where a partnership is dissolved or terminated and the contractor consists of two or more individuals practising in partnership, the contract may continue with one of the former partners provided that the former partner is formally nominated to the Commissioner by the contractor to do so. Where the death of a partner occurs refer to the policy of death of a contractor (Chapter 11).

The nomination of the former partner by the contractor must:

- be in writing and signed by all of the persons who are practising in partnership; and
- specify the date on which the contractor proposes to change its status from that of a partnership to that of an individual; and
- be provided to the Commissioner at least 28 days in advance (where possible) of the date on which the contractor proposes to change its status from that of a partnership to that of an individual; and
- specify the name of the individual with whom the contract will continue, which must be one of the partners.

Where the contractor contacts the Commissioner about a change to an individual contractor, the Commissioner should provide Annex 8.9 for the contractor to complete and return. The Commissioner must acknowledge receipt of the information in writing before the date specified in the nomination as the date on which the contractor proposes to change its status from that of a partnership to that of an individual (see the template acknowledgement letter at Annex 8.10).

Where the Commissioner agrees the nomination, the Commissioner should include a contract variation notice (Annex 8.1) with the acknowledgement. The Commissioner may vary the contract but only to the extent that it is satisfied it is necessary to reflect the change in status of the contractor from a partnership to an individual. The contract variation notice should notify the contractor in writing of the wording of the proposed variation and the date upon which that variation is to take effect.

In circumstances where the Commissioner is not satisfied that the nominated partner is eligible to hold the contract as an individual they should state this in the acknowledgement letter (Annex 8.10) and enter into dialogue with all of the partners to explore potential solutions.

These might include the partners nominating an alternative partner to continue with the contract, in which case a new notice should be issued to the Commissioner to include these details and propose a new date on which the changes will occur.

8.5.3 Changes to the partnership

Where the contractor consists of two or more individuals practising in partnership and the composition of the partnership changes, either by a partner leaving (but without the partnership terminating) or a new partner joining, the contract will need to be amended to recognise the new partnership composition.

Where a contractor contacts the Commissioner about a new partner or partners wishing to join the partnership, the Commissioner should provide the contractor with Annex 8.11. On receipt of the information, the Commissioner must determine whether the partner fulfils the conditions required.

If the Commissioner is satisfied that the conditions are met, a contract variation notice (Annex 8.1) should be included in an acknowledgement letter (Annex 8.12). If the Commissioner is not satisfied that the new partner satisfies regulation 4 of the GOS Regulations, the contractor must remove the new partner within 28 days and if

the contractor does not do so, the Commissioner must terminate the contract with immediate effect or from such date as the Commissioner may specify in the termination notice. This wording is included in the acknowledgement letter in Annex 8.12.

The Commissioner should be aware that where the contractor is two or more persons practising in partnership, the Commissioner may terminate the contract where one or more persons have left the practice during the existence of the contract. This right of termination only arises where the Commissioner, in its reasonable opinion, considers that the change of membership of the partnership is likely to have a serious adverse impact on the ability of either the contractor or the Commissioner to perform its obligations under the contract.

If the Commissioner intends to use this right of termination, please refer to the policy on contract breaches and termination (Chapter 7) for further information on this right and on termination generally.

8.6 Retirement

8.6.1 Retirement of a contractor – single handed

There is no specific reference to retirement in the GOS Regulations. The Commissioner should deal with a request to retire as a request to terminate the contract by the contractor.

The contractor must provide the Commissioner with a written notification of the intended retirement date which will be the termination date of the contract. This notice period must not be less than three months. If the termination date is not the last calendar day of a month, the contract shall terminate instead on the last calendar day of the month in which the termination date falls. Where agreed by both parties, the contract may terminate earlier.

The model GOS contracts set out the arrangements that must be made on termination of a contract, which include (but are not limited to) the contractor having to:

- cease performing any work or carrying out any obligations under the contract;
- co-operate with the Commissioner to enable any outstanding matters under the contract to be dealt with or concluded satisfactorily;
- co-operate with the Commissioner to enable service users looking to use the contractor's services to be transferred to one or more other contractors or providers of mandatory services (or mobile services as the case may be).

On termination of the contract, the Commissioner will perform a reconciliation of the payments made by the Commissioner to the contractor and the value of the work undertaken by the contractor under the contract. The Commissioner must then serve the contractor with written details of the reconciliation as soon as reasonably practicable, and in any event no later than 28 days after the termination of the contract.

Each party shall pay the other any monies due within three months of the date on which the Commissioner served the contractor with written details of the reconciliation, or the conclusion of any NHS dispute resolution procedure, or court action as the case may be.

For a list of considerations relating to termination, please refer to the policy on contract breaches and termination (Chapter 7).

8.6.2 Retirement of a contractor – two or more partners/individuals

Where a partner wishes to retire from a partnership, as constituted from time to time, the contractor will need to notify the Commissioner that it wishes to vary the contract.

Where the partnership consists of two individuals practising in partnership, the retirement of one partner will result in the contract being held by an individual. The Commissioner should refer to section 8.5.2 of this policy.

Where the partnership is more than two individuals, the Commissioner should refer to section 8.5.3 of this policy.

8.6.3 Ophthalmic Medical Practitioner (OMP) Contractors – Twenty-four hour retirement

24-hour retirement is a process by which members of the NHS pension scheme seek to qualify for their retirement benefits whilst continuing to work (albeit with a break). This option is available to OMPs who are members of the NHS pension scheme. 24-hour retirement usually involves resigning from all involvement in an NHS contract, not returning to the NHS in any capacity for at least 24 hours and not working for more than 16 hours a week in the first month of retirement The Commissioner should ensure that it is aware of the current conditions around 24-hour retirement.

