

Ealing Harrow Hillingdon Community Ophthalmology Service

SCHEDULE 2 – THE SERVICES

Service Specification

This is a non-mandatory model template for the local population. Commissioners may retain the structure below or may determine their own in accordance with the NHS Standard Contract Technical Guidance.

| | |
|---------------------------|---|
| Service Specification No. | |
| Service | EHH Community Ophthalmology Service |
| Commissioner (s) | NHS Ealing CCG NHS Harrow CCG NHS Hillingdon CCG |
| Provider | |
| Period | 3+2 |
| Date of Review | |

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1. POPULATION NEEDS

1.1 National

Almost two million people in the UK are living with sight loss, approximately one person in 30. Sight loss affects people of all ages, but its occurrence increases markedly with age. One in five people aged 75 and over are living with sight loss. One in two people aged 90 and over are living with sight loss. Nearly two-thirds of people living with sight loss are women. People from black and minority ethnic communities are at greater risk of some of the causes of sight loss. As many as three quarters of people with learning disabilities are estimated to have either refractive error or to be blind or partially sighted.

The number of people in the UK with sight loss is set to increase in the future. In addition, there is a growing incidence in key underlying causes of sight loss, such as obesity and diabetes. It is predicted that by 2020, the number of people with sight loss will rise to over 2,250,000. By 2050, the numbers of people with sight loss in the UK will double to nearly four million¹.

RNIB (2010) suggest that the annual cost of sight loss in the UK amounted to a minimum of £6.5 billion in direct health care and indirect costs, such as reduced employment.

The Access Economics research² confirms that ethnicity is a major factor in relation to eye disease. The Black population has a higher risk than the White population of developing age-related macular degeneration (AMD) at an earlier age, but at lower risk of developing it after the age of 70.

The Black population also has a much higher relative risk of developing glaucoma and cataracts. Asian people are at a higher risk of developing cataracts than the Black and White populations and at a higher risk of developing diabetic eye disease than the White population.

Poorer access to services is also likely to contribute towards higher risk burdens, resulting in health inequalities across minority ethnic and lower socio-economic groups. British Asians appear to show higher risk of cataract and develop it an average 10 years earlier than their White counterparts. The White population is more likely to experience sight loss due to refractive error, compared to the Black population.

The increasing demand on eye-health services arising from an ageing population and the availability of new treatments is creating lack of capacity within the Hospital Eye Services (HES). This relates especially to AMD, diabetic eye disease and glaucoma.

It was predicted that between 2010 and 2020, there would be a 26% increase in patients with AMD, a 20% increase in patients diagnosed with Ocular Hypertension (OHT) or glaucoma and a 25% increase in people with diabetic eye disease³. In fact, over the last five years, there has been a 30% increase in ophthalmology outpatient attendances (NHS Digital data) and this is set to rise further to capacity problems in the acute settings.

The Clinical Council for Eye Health Commissioning (CCEHC)⁴ has developed a framework for a Community Ophthalmology Service which this service specification is set to deliver. The CCEHC framework also recommends the provision of support mechanisms to tackle challenges arising from

¹ <http://www.nib.org.uk/knowledge-and-research-hub/key-information-and-statistics>

² RNIB (2009) Cost Oversight. The cost of eye disease and sight loss in the UK today and in the future

³ <http://www.nib.org.uk/knowledge-and-research-hub/research-reports/general-research/future-sight-loss-uk-2>

⁴ <https://www.college-optometrists.org/the-college/ccehc/delivery-models.html>

the increase in demand in line with the recommendations of The Five Year Forward View (5YFV). It suggests that appropriate risk stratification of patients and more consistent pathways of care will together lead to better value eye health care, better patient experience and better outcomes. These will enable HES clinics to focus on those patients who really need an ophthalmologist's expertise.

1.2 Local context and evidence base

The three CCGs (Ealing, Harrow, Hillingdon (EHH)) have a total registered population of 1,018,622 patients (June 2018). The population of the three CCGs, although ageing, has fewer people over the age of 65 than the national average. The life expectancy in all three boroughs is above the national average for men and women. Ealing has a more deprived population than the other two CCGs and higher than the national average. Harrow and Hillingdon have lower than national deprivation indices.

Although the CCGs have a young population they have a higher than average proportion of the population from BAME communities (Harrow having the highest proportion), and higher than national prevalence for diabetes. Diabetes is more prevalent in the Asian population and diabetic eye disease is a major cause of sight loss as is glaucoma.

Smoking, being overweight and having dementia are also risk factors for sight loss. The CCG have lower than national prevalence of smoking, excess weight in adults. In relation to dementia Hillingdon and Harrow CCGs have lower than national rates whereas Ealing CCG's dementia rate is higher than national prevalence.

