SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	1
Service	Community Ophthalmology Service
Commissioner Lead	NHS Lancashire and South Cumbria ICB
Provider Lead	Community Health and Eye Care (CHEC)
Period	01/04/2023 – 31/03/2024
Date of Review	June 2022

1. Population Needs

1.1 National context and evidence base

The incidence and burden of eye disease is increasing steadily as the population ages. Many eye diseases are chronic meaning patients must be managed over the long term. The eye diseases in the UK with the greatest incidence and highest care costs are cataract, chronic open angle glaucoma, age-related macular degeneration (AMD), and diabetic retinopathy.

Fight for Sight (www.fightforsight.org.uk), the eye research charity highlights the prevalence of eye conditions:

- Every day 100 people in the UK start to lose their sight;
- Almost 2 million people in the UK are living with significant sight loss, predicted to rise to around 2.3 million by 2020 and almost 4 million by 2050;
- Around 360,000 people in the UK are registered blind or partially sighted
- An estimated 25,000 children in Britain are blind or partially sighted; and
- 86% of people in the UK value sight above any other sense

In 2008, the leading eye health and sight loss organisation across the UK developed the *UK Vision Strategy* to enable them to deliver a united approach to delivering change (this Strategy was refreshed in 2013). The *UK Vision Strategy* is the UKs response to the World Health Organisation (WHO) Global Action Plan for the Prevention of Avoidable Blindness (formerly the VCISION 2020 Action Plan).

The Strategy aims to transform the eye health of the UK and enable those with sight loss to receive timely treatment and support so they can live independent lives. The updated strategy (2013 – 2018) seeks to achieve three outcomes (www.ukvisionstrategy.org.uk) :

- Everyone in the UK looks after their eyes and sight;
- Everyone with an eye condition receives timely treatment and, if permanent sight loss occurs, early and appropriate support; and
- A society in which people with sight loss can fully participate

With the rising prevalence, hospital eye attendances are increasing rapidly with over 10 million outpatient appointments in England alone in 2013/14, up from 5.5 million in 2008/9 (www.rcophth.ac.uk). This increase is largely due to the ageing population but also because previously untreatable conditions have become treatable, transforming the outlook for people who would have inevitably have gone blind in the past. Wet-AMD, DMO and RVO are prime examples.
Hospital Eye Services (HES) have failed to keep up with many becoming overloaded. As a result, the Department of Health, Royal College of Ophthalmologists (RCOphth) and College of Optometrists have worked together to modernise care within HES' and to provide guidance to enable more care to be delivered in the community. This includes an enhanced role for community and non-medical practitioners.

1.2 Clinical Context

The Department of Health (DH) has specifically identified Ophthalmology as a specialty in which of a large proportion of work can be shifted from a hospital-based service to one delivered closer to patient's homes. Current community ophthalmology services include:

- Glaucoma Referrals Refinement Services
- Cataract Referral Refinement Services
- Minor Eye Conditions Service to include some procedures such as eyelid surgery and YAG lasers.

1.2.1 Glaucoma

Chronic Open Angle Glaucoma (COAG) is a common condition affecting an estimated 480,000 people in England and accounting for 14% of UK registrations for blindness. It causes optic nerve damage and loss of the visual field that can lead to blindness if not diagnosed early and treated promptly.

However, there are usually no symptoms until the later stages of the disease when vision is already seriously damaged and so most people with the condition are unaware that their eyesight is at risk.

Ocular Hypertension (raised pressure in the eye, OHT) is a major risk factor for developing COAG, although COAG can occur with or without raised eye pressure. Glaucoma is more common with increasing age and people of African descent; or a family history of glaucoma are at greater risk of developing the condition. With changes in population demographics the number of people affected by the condition is expected to rise.

Screening for glaucoma is important and anyone attending for an NHS eye test is routinely screened for ocular hypertension, usually using a tonometer (puff test). These screening tests are less accurate than testing using a Goldmann Applanation Tonometry (GAT) or a Perkins Tonometer and tend to read high. High pressures at screening therefore need to be confirmed by GAT or Perkins (Repeat Measures / IOP). An equivocal first reading should be repeated a week or so later. An audit of IOP alone (former Manchester CCGs) found that:

- 80% were discharged to routine care
- 1% were referred direct to hospital
- 19% were onward referred to a GRRS for further assessment

Those with proven high pressures need further refinement to determine whether they have OHT or glaucoma. This requires an enhanced assessment to examine the optic disc and visual fields (GRRS). The Manchester audit of GRRS found

- 55% were discharged to routine care
- 45% were referred direct on to hospital

Both repeat measures and GRRS reduce unnecessary referrals to the HES and significantly reduce the pressure on overstretched hospital glaucoma teams.

People with glaucoma, once diagnosed, need to be followed up and treated for life. This constitutes a substantial proportion of the workload of a HES team. However, there comes a time when the condition stabilises and much of the follow up work can be undertaken in the community through shared care with the HES. NICE estimates the potential to reduce the burden on the HES by 26%.

1.2.2 Cataracts

Cataract is the presence of visually impairing opacity in the eye's natural lens which may occur in one or both eyes. It is the leading cause of blindness in the world. Symptoms include blurred vision, glare (particularly in bright daylight or night-time vision) and refractive change resulting in more frequent updates in spectacle prescription. Risk factors include age, diabetes, corticosteroid use, female gender, socio-economic status, ethnicity, smoking and alcohol.

Cataract surgery is currently the only effective treatment and phacoemulsification (removal of the cataractous lens using ultrasound) accounting for over 99.7% cataract operations and around 330,000 cataract operations per year in England. This is anticipated to increase with increasing life expectancy

and associated risk factors. However, within that there is almost a threefold variation, with rates ranging from 285 to 804 per 100,000 population; this cannot be fully explained by demographics or variations in known risk factors.

There is currently no national guidance to inform a decision to operate although NICE guidance is expected in 2018. In the meantime, the former CCGs will only commission surgery where there is a significant impact on the patient's quality of life. Specifically:

- The best corrected visual acuity score is worse than 6/9 (Snellen) or 0.2 (Logmar) in the affected eye,

AND one of the following (with correction):

- Difficulty carrying out everyday tasks such as recognising faces, watching TV, reading, cooking, playing sport/cards etc.
- Reduced mobility, experiencing difficulties in driving, for example, due to glare, or experiencing difficulty with steps or uneven ground.
- Ability to work, give care or live independently is affected.

The referral criteria for **second eye** are:

- As above for first eye

OR

- Where there are binocular considerations
- Where there is anisometropia
- Where there is disabling glare

Many cataract referrals do not lead to surgery with conversion rates being <60% in some communities. A significant cause is that many people have cataracts which have little impact on their lives and choose not to have surgery once the procedure is explained to them. The NHS has developed detailed shared decision making tools to support patients to make an informed decision on surgery prior to referral (sdm.rightcare.nhs.uk/pda/cataracts).

1.2.3 Minor Eye Conditions

Minor Eye Conditions are very common and outside the scope of many GP practices. Many patients attend A&E as a result or seek the advice of a community optometrist. Care for minor eye conditions is also outside the GOS contract. Minor Eye Conditions Services enable community provider to do so, reduce the pressure on GPs and provide an alternative to A&E.

Evaluations of MECS schemes elsewhere have found:

- 63% - 75% of MECS patients can be managed in the community.
- Only 22% need referral to the HES and
- 95% of patients were very satisfied with the service.