If the Commissioner is approached by a contractor wishing to take 24-hour retirement, it must not offer advice relating to pension arrangements.

Where a contractor confirms that 24-hour retirement requires "resignation" from the contract, steps will need to be taken to ensure that the contractor is removed from the contract, either by:

- termination on notice in the case of a single handed contractor; or
- variation of the contracting party in the case of a partnership as detailed in section 8.5.2 of this policy.

The Commissioner may wish to suggest that individual practitioners take independent advice, as 24-hour retirement using the method described above would necessitate the termination of the contract as set out in section 8.6.1.

The Commissioner must make clear to the contractor that where a contract is terminated, a person may only provide general ophthalmic services if a new contract has been issued. This application could be done in advance of the planned retirement date to ensure continuity of care.

8.7 Body Corporate Changes

Where the contractor is an individual or a partnership and wishes to form a body corporate to hold the contract, a variation is not possible. The parties will instead need to terminate the existing contract and the contractor will need to apply for a new contract in the name of the body corporate. A similar process will need to be followed where a body corporate wishes the contract to be held by a partnership or an individual.

It is a requirement for a corporate body to notify the Commissioner immediately when a new director, chief executive or secretary of a corporate body is appointed.

The notice must:

- confirm that the new director, chief executive or secretary meets the conditions imposed by regulation 4 of the GOS Regulations. Please refer to the chapter on the characteristics of a GOS contract (Chapter 4) for further information on eligibility requirements); and
- contain an application form in accordance with Schedule 3 in relation to that person. The application form should be the relevant Section B of the application form contained in the policy on contract applications (Chapter 5).

The Commissioner should carry out checks to ensure the accuracy of the information contained within the application form and confirm in writing to the corporate body that the relevant person is approved.

If the checks conducted produce unsatisfactory outcomes, then the corporate body should be notified immediately and given 28 days to remove the unsuitable director from office. Failing that, the Commissioner must terminate the contract immediately. Please refer to the policy on contract breaches and termination (Chapter 7) for further information on termination.

8.8 Bank Accounts

A contractor's bank account must reflect/be in the name of the contractor/legal entity that holds the contract, whether as an individual, a partnership or a body corporate. Bank accounts must not be in a trading name.

Bank accounts with a corporate body must be in the name of the corporate body and not a trading name. If in doubt the area team should check the registered company name at Companies House.

As a matter of good practice, where a contract is varied in accordance with this policy (with the exception of changes to new director, chief executive or secretary of a body corporate), the Commissioner must check with the contractor that payments are being made to the correct account.

Written confirmation of this should be obtained from the contractor.

9 Adverse Events

9.1 Introduction

Adverse events are dealt with in the force majeure provisions of the mandatory (premises) and additional (mobile) services model GOS contracts. Although these provisions are not required by the GOS Regulations, the model GOS contracts include them.

In cases of adverse events, the Commissioner should check whether the force majeure provisions as stated below are included in each contract and, if they are, follow the guidance in this policy.

Regardless of whether the contractor has a duty to inform the Commissioner of any adverse events likely to impact the delivery of the contract, it would be good professional practice to do so and is encouraged by the Optical Confederation.

9.2 Contract Wording

Clauses 201 to 204 of the model GOS contracts states that:

"201. Neither party shall be responsible to the other for any failure or delay in performance of its obligations and duties under this Contract which is caused by circumstances or events beyond the reasonable control of a party. However, the affected party must promptly on the occurrence of such circumstances or events:

> *201.1 notify the other party of such circumstances or events and of what obligation or duty they have delayed or prevented being performed; and*
>
> *201.2 take all action within its power to comply with the terms of this Contract as fully and promptly as possible.*

202. Unless the affected party takes such steps, clause 201 shall not have the effect of absolving it from its obligations under this Contract. For the avoidance of doubt, any actions or omissions of either party's personnel or any failures of either party's systems, procedures, premises or equipment shall not be deemed to be circumstances or events beyond the reasonable control of the relevant party for the purposes of this clause, unless the cause of failure was beyond reasonable control.

203. If the affected party is delayed or prevented from performing its obligations and duties under the Contract for a continuous period of 3 months, then either party may terminate this Contract by notice within such period as is reasonable in the circumstances (which shall be no shorter than 28 days).

204. The termination shall not take effect at the end of the notice period if the affected party is able to resume performance of its obligations and duties under the Contract within the period of notice specified in accordance with clause 203 above, or if the other party otherwise consents."

An adverse event is one which is caused by circumstances beyond the reasonable control of either the Commissioner or the contractor that could not have been avoided or mitigated with reasonable care and where the event has had a material effect on the fulfilment of the contract.

Examples of events that may invoke the force majeure provisions are:

- fire;
- flood;
- severe weather conditions and for which precautions are not ordinarily taken to avoid or mitigate the impact (for example a hurricane);
- industrial action which significantly affects the provision of public services or services upon which the party is reliant;
- death of a significant performer or close relative;
- pandemic disease or circumstances that might otherwise be considered “an act of God”;
- war;
- civil war (whether declared or undeclared);
- riot or armed conflict;
- radioactive, chemical or biological contamination;
- pressure waves caused by aircraft or other air-borne devices travelling at sonic or supersonic speed;
- acts of terrorism; and/or
- explosion.

