

## SCHEDULE 2 – THE SERVICES

### A. Service Specifications

The parties agree to work together during the lifetime of the contract to review the Service Specification on an annual basis.

<b>Service Specification No.</b>	Version 3
<b>Service</b>	Ophthalmology Triage, Tier 2, and Minor Surgery
<b>Commissioner Lead</b>	Lancashire and South Cumbria Integrated Care Board (L&SC ICB)
<b>Provider Lead</b>	iSight Ltd
<b>Period</b>	1 <sup>st</sup> April 2023 – 31 <sup>st</sup> March 2024
<b>Date of Review</b>	April 2024

#### 1. Population Needs

##### 1.1 National/local context and evidence base

###### 1.1.1 EVIDENCE BASE:

There is good evidence from the Department of Health to suggest that removing services traditionally delivered in secondary care settings and placing them in the community will improve access, reduce demand for secondary care services and consequently reduce overall waiting times for outpatient and inpatient hospital care. These types of services are a collaborative approach to clinical assessment and treatment at a more specialised level than is typically currently available in primary care. The services offer more community bases to patients therefore reducing demand for secondary care and releasing that capacity for those patients with more complex and urgent needs.

Current changes in health service provision and, as set out in the former NHS West Lancashire CCG's (now L&SC ICB) Strategic Plan, the ambition to drive up quality, improve efficiency and deliver value for money, are such that certain services and specialties will see changes in the delivery of care. Ophthalmology is a specialty specifically identified by the Department of Health (DoH) as being suitable for the relocation of a large proportion of work from being a hospital-based service to one that can be delivered closer to patient's homes in primary care under the "Shifting Care Closer to Home" Policy.

It was the intention of the former West Lancashire CCG (now L&SC ICB) to encourage a shift of appropriate services into more community-based settings. Services can be provided in such locations as health centres, high street locations (for example Opticians), GP practices, independent sector clinics, or other community-based settings – compliant with procedures being undertaken.

As the population ages, the incidence and burden of eye disease is set to increase. Many eye diseases are chronic in nature meaning patients must be managed over the long term. In England and Wales the number of cases of glaucoma, one of the most common chronic eye diseases, is likely to increase by a third by 2021. The eye diseases in the UK with the greatest incidence and highest care costs are cataract, chronic open angle glaucoma, age-related macular degeneration, and diabetic retinopathy.

###### 1.1.2 PURPOSE:

The purpose of this specification is to set out the requirements for a ***Triage and tier 2 and minor surgery service*** for Patients registered with a West Lancashire GP practice. The key aim of this specification is to deliver care at the heart of the community, which means outside of the acute hospital setting for many patients. This service will have consultant ophthalmologists at the core of the delivery, who will be responsible for ensuring that continuity and consistent quality of care is delivered by all members of the community ophthalmology team.

The vision is that people with ophthalmic conditions have access to high quality, effective and timely advice, assessment, diagnosis and treatment for their condition using integrated pathways across

primary, community and secondary care as appropriate. In addition, all patients should have the opportunity to be empowered to maximise their potential to self-manage and self-care. This can be achieved by improving access to information, advice and support. The approach is based on shared care and structured around the patient journey. Through better integration of services we can achieve a reduction in hospitalisation and provide better care and services to patients and carers alike, where and when they are needed.

## 2. Outcomes

### 2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	x
Domain 2	Enhancing quality of life for people with long-term conditions	✓
Domain 3	Helping people to recover from episodes of ill-health or following injury	✓
Domain 4	Ensuring people have a positive experience of care	✓
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	✓

### 2.2 Local defined outcomes

L&SC ICB is working towards more outcome focused services that:

- Offers all West Lancashire patients a high-quality service that is equitable, effective, efficient, responsive and affordable
- Contributes to the health and well-being of the people of West Lancashire
- Employs effective demand management of onward referrals into secondary care, if appropriate
- Ensures rapid access for to ensure patients are seen in the right place, by the right person at the right time
- Manages inappropriate referrals through education, support and feedback
- Delivers safe, appropriate and timely assessment, management and treatment of all ophthalmic procedures listed in this specification delivered in a community setting
- Manages regular follow up appointment for chronic conditions and communicates with the responsible consultant
- Delivers safe, appropriate and timely onwards referrals to secondary care
- Measures and monitors patient, carer and referrer satisfaction with services
- Delivers education and guidance to the patient, carer and referrer
- Improves quality of life for patients and carers

The service will include:

- A clinical triage for all Adult West Lancashire Ophthalmology referrals. Referral will be received from GPs / Opticians, A&E and urgent care centres.
- The undertaking of appropriate assessment and provision of treatment
- The development of evidence-based protocols and patient pathways for patients with ophthalmological conditions which clearly demonstrate good outcomes for patients, in conjunction with other relevant professionals
- Where relevant refer the patient to the appropriate professional for on-going management of their condition/treatment, in line with ICB policies and guidelines and the agreed patient pathway
- Patient referrals will be coordinated through a single point of contact via a relevant IT supporting infrastructure
- Appropriate onward referrals to Secondary Care
- Support collaborative working between Primary Care and Secondary Care
- Improve quality of referrals
- Return referrals that do not have sufficient information and offer advice/guidance to referring provider

