# SCHEDULE 2 – THE SERVICES

1. **Service Specifications**

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| **Service Specification No.** |  |
| **Service** | **Ophthalmology/Optometry** Pre and Post-Operative Cataracts Referrals |
| **Commissioner Lead** | Commissioning and Transformation Team |
| **Provider Lead** |  |
| **Period** | 1st October 2018 – 31st September 2020 |
| **Date of Review** | March 2019 |

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| **1. Population Needs** |
| * 1. **National/local context and evidence base**

The five year vision in Barnsley CCGs Strategic Commissioning Plan states that there will be ‘wider primary care provided at scale’. Giving people the option of being able to access eye care in a timely manner in a more accessible location will ensure that this is the case. As the population ages, the incidence, prevalence and burden of eye disease is expected to increase and with many eye diseases chronic in nature, this means lifelong management. As diagnostic tests become more sophisticated and easier to administer, and with the development of new treatments, demand for eye care services is increasing.Ophthalmology referrals have increased nationally compounded by the introduction of the NICE guidelines regarding the diagnosis and management of minor eye conditions. In Barnsley, GP ophthalmology referrals have risen significantly, putting pressure on waiting lists. The current waiting time for a routine appointment is on average 6 weeks, which is clearly too long when the patient could be seen with a minor condition much sooner.The increase in pressure on secondary care services and the reduction in capacity within local hospitals has escalated the need to transform the way eye care services are delivered to patients. All neighboring CCG’s have a successful service in place which is a positive indicator that the proposed enhanced services will improve the current system in Barnsley. Many ophthalmic assessments and treatments currently being carried out in secondary care could be more appropriately undertaken in primary care. Primary care optometrists are trained to perform eye examinations, which include refraction and detection of signs of injury, disease or abnormality in the eye. They are also trained to manage many minor eye conditions.Most ophthalmology referrals from primary care are initiated following a routine sight test by an optometrist. The vast majority of such referrals are then forwarded to secondary care. Those patients referred to secondary care with a field defect are often found to have no defect on repeat testing. Optometrists are qualified to have a discussion with patients about the benefits and issues of cataract surgery; however, as this falls outside their contracted work, it does not happen.Referring to an optometrist would reduce unnecessary referrals to secondary care and significantly reduce the resultant care costs. Referral refinement should also ensure sight threatening conditions are effectively examined by the correct professional and referred more rapidly for treatment as a result of reduced waiting times.Patients will find the service more convenient, being closer to home and usually offering longer opening times and weekend appointments. If the patient needs a follow-up appointment, there is consistency of care within a local optometry practice. |
| **2. Outcomes** |
| **2.1 NHS Outcomes Framework Domains & Indicators**

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| Domain 1 | Preventing people from dying prematurely |  |
| 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 | **X** |
| Domain 5 | Treating and caring for people in safe environment and protecting them from avoidable harm |  |