Examples of events that would not be considered force majeure events are:

- refurbishment of practice premises;
- adverse weather in the winter months (including snow and ice);
- planned events (including elective surgery, leave, weddings and similar events;
- long term sickness, maternity/paternity or adoption leave.

9.3 Contract Compliance

All contractors are obliged under the terms of their contracts to promptly notify the Commissioner of a force majeure event, detailing the cause or event, what service provision is being delayed or prevented and what action(s) within their power they are taking in order to comply with the terms of the contract as fully and promptly as possible.

Failure to notify the Commissioner will mean that the contractor is not absolved from its obligations under the contract.

Neither party will be responsible to the other for any failure to delay in performing its obligations and duties under the contract which is caused by an event of force majeure

A template notification is provided in Annex 9.1 which the Commissioner can send to the contractor for completion.

9.4 Clinical Governance & Risk Management/Termination

If the force majeure results in a failure to deliver services which is significant and poses a risk to patient safety or the efficiency of wider primary care services, the Commissioner may wish to consider recording the incident on the risk register or consider whether it may invoke its termination rights.

If the service provision is delayed or prevented for a continuous period of three months then either party may terminate the agreement by notice in writing within a period which is reasonable (and no less than 28 days). This termination will not take effect where the service is resumed within the period of notice or if the contractor consents to this.

9.5 Appeals

The parties should refer to the policy on managing disputes (Chapter 10) for the process in relation to dispute.

9.6 Payments

The parties should discuss the effect of force majeure on payments by the Commissioner to the contractor. The Commissioner should use its reasonable discretion in determining payments with regard to the need for the contractor to continue to provide services once it is no longer affected by the force majeure event provided the contract has not been terminated.

10 Managing Disputes

10.1 Introduction

This policy describes the process to resolve and determine disputes between a GOS contractor and the Commissioner.

It applies to both mandatory (fixed premises) and additional (mobile/domiciliary) contracts.

10.2 NHS or non-NHS Contracts

The Commissioner must first ascertain whether the contract is an NHS contract or a non-NHS contract. This is set out in clause 14 of the standard GOS contracts.

An NHS contract (as set out at section 9 of the NHS Act) is an arrangement under which one health service body arranges for the provision of goods or services to another health service body. It does not give rise to contractual rights or liabilities.

A non-NHS contract, on the other hand, is a normal legally binding contract which can be enforced through the courts.

Contractors have the option to be regarded as a health service body, and hence have an NHS contract under Regulation 10 of the GOS Regulations.

Where a contractor has chosen to be regarded as being a health service body, its contract will be an NHS contract. Where a contractor has chosen not to be regarded as a health service body, its contract will be a non-NHS contract. Health service body status affects the eligibility and application process for NHS dispute resolution.

10.2.1 Dispute Resolution

GOS contracts require both contractor and Commissioner to make every reasonable effort to communicate and cooperate with each other with a view to resolving the dispute before either referring the dispute for determination in accordance with the NHS dispute resolution procedure or, where applicable, before commencing court proceedings.

There are two different routes that can be taken for resolving contractual disputes, depending on the contractor's health service body status:

- Where the contractor is a health service body and the contract is an NHS contract the steps laid out in this policy must be used to resolve all matters of dispute. The parties may not take a claim to court in relation to the contract.
- Where the contractor is not a health service body and the contract is a non-NHS contract, then the contractor can choose that the dispute either be resolved using the process described within this policy, or using the court system.

The use of the court system can be an expensive and public route. In normal circumstances, non-health service bodies may therefore choose to follow NHS dispute resolution instead.

Where the parties have followed this policy and the NHS dispute resolution procedure to the end determination the result is binding. A referral to the court system for a further ruling on the same issue cannot be made other than to enforce the decision as having the status of a County Court Judgement or to seek Judicial Review of the process.

10.3 Managing Disputes – Informal Process

The parties must make every reasonable effort to communicate effectively about any issue of dispute and must co-operate with each other to resolve the matter informally before considering referral to the formal dispute resolution procedure.

The use of an informal resolution process helps develop and sustain a partnership approach between contractors and the Commissioner.

The informal process may include (but not be limited to):

- regular telephone communications;
- face-to-face meetings at a mutually convenient location;
- written communications.

Most disputes should be able to be resolved at the informal stage, and either party may wish to involve the relevant professional representative body (e.g. an Optical Confederation representative body or LOC) to help achieve resolution. The formal process should not be initiated until the informal process has been exhausted.

It is essential that the Commissioner maintains accurate and complete written records of all discussions and correspondence on the contract file in relation to the dispute at all levels of dispute resolution. The Commissioner should ensure that it responds to contractor concerns and communications in a timely and reasonable manner.

10.4 Managing Disputes – Stage 1 (Local Dispute Resolution)

Where a dispute arises, the Commissioner should refer to the relevant policy that covers the issue giving rise to the dispute to check that due process has been followed.

Every reasonable effort to communicate and cooperate with each other must be made by both parties prior to invoking the first stage of the formal dispute resolution process. The timescales provided in this section are for guidance only.

The contractor should notify the Commissioner of its intention to dispute one or more decisions made in relation to its contract. This notification should usually be received no later than 28 days after the Commissioner advises the contractor of its decision, except in exceptional circumstances.