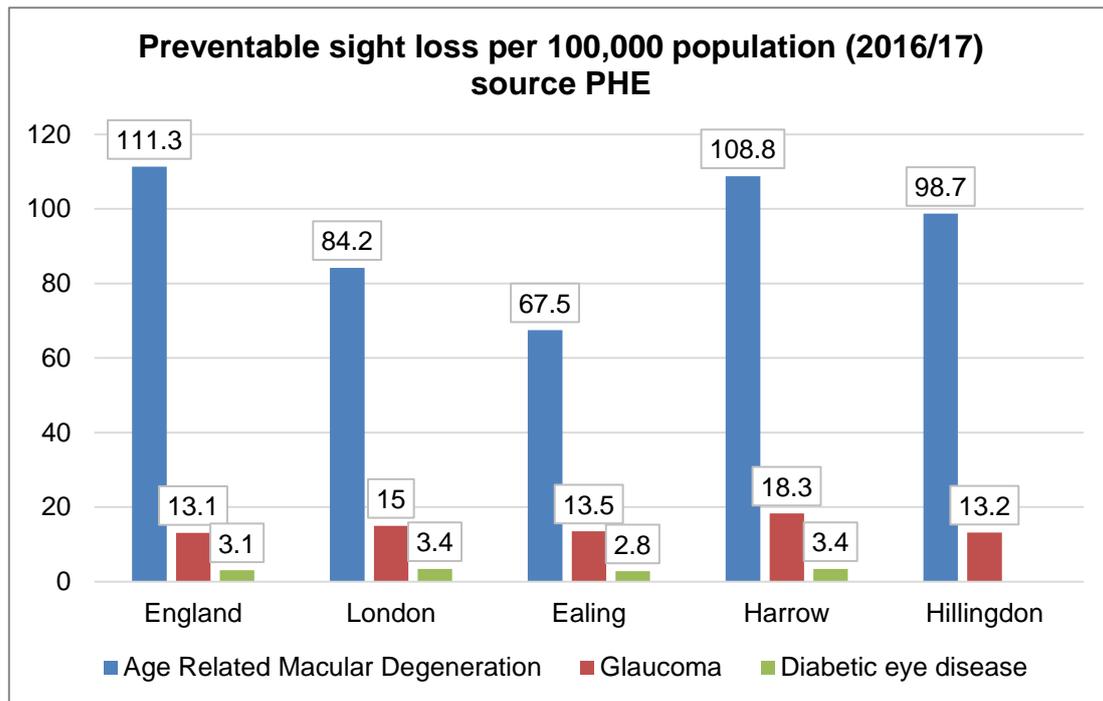
Therefore, the three CCG do have groups of patients at higher than average risk of sight loss.

| | Ealing | Harrow | Hillingdon | England |
|--|---------|---------|------------|---------|
| Registered population | 437,901 | 267,718 | 313,003 | |
| Age breakdown % over 65 | 12.0% | 15.1% | 13.2% | 17.9% |
| Life expectancy at birth (Male) | 80.7 | 82.5 | 80.8 | 79.5 |
| Life expectancy at birth (Female) | 84.2 | 85.9 | 83.8 | 83.1 |
| Deprivation indices 2015 | 23.6 | 14.3 | 18.1 | 21.8 |
| % people from an ethnic minority group | 48.5% | 52.1% | 40.2% | 13.6% |
| Smoking prevalence in adults (aged 18+) | 11.0% | 9.0% | 11.6% | 14.9% |
| % adults (aged 18+) with body mass index (BMI) is greater than or equal to 25kg/m ² | 56.9% | 57.5% | 55.2% | 61.3% |
| Diabetes diagnoses (aged 17+) | 78.3 | 87.7 | 81.2 | 77.1 |
| Dementia diagnoses (aged 65+) | 78.2 | 64.3 | 67.4 | 67.9 |

The prevalence of sight threatening eye conditions in EHH is predicted to grow due to the ageing

population, and the proportion of people from black and ethnic minorities who are much more at risk of age related macular degeneration, glaucoma and diabetic eye diseases. By 2020, it is predicted that 3,875 residents aged 65-74 on the three boroughs will have moderate or severe visual impairment, increasing by 9% to 4,223 by 2025.

The table below shows comparative data for England, London, Ealing, Harrow and Hillingdon of the number of people per 100,000 with preventable sight loss. Harrow and Hillingdon have particularly high rates of age related macular degeneration sight loss, but this is in part a reflection of having an older patient population than Ealing.



EHH CCGs are committed to improving local eye-care services across the borough. The CCGs believe that a variety of eye conditions can be appropriately treated in a community setting, thus improving the accessibility of services to patients and reducing pressure on local HES. This will be achieved by ensuring that only those patients that need specialist care and input are referred to these services.

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 |

The service will support the achievement of domains 2,4 and 5.