Furthermore, community providers can safely undertake a significant proportion of minor eyelid surgery and YAG laser

Some MECS models, however, have unintended consequences which can include:

- Increasing volumes through easier access and addressing previously unmet need,
- Increasing referrals to GPs for prescriptions when the MECS clinician is a non-prescriber
- Increasing referrals to the HES because of increasing volumes overall and a lack of appropriate skills in the community service

1.3 Local context and evidence base

Former NHS Greater Preston CCG and Chorley & South Ribble CCG wish to re-procure a community ophthalmology service and in so doing improve quality and value for money. The new service will have three elements:

- A Community Glaucoma Service incorporating:
  - Repeat Measures (Intraocular Pressure)
  - Glaucoma Referrals Refinement
  - Over time, a shared care model with the Hospital Eye Service (HES) to jointly manage those with stable glaucoma

- A Community Cataract Service incorporating
  - Post-op follow up and discharge

- Minor Eye Conditions
  - To include procedures suitable to be delivered in a community setting such as YAG laser and minor eye surgery but excluding cataract surgery

The former CCGs would expect the Service to integrate with the Integrated Urgent Care Service (IUCS) at both the Royal Preston and Chorley District Hospitals to ensure that people with appropriate eye conditions are seen by the Community Ophthalmology Service rather than the IUCS.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

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

2.2 Local defined outcomes – Community Ophthalmology Service

The provider will operate a fully managed Community Ophthalmology Service delivering:

- High quality clinical outcomes
- Excellent, timely and convenient access for patients
- Care for everyone who should be managed by the Service
- A reduced burden on the HES
- Open and transparent performance monitoring shared with commissioners
- An electronic patient record and performance management system which can integrated with the HES systems enabling whole pathway audit e.g. for cataracts and shared care e.g. for glaucoma
- A culture of innovation and continuing quality improvement (CQI)
- Best Value for money

2.3 Whole System Relationships

2.3.1 Interdependencies

Key interdependencies include:

- Local community optometrists and the Local Optical Committee (LOC)
- Local GPs
- The HES and specifically the glaucoma / cataract teams
- NHS 111 and the Integrated Urgent Care Service
- Psychological and mental health services
- Referral Management Centre

2.3.2 Subcontractors

Should the provider choose to include subcontractors in their solution they must have a signed agreement with them in place by the time the response is submitted. The subcontractors need not have submitted a proposal however the provider must assure themselves that they are clinically and financially sound.

The Provider will remain responsible for subcontractors and for meeting the obligations of the contract with full flow down of KPIs. They must also ensure that subcontracted clinicians are:

- Fully qualified and accredited
- Included within the provider's governance and reporting frameworks and that
- There are effective arrangements in place to manage poor performance

2.4 Equality

The ICB is committed to preventing discrimination, valuing diversity and achieving equality of opportunity. The availability of care and quality of service must be based on individual clinical need and should be equally available to all regardless of:

- Gender
- Age
- Race
- Religion
- Sexual orientation
- Disability
- Marital status
- Gender reassignment
- Pregnancy and maternity

Keeping the above list of protected characteristics in mind, the Service will ensure:

- The privacy and dignity of patients by ensuring informed consent for treatment and access to a chaperone is available.
- A convenient service availability to include students and those who work full time.
- Patient information to be in a format accessible to the patient including multimedia, to preferably display the Information Standard Certification and be available in the range of languages spoken in GPCSR.
- Disabled people are able to receive care in the Service without impediment

The Provider will ensure there are clear feedback mechanisms for patients and stakeholders and that such feedback is representative of the cohort of the patients it sees. It will link with the ICBs Communications & Engagement Teams and ensure that the Service is promoted through NHS Choices and a wide range of minority groups' publications / websites.

3. Scope

3.1 Aims and objectives of service

Community Ophthalmology Service

The overall aims and objectives of the Community Ophthalmology Service are to:

- Deliver community-based ophthalmology services for adults for a defined range of eye problems that achieves the outcomes detailed within Section 2.2
- Ensure that all eligible patients are managed through the service
- Reduce the pressures on the HES be delivering eye care outside the hospital where at all possible and ensuring that those that are referred are appropriate and fully worked up.

- Achieve a fundamental shift of care from acute providers into the community so that the patients can access effective and high quality services closer to home, as set out in Our Health, Our Care, Our Say (Department of Health, 2006) and the Commissioners Strategic Plan.

Whilst this is a Community Ophthalmology Service model there are x3 distinct elements to the service which are detailed below:

3.1.1 Glaucoma Service

The aims of the Glaucoma Service are that:

- Only those with a confirmed diagnosis of glaucoma are referred into the hospital service
- The diagnosis is made locally for the patient and in as few steps as is feasible clinically
- Best value across the whole pathway

A detailed specification for the Glaucoma Service is at **Appendix A** with a pathway diagram embedded below.

Annex 1B GPCSR Community Ophthalm

The service will include elements for repeat measures, referral refinement and the management of people with stable glaucoma no longer requiring treatment.

3.1.2 Stable Glaucoma

The Provider will continue the shared care model for those with stable glaucoma.

3.2 Community Cataract Service

The aims of the Cataract Service are to:

- Ensure everyone referred to a surgical provider wants, needs and is fit for surgery
    - And consequently, that conversion rates are over 80%
- Offer patients choice of surgical provider backed by up-to-date quality data (choice to be provided through the Referral Management Centre).
- Deliver the post op review / discharge appointment for all those undergoing uncomplicated surgery (>90% of the total), preferably by the referring clinician
- A whole pathway audit programme feeding back data that is no more than 1 month old to the commissioners and those advising pre-op patients on choice.

Appendix B is the detailed service specification for the Cataract Service a pathway diagram is embedded below.

Cataract Service pathway diagram.pdf

3.3 Minor Eye Conditions

Minor eye conditions include:

- Loss of vision including transient loss.

- Ocular pain.
- Differential diagnosis of red eye.
- Foreign body and emergency contact lens removal (not by the fitting practitioner).
- Dry eye.
- Blepharitis.
- Watery eyes
- Epiphora.
- Trichiasis.
- Differential diagnosis of lumps and bumps in the vicinity of the eye.
- Flashes/floaters.
- Patient reported sudden onset field defects.
- Pigmented Retinal Lesions (SPOTS tool and Virtual Review as required)

The expected outcomes from the MECS are to:

- Improve outcomes for patients,
- Ensure those who need to be seen in the Service are seen in the Service
- Minimise the burden on the acute sector
- Deliver best value for money

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
    - The ICB will support this by ensuring that any direct referrals for minor eye conditions pass via the RMC and that the RMC redirects them 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

In addition, providers will provide minor eye procedures such as eyelid surgery and YAG lasers. The service must be safe and compliant with all relevant guidance around minor surgery, infection control etc. etc. It will also comply with the ICBs policy on Evidence Based Interventions.

Appendix C is the detailed MECS service specification

3.4 Referrals, secure pathways and access

A key requirement is that everyone who should be seen by the Service is seen by the Service. The ICB will work with the provider to make this happen. To this end:

- The ICB will encourage all ophthalmology patients to go via the RMC to ensure only suitable cases are sent to the Service (i.e., excluding red flags and major eye trauma)
- The ICB will work with the HES to divert appropriate patients to the Service without being seen by them and will not fund cataract surgery that has not passed through the RMC (an RMC generated UBRN number is anticipated for every cataract).
- The provider will work with the RMC to ensure all patients can attend an appointment that is convenient for them within a maximum of 5 days (average < 3 days).
- The ICB will ensure that the service is ranked at the top of the Directory of Services for minor eye conditions
- The provider will work with the RMC and IUCS to devise and deliver a pathway that will enable those calling NHS 111 or attending the UCC will be given a timed booked appointment with the Service within 24 hours; ideally to include Sundays.