### **3. Scope**

#### **3.1 Aims and objectives of service**

##### **3.1.1 AIMS**

- To deliver a safe, high quality and cost-effective community-based ophthalmology service for adults aged 18 and over, registered with West Lancashire for a defined range of eye problems
- To appropriately clinically triage all West Lancashire Ophthalmology referrals made into the Provider ensuring the service user is onward-referred to the most appropriate provider, ensuring that patient choice is offered.
- Deliver a culturally sensitive service
- Achieve a fundamental shift of care from the acute providers into the community so that the patients can access effective and high-quality services closer to home
- To offer patient choice of location as close to their homes as possible
- To ensure attendances in secondary care are appropriate
- To improve / promote patient self-management
- To involve the patients as an active partner in their care and in any decisions relating to their care and treatment
- To provide patients with the best care experience possible in a way that embodies the spirit and substance of the NHS Constitution
- To provide a single point of referral for all Ophthalmology referral
- To help achieve delivery and coordination of locally commissioned care pathways
- To provide relevant information to the referrers
- Over the lifetime of the contract, it is expected that the Provider will work with the ICB to continue to review the service and identify efficiencies that could be made

##### **3.1.2 OBJECTIVES**

- To operate to evidence-based pathways
- Demonstrate a movement in the clinical threshold for accessing services for assessment, diagnosis and treatment from secondary into community care
- Develop common seamless patient pathways of care and protocols ensuring there is no unnecessary duplication, and promote the integration and coordination of services
- Provide targeted assessment and follow ups, and co-management of specific chronic eye conditions within the community against an agreed set of protocols
- Demonstrate improved patient experience, quality of life and improved access for patients
- Deliver improved value for money by utilising this approach
- To promote patient independence through programmes supporting on-going health education
- To provide a responsive service achieving national and local waiting time targets
- To improve Primary Care education
- Improve access to treatment for patients
- To ensure that patients who are referred into the Triage services service are contacted within 48 hours to be offered an appointment with appropriate Provider and that all providers requiring a community-based service are offered an appointment within 14 days of the original referral
- Ensure that patients are seen by the most appropriate healthcare professional in the most appropriate setting – right person, right place, right time.
- Improve patient access and equity of provision
- Deliver a package of care that moves patients swiftly along an evidence-based pathway
- Build upon partnerships and collaborative working between organisations delivering various aspects of care along the pathway
- Support earlier assessment, diagnosis and initiation of appropriate treatment
- Release limited secondary care resources for activity that only they are able to provide to support the delivery of the referral to treatment times
- Support an innovative approach to service delivery (i.e., Extended working hours, new models of care, new technologies etc.)

- To deliver excellent and sustainable clinical outcomes to patients and adhere to relevant clinical guidelines and quality standards

### 3.2 Service description/care pathway

The former NHS West Lancashire CCG (now L&SC ICB) wished to procure a Triage and community-based Ophthalmology Services for service users Registered with a West Lancashire GP.

It is expected that the Provider will Triage all Adult West Lancashire Ophthalmology referrals received and ensures that Service Users are referred on to an appropriate Provider for their symptoms. The provider is expected to follow the referral guidance describe in 3.2.2.

Any red flag / suspected cancer referrals received by the triage service are to be passed through second care immediately

Where possible patients will be assessed and provided with the appropriate treatment / advice in a single visit.

The service will include:

- Triage of all Adult Ophthalmology referrals by the Consultant Ophthalmologist (or appropriately training clinician supervised by Consultant Ophthalmologist) to place patients on appropriate pathway
- Rapid access pathways for urgent referrals
- One stop service for most routine appointments
- Management of long-term conditions and supported self-management for patients with such conditions
- Support services for all who make an ophthalmology referral including a programme of education and training
- advice and guidance service to referrers

The service will at a minimum will investigate and/or treat the following –

#### **Lids, Lashes, Tears:**

Entropion, ectropion (involutional cases), mild blepharitis, watery eye due to blocked punctum, chalazion

#### **Red Eye:**

Bacterial conjunctivitis, viral conjunctivitis, allergic conjunctivitis, sub conjunctival haemorrhage, episcleritis, iritis/iridocyclitis/uveitis, scleritis (Initial diagnosis)

#### **Red Eyes and Corneal conditions:**

Small corneal foreign bodies, corneal ulcer, superficial corneal abrasions, pterygium, pingueculae, contact lens induced corneal infection, keratitis, herpes simplex/zoster

#### **Vitreous:**

flashers and floaters, floater, vitreous detachment, vitreous haemorrhage

#### **Glaucoma:**

Screening for suspected glaucoma or ocular hypertension per agreed criteria.

Glaucoma refinement management

Follow up of stable chronic open angle glaucoma (COAG) per agreed protocol.