2.2 Local Defined Outcomes

- Improved access, choice and treatment for patients with different types of eye conditions
- Provision of high quality and safe eye care in community settings with only complex cases provided within HES
- Reduction in variations and access to services
- Reduction in referrals to secondary care services and a reduction in the number of follow-up appointments across all levels of care where clinically appropriate and alternative services have been commissioned
- Provision of services closer to patients' homes
- Improved quality of care within primary and community settings
- Improved access to advice and information and increased knowledge and awareness of the management of eye conditions across primary care settings
- The service will support the 18-week care pathway for ophthalmology and will be able to offer quick and responsive access to services, thereby easing pressure on HES

2.3 Critical Success Factors

The critical success factors outlined below are essential for achieving the successful outcomes:

- Reduction of in total outpatient appointments by the end of year one
- More step down for patients with stable eye conditions from HES, thereby releasing capacity and promoting better flow of patients within the eye-health pathway
- More patients are managed in the most appropriate setting according to risk stratification and protocol agreed in collaboration with all stakeholders
- More patients are seen in community settings and closer to home
- Greater efficiencies by avoiding more expensive secondary-care appointments for routine and stable patients

3. SCOPE

3.1 Key Aims and Objectives of Service

The primary aims and objectives of the service are:

- Provision of assessment, investigation triaging, treatment and monitoring of eye conditions specified in Annex 1 in the community
- Provision of paediatric eye service including squint assessment, strabismus, amblyopia and eye screening for children (no age restriction)
- Faster access to diagnostics and treatment for patients, thereby significantly reducing waiting time from referral to treatment in accordance with Royal College of Ophthalmologists commissioning guidance
- Reduction in inequality of access for residents in EHH by providing increased access to eye care in the community and closer to home, especially for elderly patients and those with severe sight impairment and impaired mobility
- Increased health promotion and health prevention advice/initiative by primary care providers
- Supporting self-management programme to patients and their carers
- Education and support to primary care clinicians
- Telephone and email advice to GPs

3.2 Service Description/Care Pathway

3.2.1 Service Overview

Provision of a multidisciplinary, community service, led by a consultant ophthalmologist where patients are seen by accredited clinicians working under and with direct access to a consultant.

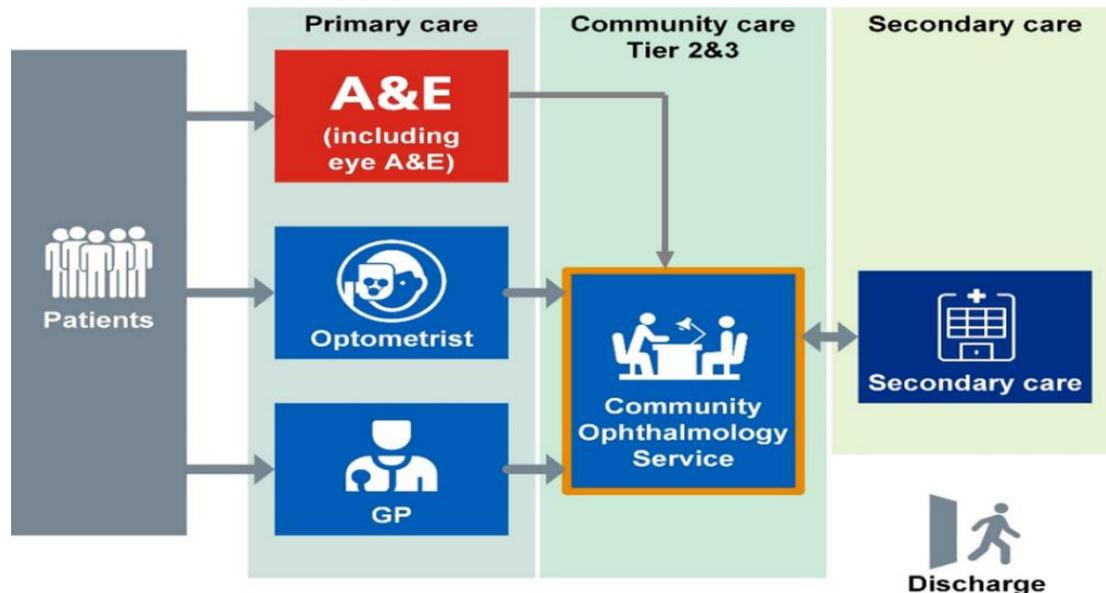
The service will provide:

- Support for adults and children registered with EHH GPs
- Single point of access for assessment, investigation, triaging and treatment of all the ophthalmology referrals from EHH GPs and local optometrists
- Facilitate onward referral to secondary care for patients who are unsuitable for management in the community
- Manage patients with low risk of sight loss, including glaucoma, from acute settings for ongoing management in community settings
- Management of pre and post-operative patients with cataracts in community settings, and directly list patients for cataract surgery, thereby shortening the cataract pathway
- Provide YAG (yttrium-aluminum-garnet) capsulotomy post-cataract surgery as a value-added service (this will be explored with bidders during the tendering exercise)
- Carry out appropriate procedures including minor surgery (where these can be safely carried out in the community)
- Manage urgent referrals (same day/next day appointment)
- Seen/offered first appointment within four weeks of receiving the referral for routine cases
- Improve knowledge of primary health care professionals around the management of eye diseases through the development and implementation of education programmes for GPs and other practitioners on the agreed clinical pathway
- Improve the quality of GP/optometrist referrals such that cases that can be safely managed in primary care are not referred to community or secondary care service
- Help develop and maintain clinical guidelines on local primary care management of common ophthalmological conditions
- Set-up advice line for referrers, providing timely advice to support better diagnosis in primary care and improved referral quality
- Delivery in the community locations, preferably at least from two different sites in the borough
- Improve the education of patients around self-management of their conditions
- Signpost to third sector organisations for additional support where appropriate
- To improve communication and smooth the patient journey between specialist and primary care
- To provide better value for money due to a more cost-effective use of resources
- Clear and accountable governance arrangements with senior clinical leadership. Clinical leadership (at consultant) level must provide accountability over care provided within the
- Service with appropriate presence at service-delivery locations
- To improve patient satisfaction through delivering a quick, accessible and quality service
- Use of SystmOne and EMIS (or a system interoperable with SystmOne and EMIS), to transfer all information for patients, appointment booking and referrals management
- Engagement with local data sharing as detailed in the CWHHE memorandum of understanding for data sharing within SystmOne and EMIS

Please note: As part of future service developments and improvements, the CCG intends to engage optometrists to manage minor eye conditions, intraocular pressure repeat readings and management of OHT (ocular hypertension) in community settings. This will be explored and considered as part of this community contract in subsequent year(s). Adequate resource allocation to develop these additional pathways will be further explored between the Provider and Commissioner within the term of the contract.

3.2.2 Referral criteria and sources

- Referral into the service by GP is via a Single Point of Access using SystmOne and EMIS
- Referrals into the service by optometrists into the service is via a single point of access
- HES will also be required to refer patients into the community service in accordance with agreed protocol and guidelines (for example patients with stable eye conditions which require on-going monitoring and review)
- Other sources of referrals will include referral from 111 or A&E



3.2.3 Medicine Management

Patients must be supplied with two weeks of new medications, or a full treatment course if the intended duration is less than two weeks. Prescribers should adhere to the NWL Integrated Formulary. Any additional medications to be prescribed or recommended must be agreed with EHH CCGs. The overall contract value will include a prescribing budget. The Provider will prescribe in accordance with all relevant local, national and professional guidance including National Service Frameworks, NICE Guidance, NICE Technology Appraisal Guidance, relevant Health Service Circulars and Guidance, Executive Letters and Audit Commission reports.

3.3 Population Covered

The service is available to all persons registered with a GP practice located within the geographical area of NHS EHH CCGs. The service will be accessible to both children and adults (there is no age restriction for children).

3.4 Exclusion criteria and thresholds

- Patients not registered with EHH CCGs
- Accident and emergency eye conditions
- Acute sight-threatening eye conditions, including transient loss of vision
- Patients receiving biological and steroid eye injections
- Screening or treatment under NHS Diabetic Eye Screening Programme
- Suspected malignancy of the eye or orbit (should continue to be referred direct to the hospital under the '2-week rule' on appropriate referral documentation)

- Patients requiring treatment that should be provided under a standard GOS contract

3.5 Interdependence with other services/providers

The Provider will be required to link seamlessly through effective and prompt communication with, and signposting to, specialist and relevant third-sector services. The Provider will be required to connect patients to appropriate patient support services such as the Eye Clinic Liaison Officer Service (ECLO) and low vision aid clinics.

All service providers will ensure that they are able to make referrals to other services including specialist services, as and when required and that patients will be made familiar with the wider healthcare community. Providers will also ensure that signposting to third sector organisations for further support where appropriate will also be included within the service offerings. Partners will include:

- General practices in EHH
- Optical practices in EHH
- Community pharmacists
- Patient forums
- HES
- Local authority (including Eye Clinic Liaison Officer Service)
- Third-sector providers

It is the responsibility of the Provider to ensure that all appropriate information is communicated to the necessary recipients and appropriate notes are made in the patients' records. The Provider will be required to work proactively with primary care referrers and local HES to ensure that the referrals are appropriate and the desired activity transfer from HES to the community service is achieved. This includes working with local hospital trusts to put in place effective arrangements for transferring follow-up care from HES to the community service. The Providers will be required to work together.