**2.2 Local defined outcomes****Local outcomes**Implementation of the Cataract Referral Scheme will use the skills of primary care optometrists to assess patients presenting with suspected cataracts. It is anticipated that patients within the Barnsley Borough will benefit from improved outcomes by gaining improved access to secondary care services if their condition requires this level of intervention. Allowing patients improved access to local optometrists will ensure that they are seen in a timely manner and will have the knock on effect of reducing secondary care waiting times.Requirements of optometrists providing the new service are :-* to provide accurate and timely information regarding the service to Barnsley CCG, i.e. number of patients seen per month, condition, and registered GP practice for audit purposes (see Schedule 6A of the NHS Standard Contract);
* to enable Barnsley CCG to monitor performance;
* to ensure the service delivered is of a high standard and demonstrates continuous service improvement.
* To ensure that assessment and treatment is undertaken by suitably qualified and accredited clinicians.
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| **3. Scope**  |
| **3.1 Aims and objectives of service**• Improved patient experience, with care closer to home, more timely treatment, increased patient choice and fewer secondary care attendances• A comprehensive, clear referral pathway for the screening service, GPs and optometrists with appropriate use of local optometry and ophthalmology services• A reduction in ophthalmology first outpatient attendances• Patients are treated in an environment which best suits their needs• Fewer unnecessary steps within the referral pathway• Easier access to appointments offering flexibility to the patient, e.g. weekend availability • Offers a high quality innovative service which is responsive and personalised• If spectacles are required they can be dispensed at the time of the appointment as this is part of the core optometry service – hospital prescriptions would usually be dispensed in the community on a prescription basis. This ensures community optometry is a ‘one-stop’ service. **3.2 Service description/care pathway*** The examination will be undertaken by an optometrist within suitably equipped premises who will manage the patient appropriately and safely
* Management will be maintained within the primary care setting for as many patients as possible, thus avoiding unnecessary referrals to hospital services
* Where referral to secondary care is required it will be to a suitable specialist with appropriate urgency
* Clinicians should implement an evidence-based approach to the assessment, diagnosis and management of patients
* Optometrists can manage the patient to the stage where surgery is necessary and conduct the extra tests required to ensure the eye is suitable and ready for surgery
* Where a patient is managed in primary care, an episode of care will be defined as 6 months in relation to an individual condition. Providers will not be paid for follow up appointments within the same episode of care for an individual patient condition.
* A patient must have a total assessment score of 7 or over to meet the threshold for first eye surgery. If the clinician considers need for referral/ treatment on clinical grounds outside these criteria, please refer to BCCG’s Individual Funding Request (IFR) policy for further information.
* For Second Eye Cataract Surgery the Optometrist must complete Part 1 of the Cataract Surgery referral form to provide second eye visual acuity and then forward to Secondary Care.
* The patient will be given counselling on the risks and benefits of the operation to determine whether he or she wishes to proceed with surgery if deemed appropriate by the the Clinician.

**Cataract Service Pathway****3.3 Population covered*** All patients registered with a Barnsley GP or Ordinarily Resident in Barnsley who meet referral criteria as in the cataract form in appendix B.

**3.4 Any acceptance and exclusion criteria and thresholds****Inclusion Criteria**See the cataract referral form in appendix B for further detail. **Exclusion Criteria**1. Patients who **do not** have significant difficulty with their vision
2. Patients who **do not** wish to be referred for cataract surgery

**In addition to the above exclusions there will be the following general exclusions to the service** * The patient is not a registered with a Barnsley GP or not Ordinarily Resident in Barnsley.
* Abusive, violent or threatening patients without a security escort. A violent patient is defined as someone who has threatened or committed violence or verbal abuse leading to fear for a person’s safety
* Patients barred from NHS services
* Patients who have a medical contraindication to the clinical services
* Patients who are medically unfit to undergo the clinical services

**3.5 Interdependence with other services/providers*** + Partnership working with other community and hospital based professionals to include Ophthalmologists in secondary care and any other appropriate service.
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| **4. Applicable Service Standards** |
| **4.1 Applicable national standards (e.g. NICE)**The service must be provided in line with national priorities, current and future recognised best practice guidance and standards in the field including :• The College of Optometrists• Local Optical Committee Support Unit• Standard General Optometric Contract* All applicable NICE guidelines

**4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)** **Professional practice principles which state in a concise form the optometrists obligations are:-****1:** The practitioner should always have as his or her prime concern the welfare and safety of both patient and public.**2:** The practitioner should ensure that s/he is adequately covered by public and products liability insurance which includes professional indemnity cover.**3:** The honor and dignity of the profession shall be upheld at all times and no activity shall be engaged in which might bring the profession into disrepute.**4:** The practitioner shall at all times have due regard to the laws and regulations applicable and maintain a high standard of professional conduct. Acts or omissions which might impair confidence in the profession should be avoided.**5:** Information relating to the health or welfare of any patient or person should be respected and remain confidential between practitioner and patient or person, unless disclosure is specifically permitted by such patient or person by law.**6:** The practitioner should keep abreast of the progress of scientific and other relevant knowledge pertinent to the profession, seek to develop his or her professional competence and maintain a high standard of professional expertise relative to his or her scope of practice.**7:** The practitioner should not agree to practice under any conditions of service which would prevent or impede his or her professional integrity, nor impose such conditions on other members of the profession.**8:** Practitioners should co-operate with professional colleagues and members of other professions to the benefit of patients and the public.**9:** No practitioner should criticise or cast doubts on the integrity of other professional colleagues except when absolute candour is required in the furnishing of evidence in legal or disciplinary proceedings, or if the practitioner considers that patients’ welfare is being placed at risk through the actions of a professional colleague.**10:** No practitioner should advise, prescribe or engage in any procedure beyond his or her competence and training. Engaging in occasional practice is not in the best interests of the patient; practitioners should be aware of their limitations and refer to a more competent colleague as necessary. **4.3 Applicable local standards****Informed Consent**In order that patients have enough information to consent to one or more of the applicable services identified within this specification, the referring clinician should provide the relevant information in a way that the patient can understand, including special formats for those who need them.**Governance**Data should be obtained, recorded, held, altered, retrieved, transferred, destroyed or disclosed in accordance with the Common Law Duty of Confidentiality, Caldicott guidance, the Data Protection Act 1998 and other national and professional guidance.The service will be delivered in accordance with individual opticians’ Information Governance policies and the law, including but not limited to:-* + Confidentiality Policy
	+ Data Protection Policy
	+ Information Governance Policy
	+ Records Management Policy