The Commissioner will immediately cease all action in relation to the disputed notice or decision, until:

- there has been a determination of the dispute and that determination permits the Commissioner to impose the planned action; or
- the contractor ceases to pursue the NHS dispute resolution procedure or court proceedings.

whichever is the sooner.

Where the Commissioner is satisfied that it is necessary to terminate the contract or impose a contract sanction before the NHS dispute resolution procedure is concluded in order to:

- protect the safety of the contractor's patients; or
- protect itself from material financial loss,

then the Commissioner is entitled to terminate the contract or impose the contract sanction at the end of the period of notice it served in accordance with the GOS Regulations (please refer to the policy on contract breaches and termination (Chapter 7 for more information).

The Commissioner should acknowledge the notification of dispute within seven days of receipt and request the submission of supporting evidence from the contractor within a further 28 days from the date they receive the letter. An example acknowledgement letter is provided at Annex 10.1.

Upon receipt of the evidence the Commissioner should review the evidence and invite the contractor to attend a meeting, which should be as soon as possible, and in any event within a further 28 days. The contractor has the opportunity to invite a representative body to support it at the meeting, e.g. its Optical Confederation representative body or LOC. An example invitation letter is provided at Annex 10.2.

Once the meeting has been held, the commissioner should notify the contractor in writing of the outcome of the meeting, whether this is that the dispute has been successfully resolved (refer to the example stage 1 outcome letter at Annex 10.3) or that it will now need to be moved to stage 2 of the NHS dispute resolution procedure (refer to the example stage 1 outcome letter at Annex 10. 4)

Either way the Commissioner should document the outcome on the contract file.

Where the matter is to be escalated to the next stage of the dispute resolution procedure, the Commissioner should ensure that the contract file is in order in case the FHSAU or court requests submission of evidence in respect of the dispute.

10.5 Managing Disputes – Stage 2 (NHS Dispute Resolution Procedure)

The informal process of resolution at stage 1 must be exhausted before proceeding to this stage 2 of the process. The Commissioner or a contractor wishing to follow this route must submit a written request for dispute resolution to the FHSAU, which carries out the NHS dispute resolution functions of the Secretary of State under the GOS Regulations. The request must include:

- the names and addresses of the parties to the dispute;
- a copy of the contract; and
- a brief statement describing the nature and circumstances of the dispute.

The request should also include:

- what the applicant sees as the appropriate outcome of the dispute; and
- confirmation that all local dispute resolution options have been exhausted.

The written request for dispute resolution must be sent within a period of three years from the date on which the matter giving rise to the dispute occurred or should have reasonably come to the attention of the party wishing to refer the dispute. Please see FHSAU determination reference 17156 for further details on the date that the dispute should have reasonably come to the attention of the relevant party.

Each party will be asked to prepare representations on the dispute, which will be circulated to the other party and an opportunity to provide observations on the other party's representations will be given. Again, the observations of each party will be circulated to the other party.

The Commissioner will be required to prepare documentation, evidence and potentially an oral presentation in response to evidence presented and should not underestimate the preparation that will be required. All records pertaining to the contractor may be required by the FHSAU, including (but not limited to) all contract documentation and contract variations, all written correspondence (both to and from the Commissioner and the contractor) and any electronic correspondence that may have passed between the parties, in relation to the dispute. This process will benefit from a clearly recorded contract file.

The Commissioner must ensure that records of communications and contract files are maintained to a high standard and all documentary evidence is collated correctly prior to submission to the FHSAU.

Once the FHSAU has reached a conclusion (the determination) the Commissioner will receive a copy and will be required to act upon it. A copy of a Guidance Note for parties involved in Dispute Resolution at the FHSAU is attached at Annex 10.5 and should be followed by the parties to the dispute.

10.6 Other Dispute Resolution Procedures

The GOS Regulations allow the NHS dispute resolution procedure to be used by the contractor as a means of resolving every dispute (except in the case of non-NHS contract disputes about matters dealt with under the complaints procedure).

Disputes may also arise prior to a contract being entered into. Such disputes may relate to the eligibility of the person seeking to enter into the contract or contract terms.

Where the Commissioner is of the view that a person seeking to enter into a contract does not meet the eligibility conditions (for eligibility conditions see chapter 5 - characteristics of GOS contracts), the Commissioner must notify the person in writing.

This notice must state the commissioner's view of the person's eligibility, the reasons for that view and guidance on the person's right of appeal.

Where the Commissioner has issued such a notice, the recipient of the notice has a right of appeal to the First-Tier Tribunal.

Before a GOS contract is entered into, there may be a dispute with the other party about a term of the proposed contract. This will be rare as it is preferable to use the relevant model GOS contracts. However, if there is a disagreement about a term of the contract, either party may refer the matter to the NHS dispute resolution procedure.

If the parties are both health service bodies, the dispute must be referred to the dispute resolution procedure as set out in section 9(7) of the NHS Act.

11 Death of a Contractor

11.1 Introduction

The aim of this policy is to provide consistency when dealing with the death of a contractor.

This policy applies to GOS contracts:

- for both mandatory (premises) and additional (mobile) services; and
- held by an individual and/or others in partnership.

This policy does not apply to GOS contracts with optical bodies corporate as they are held by a business rather than an individual and so the death in practice of a contractor cannot arise.

Where a GOS contract is held by a company limited by shares with a sole director and that director dies, the company's articles of association should stipulate the consequences. It is likely that the articles will require the shareholder(s) to appoint a new director.