**Age Related Macular Degeneration\*:**

Initial screening for Wet versus Dry AMD and adherence to 1 week referral to treatment requirement for Wet AMD

Review of Dry AMD

Low vision service for patients with confirmed dry AMD who are not eligible for treatment

**Lazer Treatment:**

laser iridotomy, goniopuncture, YAG laser

The service does not include emergencies, trauma or malignancies. Referrals must be made direct to secondary care eye service immediately.

Specific clinical requirements:

Glaucoma

The following tests should be offered for all people who have COAG, who are suspected of having COAG or who have OHT:

- IOP measurement using Goldmann applanation tonometry (slit lamp mounted)
- Central corneal measurement (CCT) measurement
- Peripheral anterior chamber configuration and depth assessment using gonioscopy
- Visual field measurement using standard automated perimetry (central thresholding test)
- Optic nerve assessment, with dilatation, using stereoscopic slit lamp biomicroscopy with fundus examination

Ensure that all of the following are available at each clinical episode to all healthcare professionals involved in a person's care:

- Records of all previous tests and images relevant to COAG and OHT assessment
- Records of past medical history which could affect drug choice
- Current systemic and topical medication
- Glaucoma medication record
- Drug allergies and intolerances

We envisage use of OCT as a valuable clinical tool for glaucoma diagnosis and detection of progression.

- (The intra-observer variability in optic disc evaluation has been reduced by use of ocular coherence tomography (OCT), which produces excellent visual records and provides quantification of exact cup:disc ratio and areas of neuroretinal thinning.)

The latest NICE Guidance should be followed

Once the service is fully established, the provider is expected to work with the local secondary care Provider to open this Service up to existing stable glaucoma patients and facilitate transfer for those who choose to do so. The ICB will support wherever possible this transition.

AMD

The community-based ophthalmology services will provide patients with confirmed Dry AMD with advice, support, ongoing monitoring, and possible access to Low Vision Services. This will include ensuring information / educational leaflets are accessible for patients, including information about local sight loss charities and information about smoking cessation, instructions on self-monitoring for progression and contact details if progression occurs.

Wet AMD – The Royal College of Ophthalmologists Guidelines on AMD say that a patient with suspected wet AMD should be referred to a retinal specialist on the same day and seen within one week. The Provider is expected to onward-refer patients with suspected AMD to the community AMD Provider as soon as is practically possible.

Key Constraints:

The scope does not include:

- Inpatient and emergency care services
- Preventative services that do not prevent outpatient attendances
- Diabetic retinopathy screening and treatment
- Cases of suspected cancer
- Wet AMD
- Cataracts

There is an expectation that the Provider, with the support of the ICB, will work with the local Trust to step down appropriate stable glaucoma patients into the community-based service.

To deliver these outcomes the provider must deliver pathways that:

- Do not encourage unmet need and consequently increasing in volumes over time
- Do not lead to an increase in patients attending the GP for a prescription
- Provide enough expertise in the Service to minimise onward referral to the HES
- Ensure that those referred direct to the HES are deflected to the Service
- Ensure that those who attend A&E / UCC or call NHS 111 / IUCS are redirected into the Service where possible.
- Minimise unnecessary attendance at the HES
- Maximise whole systems value for money
- Ensure appropriate cases are managed through the Minor Ailments Scheme delivered by local community pharmacists

The service will have a suitable level of clinical delivery, supervision and leadership and will be consultant led. This means that a consultant will be accountable for the delivery of the service available and on site while the service is open and involved with the delivery of care.

The model of care will:

- Utilise the skills of clinicians such as optometrists to bring 'care closer to home' for patients with appropriate conditions.
- Reduce hospital appointments thereby increasing capacity for patients with more serious conditions.

In addition, commissioners and patients will need to be reassured that providers are appropriately training and up to date and have direct pathways of care across a range of providers.

Services will be provided by a range of healthcare professionals working across a variety of settings, enabling patients to access care closer to home, reducing waits and unnecessary visits to hospital which will lead to better health outcomes. Services will be provided by specially trained healthcare professionals, enabling patients to access care closer to home, reducing waits and unnecessary visits to hospital which will lead to better health outcomes.

The ICB expects the Provider to keep up to date with NICE Guidance and national standards for Ophthalmology services

### **3.2.1 ACCESSIBILITY/ACCEPTABILITY**

The new ophthalmology services will offer flexible access for patients in community-based settings for the assessment, treatment, and long-term management of a range of eye conditions. The service must be responsive to the needs of patients, and this must be reflected in the hours that the service is open for business.