The provider must ensure that any and all parts of the service covered by this specification are carried out by a General Optical Council registered optometrist currently on the NHS England performers list for community optometry.All participating optometrists must have the following equipment in working order and available for inspection if required:* + - Slit lamp
		- Applanation tonometer
		- Threshold field equipment to produce a printed field plot
		- Ophthalmoscope
		- Amsler charts
		- Epilation equipment
		- Diagnostic drugs (mydriatics, stains, local anaesthetics etc.) set out in the formulary on the Local Ophthalmic Committee website (<http://www.locsu.co.uk/>)
		- Volk lens

**Audit*** The Contractor mustassess and manage risk associated with the service, investigate adverse events, and keep comprehensive records
* The Contractor must keep full patient records detailing the assessments carried out and the outcome, these will be made available to the CCG upon request
* The Contractor **MUST** ensure that equipment is fit for purpose, compliant with current electrical safety standards and maintained and calibrated in accordance with the manufacturer’s advice

**KPIs*** All patients must be seen within 5 working days of receipt of referral

These locally defined outcomes, including KPIs will be reviewed 6 months from Service Commencement and baseline information will be included to determine the ongoing standards expected from the service. |
| **5. Applicable quality requirements and CQUIN goals** |
| * 1. **Applicable quality requirements (See Schedule 4 Parts A-D)**

Not applicable* 1. **Applicable CQUIN goals (See Schedule 4 Part E)**

Not applicable |
| **6. Location of Provider Premises** |
| **6.1 The Provider’s Premises are located at:**As per contract |
| **7. Individual Service User Placement** |
| Not applicable |

**Cataracts**

 Assessment Referral Post Op

**Cataract Surgery
First Eye Surgery:** Please complete Part 1a

**Second Eye Surgery:** Please complete Part 2

Barnsley CCG will only fund Cataract Surgery, when the following criteria are met:

|  |  |  |  |
| --- | --- | --- | --- |
| **GP Details**: | …………………………………………………………………… | **Patient Details**: | ……………………………………………………………. |
|  |  | Surname: |  | Title: |  |
|  |  | Forename(s): |  |
| Postcode: |  | Tel: |  | DOB: |  |
|  |  | Address: |  |
| **Interpreter Required?** No YesLanguage: |  | Postcode: |  |
| Tel 1: |  | Tel 2: |  |

**PART 1a – First Eye Cataract Surgery**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **VA Scores**VA 6/6=0 |  | **SPH** | **CYL** | **AXS** | **VA** | **Dominant Eye** | **Score** |  |
| VA 6/9=1VA 6/12=2VA 6/18 & below=7 | **R** |  |  |  |  |  |  | **VA Score** |
| **L** |  |  |  |  |  |  |  |

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| --- | --- | --- | --- | --- |
| **Lifestyle Questions to ask Patient**  | **Not at all** | **Slightly** | **Moderately** | **Very much** |
| Is the patient’s quality of life affected by vision difficulties (e.g. car driving, watching TV, doing hobbies, reading, work etc?) |  |  |  |  |
| Is the patient’s social functioning affected by vision difficulties (e.g. cross roads recognising people, recognising coins etc?) |  |  |  |  |

|  |  |  |
| --- | --- | --- |
| Lifestyle Scoring – Please Circle Score as Appropriate | **Yes** | **No** |
| Any difficulties for patient with mobility (including aspect of travel e.g. driving, using public transport) | 2 | 0 |
| Is the patient affected by glare in sunlight or night (car headlights?) | 1 | 0 |
| Is patient’s vision affecting their ability to carry out daily tasks? | 2 | 0 |