3.6 Staffing

- The service will have an appropriate staffing structure in terms of skill, experience and numbers
- The Provider will ensure that all relevant staff engaged or employed to provide services in accordance with the service specification possess the appropriate qualifications, experience, skills and competencies to perform the duties required of them
- All staff working within the service will have achieved competency in both assessment and procedure management, including a clear understanding of possible complications
- The Provider will ensure that all clinical staff meet the qualification and CPD requirements of their professional and regulatory bodies, that they are competent to deliver the service and that their skills are regularly updated
- The Provider will be required to submit copies of relevant professional qualifications and registration of staff involved in the provision of the service prior to commencement of the contract (including Disclosure and Barring Service (DBS) checks)
- Relevant qualifications include:
 - Ophthalmic consultant post: Full Registration – General Medical Council and MRC Ophth (part 3) and FRC Ophth (fellowship assessment) CCST to clinically manage and quality assure the service
 - Nurse post: An ophthalmic registered nurse with a minimum of two years' relevant experience and NMC registration
 - GPwSI: should be undertaking at least one clinical session per week in general practice, and should also receive regular training and professional development amounting to 15 hours per year. Regular sessions must be allocated for clinical sessions with a consultant

- Staff grade or associate specialist: MRC ophth (part 3)
- Orthoptists

3.7 Safeguarding

Safeguarding children and adults remain a key priority for the CCG. All providers are expected to safeguard children and vulnerable adults and also comply with all legislation and guidance, both national and local, relating to safeguarding including:

- Children Act 1989
- Children Act 2004 and must demonstrate compliance with section 11
- Working Together to Safeguard Children 2018
- Promoting the Health and Wellbeing of Looked After Children (2015)
- Children & Families Act 2014
- Lampard Report 2015
- Francis Report 2013
- Care Quality Commission registration requirements Section 3 – Safeguarding and Safety, standard 7 – Safeguarding Vulnerable people who use services
- No Secrets Guidelines (2015)
- Safeguarding Children & Young People: Roles and Competences for Health Care Staff (Intercollegiate Document 2014)
- Pan-London Child Protection guidelines
- Pan London Multi- Agency Safeguarding Adults Procedure

Safeguarding Children

The service will comply with the requirements of their Local Safeguarding Children Board and the London Child Protection Procedures. The service must implement guidelines for safeguarding children, specific to the UTC and all UTC staff must receive training in safeguarding children appropriate to their posts. The service is required to have effective arrangements in place to safeguard vulnerable children by complying with:

1. Section 11 of the Children Act, requirements,
<http://www.legislation.gov.uk/ukpga/2004/31/section/11>
http://www.workingtogetheronline.co.uk/chapters/chapter_two.html#section_eleven
2. Safeguard children from Child Sexual Exploitation
<https://www.gov.uk/government/publications/child-sexual-exploitation-definition-and-guide-for-practitioners>
3. Safeguard children from Female Genital Mutilation
<https://www.gov.uk/government/publications/mandatory-reporting-of-female-genital-mutilation-procedural-information>
4. Safeguard children from Radicalisation
<https://www.gov.uk/government/publications/protecting-children-from-radicalisation-the-prevent-duty>
5. Protect children from and report on Domestic Violence and Abuse
<https://www.gov.uk/guidance/domestic-violence-and-abuse>
6. Adhere to National Guidance: Working Together to Safeguarding Children 2015
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/592101/Working_Together_to_Safeguard_Children_20170213.pdf

7. Pan London Guidance – London Child Protection Procedures: <http://www.londoncp.co.uk/>
8. The LSCB policies and procedures: <http://hillingdonlscb.org.uk>

3.8 Clinical Governance

The Provider will be responsible for formalising clinical governance arrangements at key transition points where patients move between providers along the pathway:

- For referring and accepting patients
- Working in collaboration with other providers to ensure patients are supported in the right setting
- Influence other providers to ensure there is protocol and guidance in place to ensure step-down arrangements are in place for stable patients
- Engage with acute providers to agree shared care protocols

3.9 Operational Governance

- The provider will ensure that there is appropriate level of consultant ophthalmologist oversight to maintain clinical safety and audit, quality in service delivery and provide advice and support to both patients and primary-care clinicians
- The overall accountability for the service will be with the provider, who will be expected to monitor the services provided to ensure quality and safety is monitored and maintained
- Appropriate protocol, guideline, risk stratification and step-down arrangements will be developed and agreed with all stakeholders to ensure patients are able to move seamlessly within the pathways

3.10 Communication and service promotion

The Provider will:

- Be responsible for engaging and communicating with acute providers to make them aware of the step-down arrangements, community pathway and other options available to patients
- Engage with patients and community groups to raise awareness
- Ensure that the service is well promoted and supported in general practice