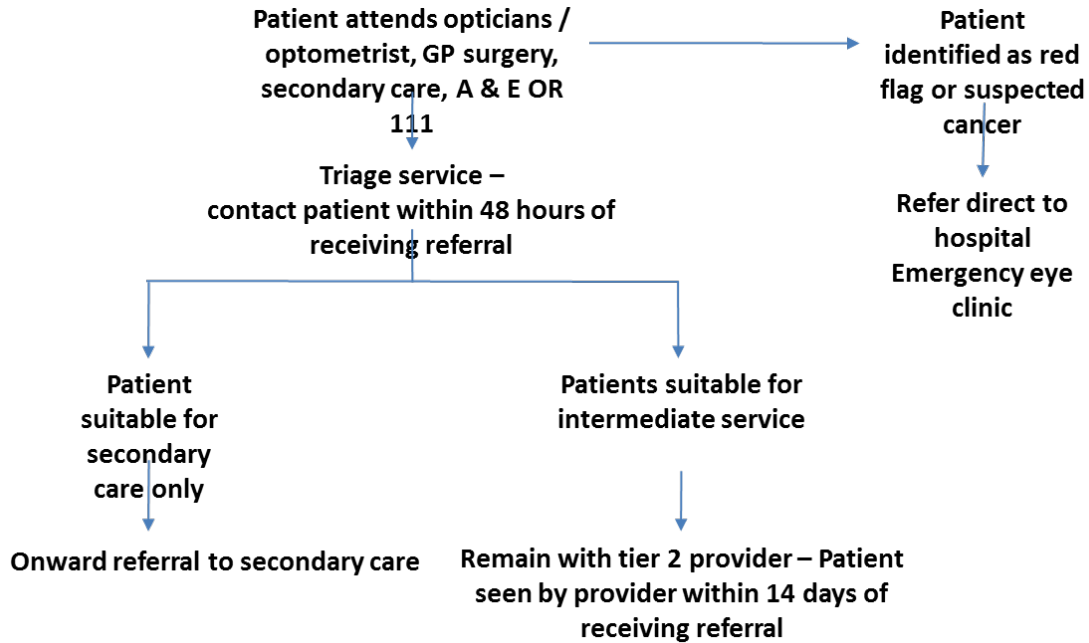
The service is a consultant led community eye service, to be delivered in accessible community locations. It includes utilising the wider multi-disciplinary team to help deliver care closer to home. All West Lancashire patients with suspected or established ophthalmological conditions will have equity of access to seamless, integrated and outcome-based pathways of care.

The service will be available at a minimum Monday – Friday 09.00 – 18.00, excluding Bank Holidays with flexibility to provide additional appointments for patients unable to attend during working hours, as required. In line with national expectations the Provider should be working towards 7/7 working.

The Service should ensure that it follows the terms of conditions of the NHS Standard contract in terms of the Equality and Diversity standards.

### **3.2.2 REFERRALS**

- Referral into the service will take place when an accredited healthcare professional (GP, Optometrist A&E, Walk in Centre, Out of Hours service) directs a patient, with their agreement, to a healthcare professional in the community Ophthalmology Service to be triaged and seen or referred on as appropriate.
- The community Ophthalmology must be able to receive referrals from all of the above sources and then inform patients that they have an assessment appointment by sending out notification to them.
- The community Ophthalmology Service must setup their service as an assessment service on the NHS e-referral Service (e-RS). There are two types of assessment service available on the e-RS:
  - Clinical Assessment Service (CAS)
  - Telephone Assessment Service (TAS)
- If the CAS setup is used patients must be able to attend the appointment to progress their referral. If the TAS setup is used patients must be able to telephone the Community Ophthalmology Service or be telephoned on the date and time of the appointment they are given to progress their referral.
- Where referrals are submitted by General Practices to the Provider these must come via the NHS e-Referral Service Any referrals from General Practice that are not submitted via the NHS e-RS should be accepted in the first instance but then also reported back to the GP that this will be phased out over time with details provided regularly to the commissioner to be followed up. Referrals received from any other Provider that is currently not set up on NHS e-RS must be added to the NHS e-RS by the Community Ophthalmology services.
- The Provider must work with those Providers not currently on NHS e-RS to ensure that a secure referral process is in place – following Information Governance guideline - and that a process is developed over time to move these providers to booking patients directly into NHS e-RS service.
- All referrals should be triaged by an Ophthalmology Consultant, or an appropriately trained clinician supervised by a Consultant Ophthalmologist to assess appropriateness and then decide the onward pathway for each referral. The outcome of the triage should be recorded on the e-RS.
- The referral must undergo the initial triage by the receiving provider within two days from receipt of referral.
- Where the services required by the patient can be provided by the Triage Provider the Patient should be given a choice of location, where they would prefer to be seen and of an appropriate appointment time. This appointment or appointment request should be created on NHS e-RS with the details given to the patient.
- Where the patient needs to be referred to another provider (where appropriate) to receive their care, the patient should be given a choice of provider and appointment time. This appointment or appointment request should be created on NHS e-RS with the details given to the patient.
- The provider will provide appropriate clinical and onward referral information (where appropriate) and clinical information on discharge from the service to the patients GP. Patients will receive a written copy of their discharge letter from the service.