It may be that the sole director is also the sole shareholder in which case, the articles will likely require the personal representatives of the shareholder to, by notice in writing to the commissioner, appoint a person to be a director.

11.2 Individual

Where a GOS contract is with an individual and that individual dies, the contract must terminate at the end of the period of seven days after the date of the contractor’s death unless, before the end of that period:

- the Commissioner has agreed in writing with the contractor's personal representatives that the contract should continue for a further period, not exceeding three months after the end of the seven day period; and
- the contractor's personal representatives have notified the Commissioner that they are employing one or more ophthalmic practitioner to perform ophthalmic services under the contract throughout the period for which it continues.

If the above option above is exercised, the Commissioner should issue a confirmation letter setting out the timescales of the continuation.

Where the Commissioner understands that another contractor may wish to enter into a contract in respect of the services which were provided by the deceased, the three month period may be extended by a period not exceeding six months as may be agreed.

11.3 Partnership

The GOS Regulations state that where the contract is with two or more individuals practising in partnership, the contract shall be treated as made with the partnership as it is from time to time constituted.

The default position in partnership law is that every partnership is dissolved as regards all the partners by the death of any partner. The partners can, however, change this position and agree between themselves that the partnership will not dissolve on the death of any partner. It is likely that most partnerships will have dealt with this issue in their partnership deed to avoid termination of their contract.

The GOS Regulations require GOS contracts to contain specific provisions relating to the dissolution of partnerships.

Where a partner dies, the GOS Regulations distinguish between GOS contracts that are entered into with a contractor that consists of only two individuals practising in partnership and those GOS contracts where the contractor consists of more than two individuals.

11.3.1 Two individual practising in partnership

Where the contractor consists of two individuals practising in partnership and the partnership is dissolved or terminated due to the death of one of the partners, the surviving partner must notify the Commissioner as soon as is reasonably practicable of the death of their partner.

Where the Commissioner receives such a notice, it must acknowledge receipt of the notice in writing.

The contract will continue with the surviving partner. The Commissioner may vary the contract but only to the extent that it is satisfied it is necessary to reflect the change in status of the contractor from a partnership to an individual. The Commissioner must notify the contractor in writing of the wording of the proposed variation and the date upon which that variation is to take effect. A variation agreement will need to be included with this letter.

To provide assurance that the individual is able to meet the contractual obligations, the Commissioner should discuss with the individual continued service delivery options bearing in mind the size of the practice, the range of services provided and any potential capacity issues.

11.3.2 More than two individual practising in partnership

Where there are more than two individuals practising in partnership, the death of one of the partners may result in the partnership being dissolved. This may not always be the case as the partnership arrangements between the partners may state that the partnership will continue or make other provision on the death of a partner that does not result in the dissolution of the partnership.

Where the partnership is not dissolved or terminated, the contract will continue and the provisions below will not apply provided that the partnership remains eligible to hold the GOS contract. Please refer to Chapter 5 (Characteristics of GOS contracts) for more information on eligibility requirements.

It is possible for the contract to continue where a partnership of more than two individuals practising in partnership is dissolved or terminated for whatever reason (which may be due to the death of a partner) and the contractor consists of more than two individuals practising in partnership. The contract may continue with one of the former partners provided the former partner is nominated by the contractor.

The nomination of the former partner by the contractor must be:

- in writing and signed by all of the persons who are practising in partnership; and
- specify the date on which the contractor proposes to change its status from that of a partnership to that of an individual; and
- be provided to the Commissioner at least 28 days in advance of the date on which the contractor proposes to change its status from that of a partnership to that of an individual; and
- specify the name of the individual with whom the contract will continue, which must be one of the former partners.

Where the Commissioner receives such a nomination, it must acknowledge receipt of the notice in writing before the date specified in the nomination as the date on which the contractor proposes to change its status from that of a partnership to that of an individual.

The Commissioner may then vary the contract but only to the extent that it is satisfied it is necessary to reflect the change in status of the contractor from a partnership to an individual. The Commissioner must notify the contractor in writing of the wording of the proposed variation and the date upon which that variation is to take effect. A variation agreement will need to be included with this letter.

11.4 Non-Continuation or Termination of the Contract

Where the contract is not to be continued, the Commissioner will need to terminate in which case refer to the policy on contract breaches and termination (Chapter 7) for further information on considerations relating to terminating a contract.

12 Procedure for Post Payment Verification visits to Optical Practices

12.1 Executive Summary

The Commissioner holds the General Ophthalmic Services (GOS) contracts with all Primary Ophthalmic Services contractors and is responsible for payments to contractors for these services. These payments include those for sight tests, spectacle vouchers, repairs and replacements and domiciliary visits.

Post Payment Verification (PPV) checks are necessary so that the Commissioner can have a reasonable level of assurance that the GOS claims being paid to contractors are in accordance with NHS regulations.

This policy includes all relevant paperwork for the different contractor types plus practice visit templates.

This policy details the arrangements for access by the Commissioner staff to records held by contractor, in order to verify that claims by contractors are made in accordance with the General Ophthalmic Services Contracts Regulations 2008 (the GOS Regulations) and the National Health Service (Optical Charges and Payments) Regulations 2013 (the OCP Regulations).

12.2 Policy Statement

Commissioners need to manage the PPV process themselves. The Head of Commissioning should be made aware of the results of PPV visits and the Head of Commissioning (or equivalent member of the Commissioner's management team) must be informed if a contractor faces recovery of significant sums and/or is referred to NHS Protect.