The service will provide the patients' GP with an electronic summary of each episode of care within 5 days. The amount of data should be minimal and agreed with the LMC as part of mobilisation.

The service will be fully digital by the end of the first year to include electronic transfers between optometrists, electronic referrals to the HES and discharge notes to the GPs.

Detailed specifications relating to each of the services are attached as Appendices A - C

3.5 Patient and Carer education

Possible diagnoses of glaucoma and cataracts can be concerning for patients who need to be fully informed of the reality, their likely pathway over time and their options around treatment. All patients passing through the glaucoma and cataract pathways must be given information with supporting resources either on paper or electronically. Both should be in a format / language that patients or their carer can access and understand.

The ICB is very also keen to see a robust approach to Shared Decision Making with patients

3.6 Patient experience

The provider will be expected to have in place appropriate capacity and capability to undertake patient experience programmes of work. A comprehensive and robust programme of work to gather, analyse, understand, and measure patient experience should be inherent in all services. Patient experience work should be achievable and align with anticipated outcomes and benefits from a new/redesigned service. The aim of the programmes will be to secure qualitative and quantitative intelligence to inform demonstrable improvement in patient/user and carer/representative experience. The expectations placed on any existing provider build on and are additional to existing programmes of patient experience work to ensure measurement of the impact of any new service in respect of patient experience, utilising where possible baseline data. Patient experience is a key placeholder in determining if a service is effective. Even in cases where the primary aim of commissioning a service isn't due to a need to improve poor patient experience, there should still be clear outcomes around ensuring current levels of patient experience and satisfaction are maintained and improved.

Where, as in this case a key outcome is that patient experience could be improved in comparison to a service or equivalent currently in place work in this area is paramount. Alongside this, there should be evidence that the provider correlates patient and carer/representative experience with health outcomes and staff experience data.

The focus of patient experience work will be around overall satisfaction, outcomes and quality of life and the aim will be to ask questions about (but not limited to):

- Overall experience
- Dignity and respect

- How involved the person/their representative/carer felt in their (the patient's) care

3.6.1 Patient Experience baseline data

Gathering of intelligence to assess baseline data around patient experience is imperative to be able to measure the success in terms of maintained and/or improved patient experience of any new service. Where no baseline data is available there will need to be a first contact survey to gather baseline data as any new service is implemented. This will help to understand if any new service demonstrates an improvement in comparison to any equivalent service previously provided.

3.6.2 Complaints

The provider will be expected, as part of the patient experience agenda, to have in place appropriate capacity and capability to manage complaints in accordance with current complaints legislation and in any associated contract (complaints includes where a provider is an NHS body Patient Advice and Liaison - for non-NHS bodies such equivalent service). This includes concerns and enquires raised by or on behalf of patients and their families. Specific requirements placed on a provider will be detailed in this specification. Intelligence in the system in respect of complaints from service users and their representatives will be utilised to allow comparative analysis of any complaints received in respect of a redesigned service and/or by any new provider of an equivalent or similar service.

3.7 Population covered

The service will be provided for all resident and registered patients with a GP practice within the geographical footprint of the former Chorley & South Ribble CCG and former NHS Greater Preston CCG. Referrals will also be accepted for the Minor Eye Conditions element of the Service for those who have called NHS 111 from a local phone number or attended the UCC.

For further information, please visit:

- https://www.lancashireandsouthcumbria.icb.nhs.uk/

3.7.1 Any acceptance and exclusion criteria and thresholds

The service will include pathways for urgent, routine and specialist eye care needs for the registered patients with a Chorley & South Ribble and Greater Preston GP as outlined in section 1.3.

The Provider is responsible for all diagnostics necessary to treat and manage patients within the Service/

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 the Care Pathway set out in **Appendices A - D**.

3.7.2 Exclusion Criteria

- Patients under the age of 18 years;
- The service will adhere to the ICBs commissioning policies relating to Evidence Based Interventions

4. Supporting Considerations and Services

4.1 Workforce

The Commissioners are seeking a single integrated high quality service community ophthalmology service. Clinical workforce for such a service 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

There are a variety of possible models for such a Service from wholly consultant to largely community optometrists delivered. Each has their pros and cons in terms of unit costs, the number of attendances needed to achieve a satisfactory outcome and proportion managed without referral to the HES.

4.1.1 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.

4.1.2 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 on request for audit purposes. 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. Where the provider chooses to subcontract aspects of the service e.g., to community optometrists or GPSIs they must ensure that they these requirements have been undertaken by the individual or their main employer and be able to demonstrate that to the commissioner,

No healthcare professional shall perform any clinical service unless he / she has 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.

4.1.3 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.

4.1.4 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 ;
- 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

4.2 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. The ICB will expect a detailed plan for both the commissioning and maintenance of all equipment and clear accountability for making sure its implementation

4.3 IM&T

The Provider must ensure that appropriate "IM&T Systems" are in place to support the services. "IM&T Systems" means all computer hardware, software, networking, training, support, and maintenance necessary to support and ensure effective delivery of the services, management of patient care and contract management.

Clinical details will be recorded on an electronic record within the first year and may be recorded on paper in the interim. The IT system will automatically collect a Minimum Dataset from each record, collate them from across the service and present them to the provider as a clinical dashboard. The ICB will have open access to an anonymised version. It will also send a short summary to the patients' GP in a format to be agreed with the LMC.

The IM&T solution must enable:

- Individual electronic patient health records;
- Inter-communication or integration between clinical and administrative systems for use of patient demographics;
- Integration between the community service and the HES system to enable:
    - Direct onward referral from community to HES
    - Shared care between the community and HES
    - Whole pathway audit e.g. tracking pathways and outcomes across a cataract pathway
    - Images taken in either service are available to the other
- Clinical services including ordering and receipt of diagnostic procedure results and reports, where appropriate;
- Prescribing and dispensing where appropriate;
- Access to knowledge bases for healthcare at the point of patient contact; and
- Access to research papers, reviews, guidelines and protocols

4.4 Prescribing

Prescribing and medication will be required for 14 days (or such shorter period of a full course of medication as appropriate) post discharge from the Minor Eye Conditions 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 Commissioner shall recharge these costs to the Provider). Dispensing costs as defined below will not be the responsibility of the Provider.

"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

who is either engaged or employed by the Commissioner;

Dispensing services

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.

4.5 Infection control

Notwithstanding main contract clause SC21, the Provider will ensure that it has appropriate arrangements for infection control and decontamination. The Provider is required to provide the services in accordance with the National Institute of Health and Clinical Excellence (NICE) guidelines on infection control "Prevention of healthcare associated infections in primary and community care, June 2003" and The Health Act 2008, Code of Practice for Infection Prevention and Control of Healthcare associated Infections (DH 2008)

The Provider will:

- Comply with the Primary Care antibiotic Guidelines;
- Take measures to minimise the risk of infection and the spread of infection between patients and staff, including any health professional which the Provider has asked to carry out clinical activity;
- Ensure the environment and equipment used for patient care is fit for purpose and where required decontaminated in line with national and local policies; and
- Ensure all staff receive suitable and sufficient training to ensure they are complying with local and national recommendations and are able to reduce the risk of transmissions of infection by good clinical practice and treatment.

The Provider will be required to participate with random unannounced audits' if required by the commissioner's e.g. environmental cleanliness and infection prevention and control. They must comply in full with recommendations made subsequent to these visits.