3.11 Equipment

- The Provider will be responsible for the purchase, maintenance and replacement as may be necessary of relevant equipment required to provide the service
- All email communications are to be via a secure encrypted pathway such as NHS.net to NHS.net
- Service provision will be monitored to ensure the maintenance of care standards and that the service is safe. All members of staff will adhere to Provider policies and procedures. All incidents will be reviewed and actions implemented as required
- All equipment should be in full working order and fit for purpose
- Portable appliances and fixed installation electrical testing certificates are required

3.12 Information Management and Technology

The Provider will have appropriate electronic communications, patient administration and financial management systems including an NHS-approved secure e-mail access. Providers will also be required to:

- Put appropriate information management and governance systems and processes in place to safeguard patient information. This will need to be supported by appropriate training of staff. As a minimum, level 2 IG toolkit compliance must be maintained
- Put appropriate information management and governance systems and processes in place to safeguard patient information. This will need to be supported by appropriate training of staff. As a minimum, level 2 IG toolkit compliance must be maintained
- The Provider will also use SystmOne and EMIS clinical software (or a system interoperable with SystmOne and EMIS), for appointments, record keeping, reporting and communications with GP practices
- Have a SystmOne and EMIS IT system, or a system with suitably highly granular interoperability with a SystmOne and EMIS enabled IT system to facilitate 2-way exchange of coded and free text data; visibility of scanned documents; bookings into clinical services; electronic referral and discharge (including summaries) with GPs and patient-linked electronic messaging
- Ensure that data to support CCG monitoring and assessment against the Care Quality Commission Annual Health Check criteria are met and data is supplied to both the Commissioners and the Commission as required
- Be signatories to the CWHHE memorandum of understanding for data sharing within SystmOne and EMIS

The Provider must be able to accurately record, monitor and report data at a CCG level specific to the Service. This is an essential requirement of the Service. A minimum dataset for reporting requirements will be agreed. Suppliers are required to ensure that their systems are compatible and interoperable with the prescribing decision support software in use by the CCG. The provider is to be registered with the Information Commissioner. All patient records are to be securely stored and backups are made regularly and kept separately and securely. All records are to be kept for 10 years for adults and deceased patients and, up to their 25th birthday for children.

4. APPLICABLE SERVICE STANDARDS

4.1 Applicable National Standards

The Provider will carry out the service in accordance with best practice in health care and will comply with the standards and recommendations contained in, issued or referenced as follows:

- Royal College of Ophthalmologists commissioning and disease management guidelines
- Clinical Council of Eye Health Commissioning
- Issued by the Care Quality Commission including Standards for Better Health
- Commissioning toolkit for eye care services, DH publication, 2007
- The Health Act (2006) Part 2 (Prevention and Control of Healthcare Associated Infections)
- The National Institute for Health and Clinical Excellence
- Audit Commission "Quicker Treatment Closer to Home" (2004)
- Any relevant National Service Frameworks; and Issued by any relevant professional body
- Data Protection Act 1998

NICE Clinical Knowledge Summaries (CKS)

- Cataracts – (Last revised in September 2015) (<http://cks.nice.org.uk/cataracts>)

NICE Interventional Procedure Guidance

- Implantation of accommodating intraocular lenses for cataract (IPG209) – Last revised in February 2007 (<https://www.nice.org.uk/guidance/ipg209>)
- Implantation of multifocal (non-accommodating intraocular lenses during cataract surgery (IPG264) – Last revised in June 2008 (<https://www.nice.org.uk/guidance/ipg264>)

NICE Guidelines in Development

- Cataracts in adults – management – Anticipated publication date June 2017 (<https://www.nice.org.uk/guidance/indevelopment/gid-cgwave0741>)
- Glaucoma: diagnosis and management (update) – Anticipated October 2017 (<https://www.nice.org.uk/guidance/indevelopment/gid-ng10017>)

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

- The Provider will comply with the standards and recommendations in the guidance issued by all relevant professional bodies including:
 - College of Optometrists guidance for professional practice⁹
 - The Royal College of Ophthalmologists – Cataract Surgery Guidelines¹⁰
 - The Royal College of Surgeons – Cataract Surgery¹¹

4.3 Applicable Local Standards

See quality and performance indicators

5. APPLICABLE QUALITY REQUIREMENTS (SEE SCHEDULE 4A-C)

a) Significant incident reporting:

- The Provider will comply with the requirements of EHH CCGs for the reporting and handling of serious incidents (SI)
- A record of all SI, near misses and potential incidents must be maintained. SI must be reported to the designated quality within 24 hours.
- Fitness to practice concerns will be reported by the provider to EHH CCGs and the Professional for Optometry (this function will be delegated to NHS England)

b) Infection Control:

The Provider will specifically ensure that:

- Premises are kept clean, including all areas of public access
- In all consulting and screening rooms used, hard surfaces are regularly cleaned using appropriate hard surface solution/wipes. Hand-washing facilities must be provided in, or near, to consulting/screening rooms
- Hot and cold water is made available, and liquid soap and paper towels provided
- All equipment that comes into contact with patients is cleaned after use. This may be by using antiseptic wipes (or similar) for head/chin rests or by using disposable chin rests

c) Waste Management:

- Part-used (or out of date) minims need to be incinerated and to be discarded in a medicine disposal box

d) Clinical Audit:

- The Provider will participate in any clinical audit activity as reasonably required by Ealing CCG and maintain appropriate records to evidence and support such activity

e) Patient Experience

- The Provider will participate in an annual patient survey by engaging patients in the completion of a patient questionnaire
- The Provider is required to carry out Friends and Family Test in accordance with NHS Standard contract and report quarterly to the commissioners

f) Performance Reporting and Audit:

- Activity and patient outcomes will be recorded on SystmOne and EMIS and should be forwarded directly to Ealing, Harrow, and Hillingdon CCG Quality teams
- Issues will be reported by the provider to EHH CCGs by exception
- Complaints will be reported quarterly by the provider to Ealing, Harrow, and Hillingdon CCG
- Other relevant information required from time to time by Ealing, Harrow, and Hillingdon CCG will be provided by the Provider in a timely manner

g) Service review:

The Provider will co-operate with EHH CCGs as reasonably required in respect of the monitoring and assessment of the services including:

- Answering any questions reasonably put to the Provider by EHH CCGs
- Providing any information reasonably required by EHH CCGs including clinical audits, distribution of patient satisfaction surveys as developed by EHH CCGs
- Release of non-identifiable patient information for the purposes of quality improvement initiatives to be undertaken by EHH CCG relating to this specific patient group
- Attending any meeting or ensuring that an appropriate representative of the Provider attends any meeting.

6. LOCATION OF PROVIDERS PREMISES

- The service will be delivered in the community locations, preferably from at least two different sites within London Borough of Ealing, Harrow, and Hillingdon
- The Provider(s) will be responsible for ensuring that the facilities for service delivery are fit for the provision of services to patients and that the CQC's essential standards requirements are complied with at all times
- The Provider will be responsible for making all necessary arrangements for occupation of the premises with the landlord/head leaseholders as required. The Provider will be responsible for the provision of all required facilities management arrangements. The Commissioner will not engage in any negotiations in the acquisition of premises on behalf of the Provider
- The Provider will be responsible for all estates costs
- The Provider will ensure that premises are accessible to patients with physical disabilities or wheelchair users and must comply with the Equality Act 2010
- The Provider must adhere to CQC Regulation 15: Premises & Equipment and any other applicable clinical guidelines, regulations and best practice. Site locations must have:
 - A blackout facility (for windows and doors in the consulting and diagnostic testing rooms)
 - Shared areas such as waiting room, reception and access to lavatories
 - Clinical waste and sharps disposal facilities
 - Clean room for minor procedures
 - Wheelchair/pram access
 - Network capability to support service delivery
 - Facilities for disposables (clinical and general waste) and a wash basin in each room

- Low light dimmer switches for consulting rooms
- Provision of vision channels
- Signage in line with guidance from RNIB
- Appropriate provision on infection control measures (including facilities designed and equipped to minimise risk of infections)
- Providers will be required to make their own arrangements for N3 connections
- Prior to the commencement of service under this contract, the CCG will undertake an inspection of the premises to ensure compliance to the contract
- Any outstanding issues would need to be rectified by the Provider within the specified time given by the CCG
- A Contract Compliance Visit will be carried out on an annual basis to all premises where the service is being provided to ensure that patient safety is not being compromised

| | Quality Requirement | Threshold | Breach | Method of Measurement | Consequence |
|---|---|--|---|---|---|
| 1 | All urgent referrals are seen within one working day. | All urgent referrals are appropriately recorded, triaged and patients are seen within one working day. | Less than 98% of all urgent referrals | QUARTERLY Anonymised record of all referrals received, time to triage and next steps decision recorded for 100% referrals received | Financial penalty 2.5% of the contract value for the quarter |
| 2 | All routine referrals to service triaged as per agreed local referral management process | All referrals appropriately recorded and assessed at triage within two working days | Less than 98% of all urgent referrals | QUARTERLY Anonymised record of all referrals received, time to triage and next steps decision recorded for 100% referrals received | GC9 |
| 3 | Onward referrals to secondary care for any procedure is accompanied by completed PPwT form where required | 100% | Below 100% | QUARTERLY Monthly provision of Minimum Data Sets for patients treated. Review against NWL PPwT procedures list | GC9 |
| 5 | Turnaround time for sending letters after assessing/ treating patient | 100% within two working days | Less than 98% of referrals in any one month | QUARTERLY | GC9 |
| 6 | Waiting times of routine cases – percentage of patients seen within 4 weeks of receipt of the referral | 90% seen within four weeks | Less than 85% of patients seen in any one month | QUARTERLY | Financial penalty 2.5% of the contract value for the quarter |
| 7 | Percentage of DNAs by new and FU (against total period of appointment) | 9% | DNA rate greater than 9% | QUARTERLY | GC9 |