12.3 Scope

To outline a consistent approach to carrying out PPV by defining:

- The responsibilities of both Commissioners and contractors;
- Selecting practices to receive visits;
- The process to be followed prior to the visit, during the visit itself and after the visit;
- Patient enquiry procedures;
- Visit Outcomes;
- Dispute resolution.

12.4 General Principles

Listed below are the general principles that will govern the operation of this policy:

- Contractors and Commissioners will always treat each other with respect and understanding
- Commissioners will give contractors notice of PPV visits and will always seek to minimise disruption to the practice.
- Commissioners will be transparent with contractors regarding all aspects of the PPV process
- PPV is not a clinical process and therefore any clinical issues identified during the process will be referred to the GOS contract management team to be picked up under the GOS assurance process
- Commissioners will treat any information provided by the contractor and patients in accordance with all local confidentiality and information governance policies
- Commissioners will ensure that staff conducting PPV visits are appropriately trained in order to carry out these visits.

12.5 Management Information Systems

There is a range of performance data available to Commissioners from the Ophthalmic Payments System (Exeter System). This allows some management information to be generated electronically without the need to run large scale manual data capture exercises on GOS claim forms. The quality and detail available via these reports depends on the level of data input when GOS claims are processed for payment. i.e. processing of GOS claims in batches will severely limit the usefulness of this data.

Other data sources can be used in assessing if practices should receive a PPV visit e.g. complaints, soft intelligence, and data capture exercises.

Key Performance Indicator (KPI) data from the Exeter System allows trends in the payment of GOS claims to be observed and outlier information generated. This will assist in identifying those contractors who have unusual claiming patterns and assist in providing assurance that the exposure to inappropriate claiming by contractors is identified and minimised.

Commissioners should arrange appropriate access to the KPI regional reports from the payments system. The reports can be used to rank outliers against Commissioner (NHS England/former Primary Care Trust (PCT) data and national data (available from the Health and Social Care Information Centre). The reports can also be used to identify sudden or unexplained increases in payments/claim numbers.

It should be noted that data can be downloaded as a Comma Separated Values (CSV) file(s) and can be manipulated as needed in order to provide comparisons between domains.

12.6 Available Indicators

Initial monitoring will take the form of a number of measures to be compared with the average for the Commissioner and/or national averages.

The measures available from the Exeter payments system include the following:

- Ratios of sight tests to spectacle vouchers issued;
- Average cost of vouchers reimbursed;
- Percentage of tints prescribed per voucher;
- Percentage of second pairs of spectacles per voucher;
- Percentage of small frame supplements per voucher;
- Percentage of complex lenses per voucher;
- Percentage of repair/replacement vouchers to spectacle voucher;
- Percentage of prisms prescribed per voucher;
- Percentage of sight test forms endorsed with an early retest code (only available if GOS1 forms processed individually); and
- Practice Profile Performance Report.

KPI reports can be selected in different formats as either PDF or CSV files and can cover a range of time periods.

Other KPI reports are also available from the Exeter System along with General Purpose Audit (GPA) reports. GPA reports can be used to identify individual claims for examination during visits. These reports contain Patient Identifiable Data (PID). Selection of contractors for monitoring will initially be based on a mixture of computer-generated statistics and manual computations depending on how much historic data is available from the Exeter System.

Additional KPI’s are available from the Exeter System for Additional Contract holders.

The measures available include the following:

- Number of Domiciliary Visits per Sight Test
- Number of Full Domiciliary Visits per Sight Test
- Number of Part Domiciliary Visits per Sight Test.

As domiciliary contractors have to submit pre notification of sight tests to the Commissioner this opens up the opportunity for monitoring around comparisons between sight tests notifications and sight test claimed.

The monitoring process should also consider the extent to which patients are routinely seen for sight tests more frequently than the average claim intervals specified in the Memorandum of Understanding. However unless payments teams are processing GOS1 forms individually then access to this data will involve lifting data manually from claim forms.

12.7 Assessing Contractors for PPV

When assessing if a contractor requires a PPV visit the team should be mindful of the reports of any previous PPV visits to the contractor. An indication of high or unusual claiming patterns may have been reviewed by previous organisations. e.g. a contractor may claim for unusually high numbers of prisms but this may have been reviewed by the Commissioner and the contractor may have presented clinical reasons for this.

The Commissioner will naturally prioritise statistical outliers and practices with sudden changes in activity/payments for PPV. It is important to be aware that practices that are statistically neutral can still be submitting inappropriate claims and for this reason a programme of random PPV visits should also be undertaken. In order to ensure transparency the Commissioner should involve LOCs in the oversight of the practice selection process. Clearly it would be inappropriate for LOCs to be involved in practice selection itself.

The Commissioner should ensure that proposed PPV activity is discussed with LOCs and the wider optical community taking the opportunity to remind contractors and performers of the OCP Regulations and the requirement to carry out point-of-service eligibility checks with regards to patients presenting for an NHS Sight Test.

The Commissioner may also wish to assess new contractors after 6-12 months of operation as part of their PPV programme. This is because a new contractor may not have previous experience of complying with the OCP Regulations when claiming.

12.8 PPV Sample Size

The Commissioner will be mindful of the disruption that PPV can cause to a practice and therefore for an initial visit should consider a sample size of approximately 100 claims although larger sample sizes based on a percentage of claims submitted should be considered if repeat visits become necessary. The sample of claims should be from the preceding 12 months. The sample size should be no fewer than 100 claims or, where the service contractor is unable to provide the minimum sample size, all available claims for the relevant period. In circumstances where repeat visits are shown to be necessary then the Commissioner may wish to expand the sample size to be a fixed percentage of claims submitted (e.g. 3%-5%).