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| --- | --- |
| **TOTAL ASSESSMENT SCORE** (VA AND LIFESTYLE SCORE) **A patient must have a total assessment score of 7 or over to meet the Threshold for first eye surgery. If clinician considers need for referral/ treatment on clinical grounds outside these criteria, please refer to BCCGs Individual Funding Request (IFR) policy for further information.** |  |
|  |

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| --- | --- | --- |
| The patient meets the Clinical Threshold for first eye cataract surgery | Yes | No |
| The patient wishes to undergo cataract surgery. | Yes | No |

**Part 1b – Assessment (Management in Practice)**Previous stable refraction prior to cataract development (if available) / Post Op refraction (Delete as required)

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **R VISION** | **SPH** | **CYL** | **AXS** | **VA** | **L VISION** | **SPH** | **CYL** | **AXS** | **VA** | **DATE** |
|  |  |  |  |  |  |  |  |  |  |  |

**PART 1c – Post Eye Cataract Surgery**

|  |  |  |
| --- | --- | --- |
| Is the patient glad that they had their cataract replaced? | Yes | No |
| Do you consider that the patient should be referred back to the hospital for any reason related to THIS surgical procedure? | Yes | No |

**PART 2 – Second Eye Surgery - To be completed by Hospital Consultant**

|  |  |
| --- | --- |
| **For second eye surgery** | Delete as appropriate |
| If vision in the first operated eye is better than 6/10 (0.20 logMAR) corrected postoperatively then the patient will need to have sufficient cataract to cause blurred or dim vision with a monocular distance acuity of 6/18 (0.40 logMAR) or worse in the second eye to qualify for cataract surgery. If vision in the first eye does not correct to better than 6/10 then second eye cataract surgery can be offered only if the binocular corrected vision is 6/10 or worse or the second eye vision is monocularly worse than 6/18 corrected. | Yes | No |

**Part 3 – Exception Criteria**

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| **The only exceptions to the referral criteria are as follows:** |  |  |
| Anisometropia (a large refractive difference between the two eyes, on average about 3 dioptres), which would result in poor binocular vision or disabling diplopia which may increase the risk of falls. | Yes | No |
| Angle closure glaucoma including creeping angle closure and phacomorphic glaucoma | Yes | No |
| Diabetic and other retinopathies including retinal vein occlusion and age related maculardegeneration where the cataract is becoming dense enough to potentially hinder management. | Yes | No |
| Oculoplastics disorders where fellow eye requires closure as part of eye lid reconstruction orwhere further surgery on the ipsilateral eye will increase the risks of cataract surgery | Yes | No |
| Corneal disease where early cataract removal would reduce the chance of losing corneal clarity (e.g. Fuch's corneal dystrophy or after keratoplasty) | Yes | No |
| Corneal or conjunctival disease where delays might increase the risk of complications (e.g.cicatrising conjunctivitis) | Yes | No |
| Other glaucoma’s (including open-angle glaucoma), inflammatory eye disease or medical retina disease where allowing a cataract to develop would hamper clinical decision making orinvestigations such as OCT, visual fields or fundus fluorescein angiography | Yes | No |
| Neuro-ophthalmological conditions where cataract hampers monitoring of disease (e.g. visual field changes) | Yes | No |
| Post vitrectomy cataracts which hinder the retinal view or result in a rapidly progressing myopia. | Yes | No |
| **Consultant use only**Please complete the following and file for future compliance audit.Referral criteria is met and the patient will benefit from the proposed treatment:           yes / noSignature…………………………Consultant name:………………….Please printHospital: ……………Date………… | **Optometrist use only**Practice stamp/addressReferring Optometrist:…………... Date: …………………………….. | **Commissioner’s use only**Criteria met as per policy: yes / noCompliance with notes: yes / noAudit date:…………………………Audited by:………………………Please print(GP/Cons) |