### **3.2.3 CLINICAL ASSESSMENT**

- Clinical Assessment requires a face to face meeting between the patient and an appropriately accredited healthcare professional at which an assessment of the patient's condition is undertaken. This may include appropriate diagnostic tests. This stage should occur as soon as practicable following triage.
- The term diagnostics refers to any investigative tests carried out to aid and support the identification and extent of the patient's condition.
- A range of diagnostic tests of varying complexity and availability will be required to support clinical assessment and its outcome. It is expected that wherever possible, these tests will be available at the time of clinical assessment to achieve the aims of a 'one stop shop' approach. Reporting of these diagnostic tests must be timely and appropriate to clinical need.

### **3.2.4 TREATMENT**

- Any surgical interventions within the service will typically be confined to those procedures undertaken under local anaesthetic and not requiring an overnight stay. Treatment may also consist of a variety of therapies and other non-surgical interventions. There must be an evidence base for all treatments offered within the service and local and national guidance should be followed as appropriate.
- The provider should demonstrate innovative models of care. All services should provide a full range of self-help and information for patients.
- Treatments undertaken within the service, if at all possible, will be delivered with no review appointment unless this is clinically indicated. However, it is recognised that patients with long term ophthalmic conditions such as stable glaucoma will require routine appointments. Any complications directly linked to the episode of treatment must be dealt with by the service provider.



- The provider will be responsible for ensuring that any patients who do not attend their appointment are followed up as appropriate.
- Onward referral to a secondary provider for investigations, treatment or interventions requires the patient to be directed back to the designated infrastructure that manages referrals for a choice of service provider. A full treatment plan must be made available to the receiving provider including the results of tests and recommended procedures.
- At all stages, opportunities should be sought to offer evidence-based health promotion advice and brief intervention to patients.

### **3.2.5 CARE PATHWAYS**

- The providers shall be expected to develop pathways which will include advice for GP practices staff, Optometrists, Walk in Centre and A&E Clinicians regarding appropriate assessment and diagnostics to be completed prior to referral, the threshold for referral, together with advice regarding ongoing support and management.
- Providers of the community service shall immediately refer directly to the locally available secondary care provider patients assessed as requiring urgent examination or treatment within the acute sector. The new care services must interface seamlessly with hospital-based services to ensure direct patient pathways exist in the event that patients are referred onwards.
- The service will act as a conduit to assist the patient to access the range of information, advice and education services available locally or nationally to facilitate supported self-care
- At all stages of the patient pathway, patients should be offered appropriate patient pathway information and they should be signposted early, and at regular intervals, to a range of local and national advice and support services

### **3.2.6 ACCESS**

Potential Providers may propose such opening times as they are confident will accommodate their indicative activity levels and the maximum waiting times, as well as supporting accessibility requirements.

All patients referred into the triage services are to be contacted within 2 working days of the referral being received. Patients whose treatment falls into the remit covered by the tier 2 Provider should be seen for their first appointment within 2 weeks.

The Provider will be responsible for administrative arrangements such as clinic referral letters and the scheduling of appointments.

The Provider will ensure that written communication with visually impaired service users follow the guidelines recommended in <https://www.actionforblindpeople.org.uk/donate/leave-a-gift-in-your-will/professionals/tips-producing-printed-material-blind-partially-sig>

### **3.2.7 WORKFORCE**

The Clinical workforce for the service that the ICB wishes to commission could include but is not limited to the following:

- Community Optometrists;
- GPs with special interest in Ophthalmology (GPwSI);
- Consultant Ophthalmologists;
- Associate Specialists in ophthalmology;
- Ophthalmic Medical Practitioner;
- Orthoptists; and
- Ophthalmic Nurses

### **Workforce standards**

Notwithstanding main contract clause GC5, the main resource of any provider is a workforce made up of a mix of clinical professionals (as indicated above) committed to providing safe, effective care to all patients, at all times and in all situations.

The Provider will enable the workforce to deliver on this commitment, now and into the future, by promoting and providing high quality relevant education and training for every member of the workforce individually and in teams.

In order to fulfil its obligation to deliver the service the Provider will undertake appropriate workforce planning activities to ensure its capacity and demand modelling will deliver the required activity.

### **Qualifications and Mandatory Training**

All staff must be appointed in line with professional qualifications / standards as appropriate and continue to update skills in line with professional codes of conduct. The Provider must maintain a record of the dates and training given to all clinicians and staff working within the service. All such records should be immediately available to the Commissioner for audit purposes on request. The Provider must ensure that training requirements and competencies are monitored through regular assessment and staff appraisal and that staff are enabled to progress through supported learning

No healthcare professional shall perform any clinical service unless he / she have such clinical experience and training as are necessary to enable him / her properly to perform such services. The Provider shall be responsible for ensuring that their staff:

- Have relevant professional registration and enhanced checks undertaken prior to seeing patients alone;
- Have, prior to starting in post, provided two references (clinical if applicable), relating to two recent posts (which may include any current post) as a health care professional which lasted for three months without a significant break, or where this is not possible a full explanation and alternative referees;
- All access robust induction training applicable to their individual role;
- Have access to and evidence of safeguarding training and development in line with their professional bodies' recommendations; and
- Undertake annual audit to ensure compliance with the above.