The Provider should demonstrate good infection control and hygiene practice and must ensure evidence-based policies and guidelines in place to facilitate this. All staff will facilitate and co-operate with the Commissioners' Infection Control Teams in monitoring, audit and investigation (including Root Cause Analysis) of the environment, patient outcomes and practices to ensure high standards are maintained.

5. Applicable Service Standards

5.1 Applicable national standards (eg NICE)

The standards pertinent to each element of the Service are detailed in the respective Appendix.

5.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

The standards pertinent to each element of the Service are detailed in the respective Appendix.

5.3 Applicable local standards

See Schedule 4 Quality Requirements for KPI's

Development of 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 services provision is adapted to meet the needs of vulnerable people, people with learning and physical difficulties and mental health needs.

The Provider will be required to demonstrate:

- How it aims to make services accessible and convenient for all patient groups;
- How it will ensure that its services are appropriate and responsive to patient needs of all patient groups;
- How it will involve all patient groups in delivering or designing its services; and
- How progress in the above areas will be monitored and evaluated

Compliance with policies and procedures

The Provider must comply with the following:

- Standards for Better Health (of most up-to-date equivalent);
- The Commissioner's policies on consent and complaints;
- Relevant legal and regulatory requirements in relation to the provider and the service provision
- Health and Safety legislation & associated legislation;
- Management of Medical Devices Policy;
- Incident Reporting Procedure; and
- Serious Untoward Incident Reporting Policy

Governance

The provider shall put into place a system that demonstrates the governance arrangements for the organisation including managing risk.

Clinical Governance

Notwithstanding main contract clause GC15, the Provider is expected to demonstrate robust clinical governance arrangements in line with the 7 recognised pillars to ensure the safety, efficacy and a positive patient experience of the service is maintained.

All significant patient safety incidents will be identified, investigated and reported to the commissioners in line with the national framework for Serious Incidents Requiring Investigation.

The Provider must have in place arrangements for effecting change to continuously drive improvements and demonstrate that lessons learnt from such events have been shared throughout the organisation.

The Provider is required to obtain an appropriate level of indemnity for clinical negligence based on the activities and services to be provided under the contract that is in line with the local standards.

The Provider should comply with all national statutory employment requirements and related NHS policy.

The Provider is required to have a detailed Clinical Governance policy, which is regularly and systematically reviewed. The system must demonstrate a chain of responsibility and accountability from the individual providing care to the patient to Board Level, and evidence policies and procedures that give assurance that care is safe and effective.

In addition, the Provider will have policies to include:

- Patient and Public Involvement and Experience;
- Risk Management and Incident Reporting;
- Clinical Effectiveness (including research);
- Information Governance;
- Education and Training including Medical Revalidation;
- Complaints and concerns;
- Serious Incidents Requiring Investigate (SIRI) and Significant Events; and
- Equality and Diversity.

All policies shall have the necessary equality impact assessments.

Clinical leadership will be supported and developed in all disciplines working within the service. The Provider Board should include a Medical Director who will be responsible for:

- The clinical governance framework; and

- Provision of medical leadership required for delivery of the services at a local level.

All consultation activity will be audited and this audit should be fed into individual staff development and should utilise the Royal College of Ophthalmologists (RCOphth) or General Practitioners (RCGP) toolkit or an agreed equivalent.

The Provider will be appropriately registered with the Care Quality Commission and any other relevant body and will inform the ICB of any restrictions on that registration.

Contract Monitoring

Notwithstanding the main contract provisions (SC2/SC3/GC9) the Provider must provide all services in accordance with the Department of Health accreditation standards and robust information systems must be in place to demonstrate compliance with those standards.

The Provider will provide robust details of historic and current activity and financial profiles so that plans can be established to manage any unplanned and planned changes to service provision.

A regular programme of contract review meetings, supported by monthly activity reports, will be held between the ICB and the Provider.

The purpose of the meetings will be to monitor and review:

- The contractor's performance against the service specification;
- The delivery of the quality standards;
- Changes in the pattern of service;
- Activity levels;
- The financial arrangements where appropriate;
- Use of contingency plans; and
- Any other relevant contract issues / problems.

The provider shall ensure a detailed patient level dataset is submitted on a monthly basis, with the fields and format agreed with the commissioner, and avoiding free text entry. As a minimum the dataset shall include (as applicable to the part of the service (Tier 2/Macular):

- On referral
    - Patient NHS number * subject to Information Governance requirements
    - Patient's registered GP practice code
    - Name of referrer
    - GOC registration number of referrer
    - Date of referral
    - Date patient seen
    - Diagnosis (ICD10)
    - Eye (left, right, both)
    - Visual acuity (letters)
- Routine follow up
    - Planned date for follow up
    - Actual date of follow up
    - Visual acuity at follow up attendance (letters)
    - Procedure operator national / professional code
    - Review SDM with patient (Y/N)

    - Time spent in department (minutes)
    - DNA or cancellation; reason
- Referred on to the HES Y/N
    - Date of referral
- Patient experience
    - Complaints
    - Patient Experience feedback information

This patient level dataset shall be aggregated up on a monthly basis to provide the following "Activity Reports" including (but not limited to):

- Total number of patients referred into the Tier 2 service;
- Numbers of conditions presented (appropriately coded);
- Number of sessions per month per service;
- Number of patients seen within each session per service;
- Number of new appointments within each session per service;
- Number of follow-up appointments within each session per service;
- Number of treatments administered (appropriately coded);
- Number of patients referred on to secondary care;
- Number of DNAs;
- Number of patients discharged at first appointment;
- Waiting times; and
- Number of Cancelled / re-scheduled appointments

This is not an exhaustive list and will be developed further with the successful provider.

The form of contract will be the 2016/17 NHS Standard Contract. The service will be paid for on a price and activity basis.

Insurance

It is the responsibility of the provider to have the following insurance and maintain all insurance policies. The provider must provide details of the following insurance cover:

- Employers liability; £5m
- Public and product liability; £10m
- Clinical negligence; £10m
- Buildings and/or property insurance (as appropriate to facilities)
- Contents insurance (as appropriate to facilities)

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5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4)

Notwithstanding the provisions of Schedule 4

Registration with the Care Quality Commission (CQC)

The ICB requires evidence of compliance with CQC registration including as a minimum evidence of robust policies / procedures for the following::

Safety Domain

Risk Management

1. An annual risk assessment is carried out for the service based on the NPSA Risk Assessment Programme to include:
    a. The level and management of risk is identified for all risks
    b. All high level risks are recorded on the organisational risk register and managed at board level or equivalent

c. All significant incidents are recorded and acted on
d. All risk data are analysed and reviewed together, to determine and act on trends

2. All SUIs are reported to the ICB, with details of investigation, recommendations and actions taken.
3. A system is in place to manage and act on patient safety notices (The Provider will be included in the ICBs system of alerts for patient safety notices).

Infection Control

4. Medical devices are used and decontaminated according to regulations.
5. All medicines are handled safely and securely.
6. The organisation has, and carries out, an action plan to implement the hygiene code, including necessary audits and improvements.
7. If controlled drugs are used by a service, CD regulations are followed, a self – assessment is carried out and any highlighted actions identified and completed.
8. Waste management is carried out in line with most recent regulations.

Clinical And Cost Effectiveness Domain

Clinical and Cost Effectiveness

9. All relevant NICE guidance is reviewed and implemented where appropriate, with decisions on implementation documented.
10. The organisation has a system to identify areas for audit which is informed by organisational priorities, and includes review of referral criteria and demand management.
11. Audits are completed with recommendations carried out and re-audit completed.