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|----|--|---|--|---|--|
| 8 | Reconciliation of activity not transferred from acute into the community in-line the activity planning | Volume of activity to be transferred on a monthly basis to be agreed between provider and commissioner by the service commencement date | Agreed volume of activity not transferred on a quarterly basis | Quarterly Reconciliation | Claw-back will be applied against the 4th quarter payment once the end of the year position is known. If annual target is missed. Claw-back will be based on the unit cost for follow-up appointment |
| 9 | Delivery of GP/primary care education sessions. | Delivery plan to be agreed between provider and commissioner by service start date | Not completing actions and meeting timescales detailed on delivery plan | QUARTERLY | GC9 |
| 10 | Patients able to choose secondary care provider if onward referral or inpatient treatment required | 95% of patients referred to secondary care able to confirm they were given sufficient information to make an informed choice of provider if onward referral or inpatient surgery required | Less than 95% | QUARTERLY Specific question in patient satisfaction survey covering 'choice'. | GC9 |
| 11 | Patients satisfaction with the service | 90% satisfied with the service. Friends and Family Test carried out. Minimum response 40% of patients who attend the service | Less than 90% satisfied with the service. Less than 40% of patients who attend the service clinic | QUARTERLY Establish a regular programme of surveying the COS patients to elicit views about patient experience, service quality and barriers to attending. Commissioners required to agree questionnaires and means of administration | GC9 |

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|----|--|--|---|---|-----|
| 12 | Breakdown of incidents, SI, never events and complaints | No occurrences | Occurrences of any events | QUARTERLY Submission with the contract performance report | GC9 |
| 13 | Delivery against all agreed adult and child safeguarding protocols and procedures set out in service specification | 100% compliance required | Required level of compliance falls below 100%. Referral to CQC if concerns persist | QUARTERLY Monthly update on agreed indicators. Agreed reporting schedule as part of contract review process | GC9 |
| 14 | Infection control standard | 85% compliance with infection control audit standard | If required level of compliance falls | QUARTERLY | GC9 |

**ANNEX 1:
INDICATION OF CONDITIONS APPROPRIATE TO BE SEEN IN THE COMMUNITY SERVICE**

a) Acute conditions:

The service is expected to undertake diagnosis, management and treatment of all ages for the following conditions:

- Chronic vision loss
- Ocular pain
- Systemic disease affecting the eye
- Differential diagnosis of the red eye
- Foreign body and emergency contact lens removal (not by the fitting practitioner)
- Dry eye
- Epiphora (watery eye)
- Trichiasis (in growing eyelashes)
- Differential diagnosis of lumps and bumps in the vicinity of the eye
- Recent onset of diplopia – consider stroke (binocular diplopia always significant)
- Flashes/floaters
- Retinal lesions
- Field defects
- Blurred vision
- Mild Trauma

b) Chronic conditions:

Glaucoma

- Screening for suspected glaucoma or ocular hypertension as per agreed criteria and informed by NICE guidelines
- Follow up of low risk of sight loss primary open angle glaucoma, ocular hypertension and suspected ocular hypertension as per agreed protocol and informed by NICE guidelines
- Transfer of low risk of sight loss glaucoma patients from secondary care into the community for on-going monitoring

Cataract

- Management of pre and post-operative cataracts in the community settings, thereby shortening the cataract pathway. The service will act as a triage service for patients who may require cataract surgery, in line with the NW London PPWT pathway, and will undertake the approvals process on behalf of the patient/GP
- Post-surgical follow up per agreed protocol
- Direct surgical listing of cataract surgery as per agreed protocol

c) Paediatric Eye Conditions

- Strabismus
- Amblyopia

The service will undertake appropriate procedures including minor surgery (which can be safely done in the community) to manage the above list of conditions. Examples of minor surgery to be undertaken at community setting are:

- Lacrimal syringing
- Extirpation of eyelid cysts
- Snip procedure
- Insertion of punctual plugs

- Chalazion (if funding approved by PPwT)/Meibomian cyst
- Removal of any other lumps and bumps – warts (if funding approved by PPwT), cysts, skin tags
- Entropion and ectropion

The service will operate in line with the North West London PPwT policy and threshold for eye conditions.