### **Workforce requirements**

The Provider must have in place a comprehensive, coherent, robust plan for recruitment, management and development of staff with the principle objectives to:

- Meet the essential day to day staff leadership, management and supervisory needs to the contract during its lifetime, including during mobilisation and, if appropriate, contract termination;
- Adhere to TUPE legislation (as applicable);
- Support the provision of safe, high quality clinical services;
- Ensure through appropriate audit, training and continuous professional development that all staff involved in treating NHS patients are and remain qualified and competent to do so;
- Support the implementation of all relevant statutory and non-statutory NHS standards, regulations, guidelines and codes of practice;
- Maintain an effective working partnership with local NHS employers to continuously develop and maintain best people management practices and ways of working; and
- Reduce dependency on agency or locum staff to delivery services, such use not to exceed 10% unless in extreme circumstances.

The Provider must have in place a recruitment and retention strategy. This must:

- Be capable of attracting and retaining high quality job applicants;
- Optimise individual skill levels and potential;
- Fully harness available skills and commitment; and

- Encourage and engender support for new ways of working.

There are continual challenges to the UK's viability to opt out of the Working Time Directive on a European basis and therefore to sustain the future viability of this service the Provider must have in place a working hour's policy which ensures the health and wellbeing of staff and users of the service. This policy must also cover the working hours of clinical staff outside of the service, and in particular, the Provider must ensure they have a mechanism in place which supports them in reviewing and monitoring the hours worked by clinical staff and assuring themselves that the service they provide is safe. The Provider must have in place a staffing strategy to meet specified levels of service that identifies the requirements for support ancillary staff services. The strategy should include contingency plans for times of high demand and/or high levels of staff absence. The Provider must have in place mechanisms for keeping the commissioner informed when staffing capacity is unlikely to meet demand and the actions that will be taken to address this. It is expected that the Provider will have in place mechanisms to actively review and monitor the working hours of all staff members. The Commissioners reserve the right to carry out unannounced audits to assess compliance.

### **Workforce standards**

The Provider must ensure that all proposed workforce strategies, policies, processes and practices comply with all relevant employment legislation applicable in the UK.

In addition, the Provider is required to comply with the provisions of the following policies and guidance as amended from time to time:

- NHS Employment Check Standards, March 2008 (revised July 2010);
- Registration with Care Quality Commission (<http://www.cqc.org.uk/>);
- Criminal Records Bureau Code of Practice and Explanatory Guide for Registered Persons and other recipients of Disclosure Information published by the Home Office under the Police Act 1997 (revised April 2009) ("Code of Practice on Disclosure");
- The DH's guidance on the employment or engagement of bank staff, if any;
- Any guidance and/or checks required by the Independent Safeguarding Authority or any other checks which are to be undertaken in accordance with current and future national guidelines and policies;
- All guidance issued by the Care Quality Commission including the guidance entitled "Compliance: Essential Standards of Quality and Safety (March 2010)" and any other guidance issued by the Care Quality Commission from time to time;
- The Code of Practice for the International Recruitment of Healthcare Professionals (December 2004) [www.dh.gov.uk/assetRoot/04/09/77/34/04097734.pdf](http://www.dh.gov.uk/assetRoot/04/09/77/34/04097734.pdf) ;
- The Cabinet Office Statement entitled "Principles of Good Employment Practice (December 2010);"
- The Cabinet Office Statement; and
- All relevant employment legislation and codes of practice applicable in the UK.

The Provider has the following responsibilities in line with the delivery of this service:

- Initial Training and Accreditation for clinicians, such as Optometrists or GPwSI, including protocols and conditions to be obtained by the Provider and to be signed off by the Commissioners;
- To ensure that all members of the service maintain their knowledge and skills by keeping up to date with the ophthalmic literature, attending meetings and participation in in-house academic sessions. This requirement would be assessed during an annual appraisal;
- To provide clinical education to practices within the locality to support further development of their knowledge and skills in the on-going management of patients; and
- To ensure that all professional staff are supported to undertake clinical supervision in line with the relevant statutory body requirements

### **3.3 Equipment**

It is the responsibility of the provider to purchase, maintain to a high standard and replace all relevant equipment required to provide the service. Equipment required includes the following (**this is not an exhaustive list**):

- Threshold Visual field screener and printer
- Slit lamp
- Goldmann contact tonometer
- Direct and indirect Ophthalmoscope, retinoscope,
- Amsler Charts
- Epilation equipment and 28-gauge needle for removal corneal FB's
- Diagnostic drugs (mydriatics, stains, local anaesthetics, etc)
- Volk lens 78d, 28d, plus fundus contact lens, gonio and 3 mirror lenses
- Visual acuity chart
- Indenter
- Pachymeter
- OCT machine
- All other equipment necessary to provide an adequate service

All machines and measurement instruments (e.g. tonometers) must be calibrated regularly according to manufacturer's instructions.