Staff training, development and supervision

12. All staff have annual appraisal and development plans that are monitored.
13. Agreed mandatory training is available to staff and is monitored and action taken to ensure attendance.
14. All staff have appropriate training for the work being carried out, including induction.
15. Staff have opportunity for reflective learning / clinical supervision.
16. All staff are appropriately recruited, trained, qualified and registered for the role undertaken.
17. Any delegation is carried out in line with agreed delegation guidance.

Partnership working

18. The organisation works with other organisations to ensure effective collaboration to meet patient needs.

Governance Domain

Clinical Governance

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

Information Governance

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

Patient Focus Domain

22. There is a Consent to Treatment policy that is fit for purpose and audited, and supports the process for obtaining valid and informed consent from patients.
23. Clear and up-to-date patient information is available for all services.

24. The organisation has a procedure for complaints which is easily available to patients.

Accessible and Responsive Care Domain

25. Patients' views are sought at any service change and cover information, waiting times and access, quality of care, patient's understanding and other priority areas. The results of the survey are discussed acted on and feedback provided to patients.
26. Equality and diversity, including accessibility, are discussed and acted on for all services. These include both staff and patients.
27. The provider will co-operate and participate in Healthwatch work around assessing accessibility and responsiveness including allowing access for service reviews.

Care Environment and Amenities Domain

35. Environments used by the organisation are clean, safe, secure and fit for purpose.

Public Health Domain

28. The organisation takes opportunities to promote and improve health and identify and address health inequalities.
29. The organisation, together with other local organisations, has a plan to cover emergency situations (including business continuity).

All commissioned organisations are required to:

1. Make a self-assessment of compliance against both CQC and additional agreed quality indicators, e.g. controlled drugs, information governance.
2. Report to the ICB on CQC and agreed quality indicators every three months. This would involve an in-depth review of all indicators annually, and a brief three-monthly evidence based overview assurance report showing lapse where standards are not met. Where there is lapse a Non Compliance Action Plan will be completed and submitted with the report.
3. Report all Serious Untoward Incidents (SUI's) to the ICB, and provide details of investigations, recommendations, actions taken and learning from the investigations.
4. Carry out and report on clinical audits to show implementation of relevant national guidance and organisational policies, and any areas where the ICB has concerns.
5. Allow relevant ICB staff to carry out inspections to determine compliance with elements of the contract with the ICB, and with CQC.

5.2 Applicable CQUIN goals (See Schedule 3)

6. Location of Provider Premises

The Provider's Premises:

The provider will be required to demonstrate the locations in former Greater Preston, Chorley & South Ribble CCG footprints from where it will provide this service. The service should be delivered from registered healthcare facilities within the former Preston, Chorley & South Ribble CCG boundaries and it is the expectation that there will be a minimum offer of at least one site in each locality (i.e. at least 3).

The location(s) of premises should be accessible by public transport and should have parking facilities. Premises should also be accessible by patient transportation service vehicles for those patients with a medical need for transportation.

All services and facilities must comply with the Disabilities Discrimination Act 1995 relating to access arrangements for people with hearing and visual impairments.

Providers shall ensure that the facilities provided should incorporate suitable waiting areas, consultation and examination rooms, furniture, fittings and equipment as required to provide a safe service. Equipment includes all computer hardware and software required to operate the service.

There must be clear signage in place to ensure easy access for patients.

All premises should meet statutory requirements and follow best practice guidance.

National Building Requirements define the standards of the above facilities and will be complied with.

Premises must:

- Facilitate the effective and efficient delivery of the services to patients;
- Deliver a patient experience and environment that is in line with NHS guidelines;
- Enable the services to be delivered conveniently to patients and NHS standards; and
- Take into account the mobility for the local population and the availability of local public transport to maximise access to patients.

All parts of the premises in which the service operates must be suitable for the purpose, kept clean and maintained in good physical repair and condition. In particular, the physical environment must comply with Infection Control in the Built Environment (NHS Estates: 2002). The document specifically includes (but is not limited to) the following aspects to reduce risks of infection:

- Sizing / space;
- Clinical sinks;
- Ancillary areas;
- Engineering services which incorporates advice on ventilation, lighting, water supply;
- Storage;
- Finishes, floors, walls, ceilings, doors, windows, fixtures and fittings;
- Decontamination;
- Laundry and linen;
- Waste – segregation, storage and disposal; and
- Workflow

Where premises are used to deliver surgery of procedures the provider must be able to demonstrate that the premises are fully compliant with the relevant regulations and legislation.

The ICB reserve the right to inspect the services premises / records and policies at any time in accordance with main contract clause GC15.2.

7. Individual Service User Placement

Appendix A

A(i) Community Ophthalmology Service Specification Community Glaucoma

This pathway specification should be read in conjunction with the main Community Ophthalmology Service Specification

1. Population Needs

National/local context and evidence base

Raised Intraocular Pressure

NICE guidance stipulates that a patient with an IOP greater than 21 mm Hg has Ocular Hypertension (OHT) and enters the OHT pathway. However, IOP is often measured by optometrists using a non-contact tonometer (NCT or air-puff) for which the upper limit of normal is about 27 mm Hg whereas with Goldmann Applanation Tonometry (GAT) it is 21 mm Hg. The NICE limit of 21 does not distinguish between the two methods with regard to entering the OHT pathway but specifies GAT thereafter.

The Association of Optometrists (AOP) has advised its members to refer any patient to secondary care with IOP in excess of 21 mm Hg. As expected, this resulted in an increase in referrals the majority of which were found to have IOP lower than 21mm Hg on repeat tonometry with GAT. The former CCGs consequently established a repeat measures IOP service through which accredited optometrists undertook repeat IOP readings using a GAT. Audits elsewhere have found the service effective in deflecting 70% of inappropriate IOP patients from referral to hospital; however uptake tends to be very low due poor uptake by optometrists; reluctance on the part of non-accredited optometrists to refer to a competitor and because optometrists viewed the low fee available as not commercially worthwhile.

Suspected Glaucoma

An estimated 480,000 people in England have Chronic Open Angle Glaucoma (COAG) with around 14% of UK blindness registrations due to glaucoma. Glaucoma involves optic nerve damage and loss of the visual field that can lead to blindness if not diagnosed early and treated promptly. It is more common with increasing age, and people of African descent or with a family history of glaucoma may be at greater risk of developing the condition. The prevalence is expected to rise with changing demographics.

Locally, the former CCGs are re-procuring the Community Ophthalmology Service and within it a single integrated Glaucoma Service comprising:

- a repeat measures element
- a referrals refinement element
- management of people with stable glaucoma

Whole systems costs

There are a variety of models that could deliver the outcomes required of the Glaucoma Service and commissioners will be primarily be looking for the one that delivers the best clinical outcomes and most streamlined pathway patients.