A percentage of the sample, but no more than 50% of the total sample taken, will be checked by Patient Enquiry, and the remaining percentage will be checked by the Practice Visit. The Commissioner should issue patient enquiry letters (see Annex 12.2) and patient questionnaires (Annex 12.3 and 12.4) in plenty of time so that any responses requiring clarification can be raised with the contractor during the visit.

All communication with patients should be treated with the upmost sensitivity and should not undermine the relationship between the patient and the contractor. All communication should emphasise the routine nature of the enquiry and the contractor should be advised that patients will be contacted to verify provision as part of the PPV process. The contractor will not be advised of the individual patients being contacted.

The contractor will be provided with a list of the claims being reviewed by the visiting team on the day of the visit. Details of claims being reviewed should not be made available to the contractor in advance.

12.9 Pre Visit Procedures

The purpose of the practice visit is to gain assurance that:

- There are adequate procedures for recording services provided to patients.
- There is a satisfactory understanding and application of the GOS Regulations and the OCP Regulations in respect of each claim type; and
- Systems exist to prevent errors and omissions, as far as possible, in the claims submitted.

In preparation for the visit, the Commissioner will select a representative sample of each type of claim made by the contractor. These should undergo a quality check to ensure that claims have met appropriate quality standards prior to payment. This will be particularly important if claims have been batch processed for payment.

12.10 PPV Visits

Visits to practices will be made by prior appointment (minimum calendar 21 days' notice) and timed so as to minimise the inconvenience to contractors and their staff. Advance notice will be given to the contractor of the names of those staff from the Commissioner who will be visiting.

Generally the PPV sample will be drawn from claims made in the preceding 12 months, should further repeat visits be considered necessary then the claims sample may be extended to up to 6 years. It is important that the Commissioner takes into account previous PPV visits when assessing timescales.

PPV visits to practices should not normally last more than half a day depending on the size of the visiting team and the number of records reviewed. Additional time may be required where staff from the Commissioner experience difficulty in verifying claims.

Normally two staff members from the Commissioner will undertake these visits. The composition of the team is at the discretion of the Commissioner, which will ensure that those who are involved in the post-payment checks, including those who visit practices, are aware of the need to respect patient confidentiality. Procedures will be consistent with guidelines issued by the Department of Health and contained in the document "The Protection and Use of Patient Information" which was issued on 7 March 1996 under cover of HSG (96)18. The Commissioner's PPV teams will be aware that their contracts oblige them to comply with Data Protection Act 1998, Information Governance requirements and maintain confidentiality at all times in respect of patient data.

A member of the practice staff should be available to assist the Commissioner's team and should normally include the contractor or their nominated representative. The presence of an optometrist during the verification process is at the discretion of the

contractor and the contractor may invite any other person to attend the visit, such as a LOC or Optical Confederation representative, should they desire to do so.

12.11 Procedures for PPV Visits

At the start of the visit, the Commissioner will provide to the contractor or their nominated representative, details of the sample claims they wish to inspect. The team will seek evidence from practice records of the service having been provided. Acceptable evidence of claims will include any, but not all, of the following documents:

- Patient attendance records/Appointments Book;
- Patient notes/ clinical records both ophthalmic and dispensing;
- Order Books;
- Supplier invoice documents;
- Sight Test/Dispensing records;
- Workshop records;
- Day books and ledgers.

Any or all of the above documents may be in paper or electronic format.

It is a GOS contract requirement that the patient records should be retained for a minimum period of 7 years. Other paperwork relating to supply should be retained for a minimum 6 years. Much of the documentation is required to be retained for longer periods than this by other agencies such as HM Revenue & Customs.

The visiting team will aim to achieve 100% confirmation/verification of the sample taken and will recover fees paid where this is not achieved. Should the visit show that the contractor has under claimed then reimbursement of the under claimed amounts will be made. It is accepted that occasional recording errors may occur but frequent and systematic recording errors will be a cause for concern.

12.12 Audit Process

If the visit identifies issues with the claims, then it may be appropriate for the team staff to look at:

- Systems and procedures within the practice for submitting each type of claim and for ensuring compliance with the GOS Regulations and the OCP Regulations
- Preparation of the claims for submissions to the Commissioner and who is involved
- Records maintained by the practice to provide evidence of services provided to patients
- Practice protocols regarding the provision of GOS services to patients
- Adequacy of procedures, for recording services provided by the contractor to patients

- Understanding and application of the regulations set out in the GOS Regulations and OCP Regulations in respect of each claim type

- Systems in existence to prevent errors and omissions, as far as possible, in the claims submitted

- Other information sources.

This will be a supportive process to enable the contractor to identify where errors have occurred.

Where access, by authorised staff from the Commissioner, to patient records for the purpose of verifying claims is considered necessary, it will be sought on the clear understanding that proper safeguards are observed about accessing confidential patient information. In particular, staff from the Commissioner will only request sight of records and information directly relevant to the stated purpose of their enquiry and only in respect of NHS patients.

Practice staff may facilitate the verification process by extracting the relevant records from the patient's clinical notes and showing them to staff from the Commissioner. The information supplied should be sufficiently comprehensive to verify the claim. With regard to a sight test the evidence required will be a clinical record of the sight test taking place. For GOS voucher claims the required standard will be evidence of the provision of the required item/product to qualify for the voucher claim.