The provider will:

- Ensure the equipment meets the requirements of the service
- Arrange for the provision of substitute equipment to ensure continuity of the service where necessary
- Ensure equipment complies with statutory requirements, including health and safety standards, and appropriate British standards concerning the inspection, testing, maintenance and repair
- Maintain records open to inspection by the ICB of the maintenance, testing and certification of the equipment
- Train and regularly update staff in the safe and compliant use of equipment

### **3.4 Information Management and Technology**

The provider must ensure that appropriate IM and T systems are in place to support the services. IM and T systems means all computer hardware, software, networking, training, support and maintenance necessary to support and ensure effective delivery of the services, management of service user care, contract management and of the service business processes. Please refer to Services and General Conditions in the NHS Contract.

### **3.5 Prescribing**

Prescribing and medication will be required for 14 days (or such shorter period of a full course of medication as appropriate. Full courses must be supplied) post discharge from the community service and will be provided as part of the service and included in the price.

The Provider is a Prescriber and will pay the drug costs for the service. The provider will also be responsible for dispensing costs, as defined below will not be the responsibility of the Provider at the rate defined by NHS England

[http://www.nhsbsa.nhs.uk/PrescriptionServices/Documents/PrescriptionServices/NHS\\_Reforms\\_factsheet\\_4\\_v2.0.pdf](http://www.nhsbsa.nhs.uk/PrescriptionServices/Documents/PrescriptionServices/NHS_Reforms_factsheet_4_v2.0.pdf)

"Dispensing Services" means the provision of drugs, medicines or Appliances that may be provided as pharmaceutical services by a medical practitioner in accordance with arrangements made under regulation 20 of the Pharmaceutical Regulations;

"Prescriber" means:

- (a) a medical practitioner;
- (b) a Pharmacist Independent Prescriber;
- (c) an Independent Nurse Prescriber; and

- (d) a Supplementary Prescriber
  - (e) an Optometric Independent Prescriber
- who is either engaged or employed by the Commissioner;

The parties agree to monitor and review the drug cost every quarter following the commencement date.

The Provider is responsible for drug costs for acute conditions for the initial prescription.

The Provider is responsible for all drug costs for glaucoma patients at the first outpatient appointment and shall continue to dispense the necessary medicines for the first 14 days until the patient is referred back to the GP for ongoing management and treatment. For clarity, the Provider shall retain responsibility for any patient who fails to tolerate the initial drug or has treatment failure and requires a change in therapy; whereby the Provider shall bear the costs of any further treatment and drug costs.

Drug choice will be made in line with local guidelines from Lancashire Medicines Management Group

### **3.6 Population covered**

Patients registered with a West Lancashire GP practice of a population of approximately 110,000 people

### **3.7 Any Acceptance and Exclusion criteria and thresholds**

The tier 2 service will accept:

Adults over the age of 18 who require treatment and management for the Acute and Chronic conditions listed in section 3.2

The Provider is responsible for all diagnostics necessary to treat and manage the Acute and Chronic Conditions listed in the section 3.2

This excludes any patients requiring MRI, CT and GDX, who should be referred to secondary care for diagnosis and any management. This is subject to review by both parties.

If in accordance with good clinical practice the Provider is of the opinion that a patient should be onward-referred, then it shall comply with any existing Care Pathways.

#### **3.7.1 EXCLUSION CRITERIA**

The Tier 2 service is not available to:

- Patients not registered with a West Lancashire GP
- Patients who require emergency treatment
- Patients with post-operative or post-traumatic complications
- Patients who require a second surgical opinion
- Cases where cancer is suspected based on agreed protocols with primary and secondary care or;
- Two-week cancer referrals
- Patients requiring Diabetic Retinal Screening
- Follow up post cataract surgery appointments
- Patients under the age of 18

### **3.8 Interdependence with other services/providers**

The service will be dependent on referrals from West Lancashire GPs, Optometrists and Health Professionals and the Provider will work collaboratively with stakeholders in the local health economy and to develop shared care pathways and joint working across primary and secondary care.

The Provider will develop strong relationships with:

- Primary care and local Optometrists
- Acute secondary care
- Other community providers
- Lancashire Eye Health Network
- The wider community of patients and the public.

The Provider needs to develop their relationships with other Providers to become an integral member of the health and social care community as it is critical that good working relationships are formed. This includes any other community providers of eye services and third sector organisations providing treatment, help and support for patients to ensure they receive the best care in the most appropriate setting. The development of local clinical networks will be encouraged with the aim of providing parallel services which provide complementary services allowing for further clinical services to be offered closer to home and within the community.

#### **4. Applicable Service Standards**

##### **4.1 Applicable national standards (e.g., NICE)**

It is the responsibility of the Provider to ensure the implementation of all relevant NICE guidance relating to ophthalmic conditions and low priority procedures as directed by the Commissioner's Risk & Clinical Governance Committee, Commissioner's Board and Public Health Directorate

##### **4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g., Royal Colleges)**

Providers must comply with all national legislation or regulations pertaining to eye services and the management of patients who present for treatment.

The Provider should ensure that the appropriate CQC registration is in place.