2. Outcomes

The outcomes required of the Glaucoma Service are to:

- **Deliver an excellent local service for people with a raised IOP**
- **Minimise inappropriate referrals to hospital**
- **Develop a closely integrated pathway with the HES to include shared care**

- Contribute to best value across the whole glaucoma pathway

3. Scope

3.1 Aims and objectives of service

The service deliver the expected outcomes by:

- Providing a local accessible service
- Managing those requiring a repeat IOP measurement within 14 days (subject to patient choice) and ideally on the same day
- Managing those requiring a second repeat measures measurement with 14 days of the first but no later than four weeks
    - And that any follow up glaucoma referrals refinement assessment is managed at the same attendance
- Identifying patients with raised IOP and no other signs of glaucoma, providing them with appropriate patient information and arranging a follow up as required
- Referring those with a firm diagnosis of glaucoma onto the HES team
- Being able to offer patients a directly booked appointment into a HES glaucoma clinic before they leave the clinic
    - With the Glaucoma Service record available to the HES team when the patient is seen
- A feedback loop from the HES to monitor the quality of referrals and improve them with time

The provider will work with the former CCGs and the HES to implement a shared care model for those with stable glaucoma by the end of Year 1.

3.2 Service description/care pathway

3.2.1 Referral

Patient may be referred into the service from:

- Community optometrists
- GPs
- HES' for people with stable glaucoma and suitable for shared care

Both should refer via the RMC where they will be redirected to the provider booking arrangements. The ICB will encourage referrals from community optometrists to go direct to the RMC without an intervening step for referral by the GP. The provider should support this.

Referrals from the HES will be through regular joint MDT meetings between the two services,

3.2.2 Description

The service will have three distinct elements which will be closely integrated;

- Repeat measures
- Referral refinement
- Ongoing management of people with stable glaucoma no longer requiring treatment

3.2.2.1 Repeat Measures

First repeat measure

Patients identified as having IOP > 21 mmHg and no other signs of glaucoma during a GOS or private sight test will have a slit lamp GAT or Perkins tonometry within 14 days and ideally at the same attendance. This falls within core competencies of community optometrists. Although we recognise that

some may not choose to do so, the provider should include measures to encourage as many community optometrists to offer this safely as possible.

There are four possible outcomes from this first repeat of pressures:

- Patients with IOP ≥ 32mmHg will be referred to the HES glaucoma team without further follow up.
    - Referral should be urgent where closed angle is suspected, routine where not.
- Those with a pressure of 22 – 31mmHg should proceed to Part 2 (2nd repeat pressure)
- Those with a pressures difference between the eyes of >/=5 mmHg should proceed to Part 2
- Reading below 22mmHg should be discharged to routine sight tests.

2nd Repeat measures

Patient attends for repeat Goldman or Perkins Applanation tonometry on a separate occasion within 14 days and no longer 4 weeks.

There are four possible outcomes from this second repeat measure:

- IOP>32mmHg - refer direct to the HES glaucoma team
- IOP > 21mmHg and <32mmHg - progress to glaucoma referral refinement (see discretions below) which should occur at the same attendance.
- Where repeat applanation measurements show a difference in pressure of >/= 5mmHg, the clinician may choose to
    - Proceed to glaucoma referral refinement or
    - Discharge if they consider there is a reasonable explanation (e.g. surgery to one eye).
- The results are within normal limits and the patient can be discharged to routine sight tests.

  In line with College of Optometrists guidance practitioners have the option to not refer patients at low risk of significant visual field loss in their lifetime:

- Patients aged 80 years and over with measured IOPs > 26 mmHg with otherwise normal ocular examinations (no other signs of glaucoma), or
- Patients aged 65 and over with IOPs of > 25 mmHg and with otherwise normal ocular examinations (no other signs of glaucoma).

Both Perkins and Goldmann tonometry will be acceptable for this service. This will enable housebound patients to be access this service as the Perkins tonometer is portable.

3.2.2.2 Referral refinement

The service will confirm glaucoma or glaucoma suspect status or ocular hypertension by:

- Measurements of the intraocular pressure via contact tonometry;
- Anterior chamber examination (to include angle width estimation).
- Central corneal thickness measurement via pachymetry;
- Assessment of optic nerve head by dilated binocular indirect ophthalmoscopy;

- Suprathreshold automated perimetry.

Patients confirmed as having raised IOP with suspect optic discs; and/or optic nerve head; and/or fields and including central corneal thickness measurements will be referred to HES in line with agreed referrals criteria
Patients not requiring onward referral will be discharged.

Single referral criteria

- IOP ≥32*mmHg confirmed at a 2nd visit.
  - If IOP >32mmHg then no confirmatory measurement is necessary.
- Unequivocal pathological cupping at the optic nerve head. Abnormal neuroretinal rim configuration. Large cup, taking into account the overall size of the disc. Notched neuroretinal rim. A >0.2 asymmetry of cup to disc ratio.
- The existence of a disc haemorrhage merits closer inspection for early nerve fibre loss.
- Refer for an optic disc haemorrhage through GRRS only where there are additional optic disc and/or other indicators of glaucoma.
- Visual field loss consistent with a diagnosis of glaucoma, confirmed at a second visit. If explained by other disc or retinal pathology to be referred as such and not through scheme.

Combined referral criteria

- IOP, age and CCT criteria aligned with the NICE treatment algorithm as per **Table 1** below.
- Raised IOP (age related criteria) plus an optic disc appearance suspicious of glaucoma or optic disc asymmetry
- Glaucomatous optic disc and corresponding visual field defect (IOP not raised) (no need for confirmatory measures).

CCT	**>590 micrometres**		**555–590 micrometres**		**<555 micrometres**		**Any**
IOP (mmHg)	>21-25	>25-29	>21-25	>25-29	>21-25	>25-29	≥30
Referral	No	No	No	Refer if ≤60	Refer if ≤65	Refer if ≤80	Refer

Table 1: NICE referrals criteria for glaucoma

Additional referral criteria

- Optic disc change over time e.g. increase in cup size, change in the rim appearance, or the occurrence of a new haemorrhage (documented within the scheme.) Refer for an optic disc haemorrhage through GRRS only where there are additional optic disc and/or other indicators of glaucoma.
- Anterior segment signs of secondary glaucoma (e.g. pseudoexfoliation) with raised IOP (age-related criteria) on two occasions
- Suspected narrow-angle glaucoma (symptoms of sub-acute attacks or occludable angle and raised IOP
- Emergency referral for suspected angle closure glaucoma should be made directly to emergency secondary care services such as MREH Acute Referral Centre or Emergency Eye Centre.
- In the event of an unusual clinical presentation or for those patients under 40 years of age suspected of having developmental glaucoma, GRR optometrists should ring the hospital for advice on referral.

3.2.3 Onward referral and discharge

Onward referral to the HES should be direct to the HES using a glaucoma referral proforma to be agreed with the HES. The referral should be copied to the RMC, the patients GP and the referring optometrist if applicable.

Those not requiring onward referral will be discharged with a summary to the GP and referring optometrist if applicable.

3.2.4 Stable Glaucoma

The service will continue to manage those patients with stable glaucoma already under the care of the existing community tier II service. Thereafter they will work with the HES glaucoma team to closely integrate the two teams and ensure that patients are managed by the most appropriate, the main aim being to relieve pressure of the HES team thus giving them the capacity to manage the more complex cases to plan.

Transfer of patients between the two services will be agreed at regular, probably monthly, MDT meetings some of which may be virtual following meetings being established. The provider will also work with the HES so that clinical records, or at least key clinical data, can flow freely between the two. The services will maintain a common glaucoma register to ensure that patients do not "fall between the cracks" and will fully share activity data and clinical outcomes with the ICB.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

- NICE Clinical Guideline 85: Diagnosis and Management of Chronic Open Angle Glaucoma and Ocular Hypertension
- NICE Quality Standards: Glaucoma

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

- Guidance on the referral of Glaucoma suspects by community optometrists Issued by The College of Optometrists and The Royal College of Ophthalmologists December 2010

Appendix B

A(ii) Community Ophthalmology Service Specification Community Cataracts

This pathway specification should be read in conjunction with the main Community Ophthalmology Service specification

1. Population Needs

1.2 National/local context and evidence base

Cataract is the presence of visually impairing opacity in the eye's natural lens which may occur in one or both eyes and is the leading cause of blindness in the world. Symptoms include blurred vision, glare (particularly in bright daylight or night time vision) and refractive change resulting in more frequent updates in spectacle prescription. Risk factors for cataract include increasing age, diabetes mellitus, corticosteroid use, female gender, socio-economic status, ethnicity, smoking and alcohol.