When the patient records are computerised, practice staff should produce relevant information on the computer screen for the visiting team. There will normally be no need to produce the records in a printed format.

When reviewing sight test records as part of the PPV process the Commissioner will refer any quality concerns to the GOS contract management team to be picked up under the GOS assurance process (see action point 5 below). Recovery of sight test fees should only take place where there is no written clinical record that a sight test took place. Sight test fees should not be recovered if a record exists even if the record is incomplete. Interested parties should reference the following NHSLA case 17229 (February 2014).

12.13 Visit Outcomes

The contractor or nominated representative will normally be informed of the visiting team's early conclusions at the end of the visit. In cases where there is an area of concern or where fraud is suspected this will not always be possible.

Staff from the Commissioner will inform the contractor of any observations and advice about the practice's systems and procedures, and the level of services being provided. In this way the contractor has an opportunity to discuss any points immediately arising from the visit.

Follow-up visits may be required to verify changes to practice procedures where recommendations have been made by the Commissioner.

If systems are so inadequate that verification cannot be properly made, the contractor will be expected to make immediate improvements in their procedures. The Commissioner will provide assistance and support to help the contractor in the development of a more appropriate management model and contractors may wish to seek the support of their LOC or Optical Confederation representative body. Poor performance may also need to be managed through the appropriate contractual mechanisms such as breach notices and contract sanctions (see the GOS Regulations) and the NHS Framework for Managing Performer Concerns (Published July 2014).

Where it is ascertained that some claims have been submitted incorrectly or there are doubts about their validity, then certain actions will be taken by the Commissioner which may include:

Action 1

Extending the sample of claims, especially in the relevant claim type, to establish whether it is an isolated incident or a more widespread problem. This should take place as soon as possible after the original visit. This may be possible on the day of the visit if time allows but this should only be done with the agreement of the contractor.

Action 2

If a practice has been paid for claims that were incorrect, then the contractor and the Commissioner will agree a mutually acceptable timescale for the repayment of the fees involved and the method of recovery. This can be via a lump sum payment or instalments that can be offset against the monthly GOS payment made to the contractor. Details of the repayment arrangements should be set out in writing and the Commissioner should endeavour to avoid causing undue financial hardship to the contractor.

Where there is evidence of under claiming, reimbursement will be made to the contractor. Submission of amended claim forms to the Commissioner by the contractor will not normally be necessary.

In addition, the contractor will undertake to improve their systems so as to prevent any repetition of the errors in the future.

Action 3

Where the Commissioner is dissatisfied with the evidence or the explanations given in respect of errors found, the matter will then be referred to other parties, for example, the Optometric Adviser, internal auditors or the relevant Commissioner Group for comment and/or further action. The Commissioner may also extend its enquiries with patients if it is appropriate to the type of claim under review.

The Commissioner will report its findings, along with any recommendations, back to the contractor.

Action 4

If the Commissioner becomes aware of or suspects fraud, then it must refer this to NHS Protect at https://cfa.nhs.uk/reportfraud. The Commissioner should give a detailed description of the issues and include the PPV report if possible. The contractor should not be confronted about allegations of fraud as this may lead to important evidence being destroyed. The Commissioner must ensure that they consult NHS Protect about the appropriateness of continuing the PPV process following a referral.

Action 5

Although PPV is not a tool to assess contract compliance around clinical record keeping there may be occasions where PPV shows cause for concern in this area. The visiting team should communicate these concerns to the appropriate directorate within the Commissioner for further action.

12.14 Reporting Procedures

The Commissioner should aim to send the report (see Annex 12.5) on the visit to the contractor within 10 working days of the visit date.

The contractor will normally have one month to respond to the report and will be able to accept or query its contents. Should the report contents be queried then the contractor should provide written evidence of the reasons.

If the reports contents cannot be agreed between the parties the final report will be submitted along with the contractor’s comments to the Commissioner's management team for a decision on any further action as appropriate.

Each year the Commissioner will produce an anonymised summary of practices visited. This will be made available to the relevant LOC’s and/or the Optical Confederation for review and for general communication to contractors.

12.15 Co-operation of the Contractor

PPV visits are a financial fact-finding exercise and should not in any way be threatening to the contractors or undertaken in an atmosphere of mistrust. It is in the interest of contractors to co-operate fully with this protocol, which is designed to create understanding and trust between the Commissioner and contractors and to allow the visits to be informative for both parties.

All contractors are required to complete a self-assessment contract compliance questionnaire on a three yearly cycle. These assessments are rated on a RAG basis, with those practices in a red category or un-rectified amber receiving a compliance visit, along with a random 5% of those in the green category. This process is separate from PPV.

If a contractor refuses to co-operate with the Commissioner, for example, not allowing reasonable access to contractor-held records within the terms of this

protocol, the Commissioner will contact the Local Optical Committee (or in the case of Ophthalmic Medical Practitioners, the Local Medical Committee) and seek its assistance in resolving the problem as quickly and amicably as possible. The Commissioner reserves the right to take such further action as it deems necessary, including in extreme cases the suspension of further payment of ophthalmic claims to the contractor or take other contractual action in order to resolve the matter.

Most practices visited under these arrangements will hold a mandatory and/or additional GOS contract. The Commissioner should be aware that contractors may be dispensing only practices and thus will not be subject to the GOS contract and its provisions. These practices should be managed as per the OCP Regulations.