##### **4.3 Applicable local standards**

Patients will have access to evidence based, integrated pathways of care. Local referral guidelines should be underpinned by evidence-based knowledge and accepted guidance e.g. NICE guidelines. These should conform with and contribute to local governance arrangements for health and social care.

The key features of clinical care should be based on the premise that these services will be delivered locally and should include:

- The care of the patient must be in line with national guidance and evidence-based practice including NICE guidance
- Regular updating and up skilling of knowledge and skills must be completed by all participating clinicians
- Participation in shared care protocols to enable monitoring of patients with stable well controlled disease.
- Adhering to published referral guidelines

##### **Governance Domain**

###### **Clinical Governance**

1. The organisation has a clinical governance lead.
2. There are systems for ensuring sound clinical and corporate governance.

###### **Information Governance**

3. A robust records management system is in place, covering all stages of records management, data confidentiality issues and patient consent.

#### **4.3.1 DEVELOPMENT OF A PATIENT CENTRED SERVICE**

Clinical services must be patient-focused and of a high quality resulting in high patient satisfaction levels, delivered in an environment that provides a positive patient experience using correct clinical facilities by appropriately qualified clinical staff. The Provider will need to ensure that service provision is adapted to meet the needs of vulnerable people, people with learning and physical difficulties and mental health needs.

## 5. Applicable quality requirements and CQUIN goals

### 5.1 Applicable quality requirements (See Schedule 4)

#### Contract management and reporting

As well as following the NHS Standard national reporting requirement the Provider will be required to present local monthly activity and key performance indicator reports to the ICB, this is to include but not be limited to the following information:

Activity Reporting-Split by GP practice code:

#### Triage

- Total number of referrals received into triage service
- Total number of service users suitable for tier 2 service
- Total number of service user stay with tier 2 provider
- Number of service users referred on to secondary care / alternative Provider

#### Tier 2 service

- Total number of patients referred into tier 2 services
- Number of conditions presented
- Number of sessions per month per service
- Number of service users seen within each session
- Number of new appointments within each session
- Number of follow-up appointments within each session
- Number of service users discharged at first appointment
- Number of DNAs
- Number of cancellations / re-scheduled appointments
- Waiting times

Key performance Indicators:

No	KPI Descriptor	Rating
1	Referrals to be clinically triaged and onward referred to appropriate service with 2 working days	99%
2	Referrals to tier 2 service be offered a first appointment that is within 14 days from referral being received	99%
3	Service users with suspected Wet AMD to be referred to local specialist services within 24 hours of referral being triaged	100%
5	Service user satisfaction rating	> 90%
6	DNA rate	5%
7	Cancellation Rate	5%

8	Details of information, support and training offered GP practices and Opticians	?
9	Decrease of overall Ophthalmology referrals year on year over the lifetime of the contract	?

On the anniversary of the contract a review will be conducted. The provider must regularly provide information to reassure the ICB that the service continues to deliver value for money and that the terms and conditions of the contract are being met.

Over the lifetime of the contract, it is expected that the Provider will work with the ICB to continue to review the service and identify efficiencies that could be made. As a result of the education programme for Optoms and GPs the ICB is confident that it should expect to see overall ophthalmology referral decrease

. The ICB will reserve the right to immediately terminate the Contract if the activity and the KPI reporting and the clinical audits are not completed within stated time frames and to the satisfaction of the ICB, or there is a failure to deliver the service in line with the specification.

**5.2 Applicable CQUIN goals (See Schedule 3)**

**6. Location of Provider Premises**

Locations and frequency of clinics should be as convenient to patients as possible, and this will be a key criterion for evaluation.

There must be a minimum of 3 locations across West Lancashire for clinics, 1 in each neighbourhood. The neighbourhoods are:

1. Northern Parishes (Parbold, Burscough, Tarleton, Banks)
2. Skelmersdale
3. Ormskirk and Aughton

Minor Surgery should be provided within West Lancashire or within a 3-mile radius.

The premises should be accessible by public transport and should have parking facilities available or very nearby. Premises should also be accessible by patient transportation service vehicles for those users with a medical need for transportation.

The provider must demonstrate that the premises are fit for purposes and are compliant with all relevant Building Regulations and requirements, are DDA compliant and are clean and comfortable.

The provider will be expected to negotiate where appropriate facilities exist and ensure that all diagnostic equipment can be housed safely.

**7. Individual Service User Placement**

**7.1 Ophthalmology Pricing Model**

The Provider will only be reimbursed for activity which has followed the referral pathway as per the Service Specification paragraph 3.2.2

Payment is made for complete episode of care for acute conditions (as specified in the Service Specification)



Notes:

- No additional payment will be provided for the undertaking and administration of referral clinical triage; this is included in the Complete episode care for acute conditions
- The unit price for acute conditions is a pathway price. Where clinically appropriate follow-up appointments must be provided for service users however there shall be no additional payment for follow up appointments.

The Provider will source and supply all licenses, venues, interpreter services, staff and materials and cover all associated costs in the delivery of the Triage and the Community Based Ophthalmology service. The Provider will also be responsible for the publicity of the services, however support will be available from commissioners where appropriate.