Cataract surgery whereby the natural lens is replaced by a clear intraocular lens implant, is currently the only effective treatment to improve or maintain vision. Phacoemulsification (removal of the cataractous lens using ultrasound) accounts for 99.7% cataract operations in the NHS and is the most common elective surgical procedure in the UK. There are around 330,000 cataract operations each year in England, anticipated to increase with increasing life expectancy and associated risk factors.

There is an almost threefold variation in people having cataract surgery across England (ranging from 285 to 804 per 100,000 population) which cannot be fully explained by demographic factors or known variations in risk factors. There is currently no national guidance to inform a decision to operate although NICE guidance is expected in 2018. In the meantime the former CCGs will only fund cataract surgery where:

- The best corrected visual acuity score is worse than 6/9 (Snellen) or 0.2 (Logmar) in the affected eye,

AND has one of the following (with correction):

- Difficulty carrying out everyday tasks such as recognising faces, watching TV, reading, cooking, playing sport/cards etc.
- Reduced mobility, experiencing difficulties in driving, for example, due to glare, or experiencing difficulty with steps or uneven ground.
- Ability to work, give care or live independently is affected.

The referral criteria for **second eye** are:

- As above for first eye

OR

- Where there are binocular considerations
- Where there is anisometropia
- Where there is disabling glare

Many cataract referrals do not lead to surgery with conversion rates being as low as 60% in some communities. A significant cause for this is because many people have minor cataracts which have little impact on their lives and choose not to have surgery once the procedure is explained to them. The NHS has developed detailed shared decision making tools (sdm.rightcare.nhs.uk/pda/cataracts) to support patients to make an informed decision on surgery prior to referral.

2. Outcomes

The outcomes required of the Cataract Service are to:

- Ensure that anyone referred on to a surgical provider wants, needs and is fit for surgery and consequently that conversion rates are over 80%
- Deliver the post op review / discharge appointment for all those undergoing uncomplicated surgery (>90% of the total)
- A comprehensive whole pathway audit programme that is no more than 1 month old feeding back to the commissioners and those who are offering choice to future patients.
    - Clinical outcomes
    - Patient experience

3. Scope

3.1 Aims and objectives of service

The service aims to reduce the strain on the HES and inconvenience for patients by minimising inappropriate referrals to secondary care and ensuring that all referrals comply with the ICBs criteria.

3.2 Service description/care pathway

3.2.1 Referral

Patient may be referred into the service from:

- Community optometrists
- GPs
- Consultant to consultant (C2C) referrals within the HES.

GPs and optometrists should refer via the RMC where they will be redirected to the provider. HES' should notify the RMC of all C2C referrals which must also comply with the ICBs referrals criteria and will be subject to audit at the ICBs discretion.

3.2.2 Description

- A **post-cat stage** which will undertake the post op follow up and discharge appointment for all uncomplicated surgery, preferably by the referring clinician

3.3.1 Referrals criteria

The **need for cataract surgery** is covered by the following criteria:

- Best corrected visual acuity (BCVA) is worse than 6/9 (Snellen) or 0.2 (Logmar) in the affected eye

AND

- Impairment of lifestyle such as:
    - Patient at significant risk of falls
    - Patient's VA affecting their ability to drive
    - Patient's VA substantially affecting their ability to work
    - Patient's VA substantially affecting their ability to undertake leisure activities such as reading, watching TV or recognizing faces,
- OR
- Anisometropia and/or Glare

- Patients with cataract suffering significant functional disability from anisometropia and/or glare. These patients will not be required to fulfil the previous criteria fully
- Ability to remain still and lie supine (flat on their back) for approx. 20 mins.

Dilation of the eye is not mandatory but should be carried out where clinically necessary. The attendance should also include an assessment of the second eye and onward referrals should state whether surgery on one or both eyes has been authorised.

3.3.2 Shared Decision Making

Having determined that the patient meets the criteria for surgery, the Service will establish whether they **want an operation**. There is good evidence to show that some patients are referred for surgery without being fully informed of the pros and cons and would not have wished to be referred had they known the facts beforehand. The Service will therefore use Shared Decision Making (SDM) with the patient to ensure that only those who wish to consider surgery are referred. The provider may use whichever patient decision aids they wish but should consider the NHS model produced by Right Care (available at sdm.rightcare.nhs.uk/pda/cataracts).

SDM discussion should include:

- The relative risks and benefits of cataract surgery
- Any co-existing ocular disorders requiring separate referral or which may impact on the surgery
- Discussion of the health questionnaire and any outstanding issues dealt with prior to referral

The provider should encourage those wishing time for further consideration to take a “pause for thought” and follow them up by phone. There will be no additional payment for this step.

Referrals will be permissible where the patient has been fully informed yet remains unsure and wishes the advice of a specialist doctor. In this case the situation should be made clear in the referral letter.

3.3.3 Choice of provider

The provider will maintain up to date comparative data illustrating the relative performance of the local surgical providers no older than one month. They will combine that data with locally relevant information such as ease of access to support the patient’s choice of provider. The choice discussion with the patient will take place through the Referral Management Centre (RMC) and will include the allocation of the UBRN for the patient.

3.3.4 Onward referral

The Service should complete the cataract referral form and refer on electronically directly to the RMC for choice discussion and the patients’ GP in accordance with the local protocol. Referrals should clearly state whether the patient has been authorised for one or both eyes.

3.3.5 The second eye

People requiring surgery to both eyes will usually have their procedures on separate occasions 6 weeks or so apart. The majority will be clear at the initial assessment in which case the provider will authorise surgery to both eyes at the time. Occasionally people become eligible for the second eye after the first procedure, particularly with the onset of glare or anisometropia. This group may be identified by the surgical provider in which case they may proceed to operate on the second eye whilst informing the RMC. Most will be identified at the post cat attendance and re-referred.

3.4 Post-cat

Post-cat aims to further reduce the pressure on HES providers and provide an independent assessment of the impact of surgery. The post cat assessment will be undertaken at about 6 weeks post op and will feed back the outcomes to the surgical providers and back to the GP to inform choice for subsequent activity. The ICB accept that <10% of patients will undergo complicated surgery and that it is reasonable

for these to be followed up by the surgical provider. The Cataract Service provider should liaise with the surgical provider to agree a process to identify who will be followed where and that no-one "falls through the cracks".

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

- NICE Clinical Guideline 85: Diagnosis and Management of Chronic Open Angle Glaucoma and Ocular Hypertension
- NICE Quality Standards: Glaucoma

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

- Guidance on the referral of Glaucoma suspects by community optometrists Issued by The College of Optometrists and The Royal College of Ophthalmologists December 2010

Appendix C

A(iii) Community Ophthalmology Service Specification Minor Eye Condition Service (MECS) Pathway

This pathway specification should be read in conjunction with the main Community Ophthalmology Service Specification

1. Population Needs

1.1 National/local context and evidence base

Hospital eye attendances increased by 30% in the UK over the past five years (www.rcophth.ac.uk) with over 10 million outpatient appointments in England alone in 2013/14; Hospital Eye Services (HES') often struggle as a result. Minor Eye Conditions account for around 20% of all referrals to hospital and many communities have developed community MECS services to reduce the pressure on HES' and provide a more convenient service for patients. The experience of MECS nationally has been:

- Nationally
  - 63% - 75% of MECS patients can be managed by community optometrists;
  - Only 22% need referral to the HES; and
  - 95% of patients were very satisfied with the service.
- A recent audit of MECS services across 3 CCGs in Greater Manchester showed that:
  - 19% of patients would have gone to A&E
  - 57% of patients would have gone to the GP
  - 38% of patients would have gone to ophthalmology
  - 97% of patients would recommend the service to a friend or family.
  - 99% of patients were seen within 30min of their appointment time.
- MECS that include self-referral have generated increasing volumes by meeting otherwise unmet need leading to a substantial increase in whole system costs without many associated benefits.
- There is often overlap with Minor Ailments Schemes delivered by community pharmacists which can manage some eye conditions at lower cost e.g. viral conjunctivitis
- Many referrals which could have been managed by a MECS still reach the HES

There are a number of MECS models nationally some of which have significant flaws. These include,

- Increasing volumes through easier access and addressing previously unmet need,
- Increasing referrals to GPs for prescriptions when the MECS clinician is a non-prescriber
- Increasing referrals to the HES because of increasing volumes overall and a lack of appropriate skills in the community service to manage more complex minor eye conditions
- A substantial number of patients with minor eye conditions still choose to attend A&E.

Furthermore, the former CCGs wish the MECS service to include minor surgery e.g. for eyelids and YAG lasers. Cataract surgery is excluded.

2. Outcomes

The expected outcomes from the MECS are to:

- Improve outcomes for patients, particularly minimised time and steps to achieve closure
- Ensure that all those who need to be seen in the Service are seen in the Service

- Minimise the burden on the acute sector
- Deliver best value for money within the Service and the overall Programme Budget

3. Scope

3.1 Aims and objectives of service

To achieve those outcomes the Service will deliver

- A high quality and distinct community Minor Eye Conditions Service
- Excellent access and a high quality experience for patients
    - With direct and timely referral to the appropriate HES clinic for those who need it
- Redirection of appropriate urgent care patients to the MECS including from the UCC and NHS 111
- Minimise the burden on general practice, particularly by avoiding referrals to them for prescriptions or onward referral
- MECS distinct performance monitoring and reporting shared with the ICB;
- Best value through a low local MECS tariff, high completion rates and low onward referrals to the HES
- Effective measures to prevent an increase in activity over time by encouraging unmet need

3.2 Service description/care pathway

3.2.1 Referral

Patients may be referred into the service from:

- Community optometrists
- GPs
- Urgent care services including NWAS, A&E, IUCS and NHS 111

Community optometrists and GPs will be able to book patients into the Service either direct or via the RMC. All routine ophthalmology referrals will be triaged by the RMC and those suitable for MECS referred to it. The precise arrangements around triage and booking will be agreed post PB. Self-referral is not to be encouraged.

In addition the provider will operate a booking service (which may be subcontracted to the RMC / IUCS) enabling GPs, community optometrists and urgent care services to book patients into MECS on a single phone call that has been answered within 60 seconds. They will further liaise with the ICB to maintain an up to date and appropriately ranked DoS.

3.2.2 Description

MECS will manage a range of minor eye conditions to include:

- Loss of vision including transient loss.
- Ocular pain.
- Differential diagnosis of red eye.

- Foreign body and emergency contact lens removal (not by the fitting practitioner).
- Dry eye.
- Blepharitis.
- Watery eyes
- Epiphora.
- Trichiasis.
- Differential diagnosis of lumps and bumps in the vicinity of the eye.
- Flashes/floaters.
- Patient reported sudden onset field defects.
- Pigmented Retinal Lesions (SPOTS tool and Virtual Review as required)

The following cases need to be referred directly to the nearest UCC or the HES team:

- Severe ocular pain requiring immediate attention
- Suspect Retinal detachment
- Retinal artery occlusion
- Chemical injuries and Penetrating trauma
- Orbital cellulitis
- Temporal arteritis
- Ischaemic optic neuropathy

Other conditions excluded from the service are:

- Diabetic retinopathy
- Adult squints, long standing diplopia

The Service will also include minor eye procedures such as eyelid surgery and YAG lasers and proposals should include an assessment of the impact on patients, the HES and whole systems costs. Cataract surgery is excluded.

The ICB will work with the Provider to agree clear criteria for MECS to refer on some specific minor eye conditions to a local pharmacist under the Minor Ailment Scheme. The Provider will institute an audit process to verify that this is happening.

MECS will normally be a same or next day service although discretion will be allowed for non-acute conditions such as lumps and bumps around the eye and flashers and floaters, to be seen within 7 days.

MECS attendances will normally be a single attendance with follow up only where the patient does not make the expected recovery. The price charged will be a “price per episode” adjusted to allow for a proportion needing to be seen again. There will be no separate payment for follow ups.

Clinical details will be recorded on an electronic record within the first year and may be on paper in the interim. The IT system will automatically collect a Minimum Dataset from each record, collate them from across the service and present them to the provider as a clinical dashboard. The ICB will have open

access to an anonymised version. The provider will also send a short summary of each episode to the patients' GP in a format to be agreed with the LMC.

All cases should be closed without referring on to the GP. Onward referrals will be via the RMC within an appropriate timeframe offering patient choice. The Provider will establish an audit programme with the HES to verify the appropriateness of these referrals and steadily improve them with time.

3.2.3 Supply and use of medicines

The MEC Service provider will need to be able to arrange the supply of the following medicines:

- Chloramphenicol
- Cyclopentolate hydrochloride
- Fuscidic Acid
- Tropicamide

In making the supply of therapy to the patient the provider must ensure:

- Sufficient medical history is obtained to ensure that the chosen therapy is not contra-indicated in the patient.
- All relevant aspects, in respect of labelling of medicine outlined in the Medicine Act 1968 are fully complied with.
- The patient has been fully advised on the method and frequency of administration of the product.

Practitioners using or supplying therapeutic drugs must maintain their competency to do this.

Where patients are eligible for free NHS prescriptions a written order with a pro forma claim form will be provided to the patient to take to the pharmacy to have dispensed and the Pharmacy will claim their fees from the ICB.

Alternative methods of this free provision will be kept under review – to maximise the efficiency of the patient pathway and minimise processing costs.

The use of medicines

Providers will be expected to:

- Maintain their skills and knowledge with regards the use of drugs
- Demonstrate continuous professional development in line with their professional requirements
- Inform patients of the any adverse reactions prior to application and provide them with the appropriate information
- Record all batch numbers and expiry dates of drugs in the patients notes
- Follow guidance K1.10 in relation to the use of diagnostic drugs
- Ensure that all drugs are stored according to the manufacturer's instructions.

3.3 Accreditation

Any clinical subcontractors must be trained and accredited through a process determined by provider and approved by the commissioners. Clinicians who have been accredited elsewhere will normally become accredited for this service as long as their training is considered equivalent and the provider is confident in their abilities.

The provider will be contractually responsible for assuring clinical quality in this service and steadily improving it over time. They will be required to oversee clinical quality, identify outliers and take steps to correct it. Anyone accredited under this scheme must accept this and comply with any requirements required of them in order to maintain their accreditation. Details of the local training programme are contained in attached document: