

Service Specification No.	
Service	Hounslow Community Ophthalmology Service (HCOS)
Commissioner Lead	NHS Hounslow CCG
Provider Lead	
Period	3 + 2 years
Date of Review	

1. POPULATION NEEDS

1.1 National/local context and evidence base

Increasing eye health needs due to the ageing population and availability of new treatments is creating capacity issues within the Hospital Eye Service, especially in relation to age-related macular degeneration (AMD), diabetic eye disease and glaucoma.

Between 2010 and 2020, it is predicted that there will be a 26% increase in patients with AMD, a 20% increase in patients diagnosed with OHT or glaucoma and a 25% increase in people with diabetic eye disease.

NHS Five Year Forward View

The drive for more healthcares in the community is in the NHS Business Plan 2015/16 and embedded throughout the NHS Five Year Forward View (5YFV). A key objective in reorganising services has to been to achieve better management of patient flows as well as freeing up capacity in the Hospital Eye Service.

A number of Community Ophthalmology Services have already been commissioned across CCGs in response to the increase in demand. New models need to be tested at scale but it is important that there is a common framework around each one and we do not continually reinvent the wheel. *“While the answer is not one-size-fits-all, nor is it simply to let a thousand flowers bloom” (FYFV page 17).*

In line with the strategy set out in Shaping a Healthier Future and the Out of Hospital Strategy, Hounslow CCG has recognised the need for a Community Ophthalmology Service to bring eye care closer to patients’ homes, with shorter waits, at a reduced cost. This view is also supported by the Royal College of Ophthalmologists: ‘Transferring patient care from hospital eye services to the community could provide better care for less serious cases and make better use of the limited capacity in secondary care for those with sight threatening conditions¹. They further note that ‘many patients are elderly and most cannot drive to their eye appointment as they might need dilating drops so shorter distances to travel have significant benefits for patients and their carers².

The main aims of a Community Ophthalmology Service should be the assessment and management of patients whose eye conditions are at low risk of deterioration who are either referred by primary care for assessment or discharged from secondary care for monitoring.

2. OUTCOMES

¹ Hornby, Stella (2013) The Royal College of Ophthalmologists , Ophthalmic Services Guidance, Primary Care Ophthalmology Care, page 2, Ref. 2013/PROF/234

² Ibid 7

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	√
Domain 3	Helping people to recover from episodes of ill-health or following injury	√
Domain 4	Ensuring people have a positive experience of care	√
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	√

2.2 Local defined outcomes

- a) More equitable access and treatment of ophthalmology patients within different levels of deprivation
- b) A reduction in referrals to secondary care services, reduction of referrals into the community service and a reduction in the number of follow ups across all levels of care
- c) Increased patients satisfaction with ophthalmology services
- d) Services closer to patients' homes
- e) Improved communication between specialist clinicians and GPs
- f) Improved quality of care within primary and community setting
- g) Increased patient choice
- h) Improved access to advice and information and increased knowledge and awareness of the management of ophthalmology across primary care settings
- i) Increase self-management by patients and carers
- j) Clearly defined Standard Operative Procedure (SOP)/ consistent care for low risk eye conditions

3. SCOPE

3.1 Aims and objectives of service

The primary objectives of the Service are to:

- Deliver improved access for patients to specialist ophthalmology services;
- Provide care closer to people's homes, in a community environment;
- Deliver high quality specialist services that support patients get the right care first time;
- Support the education and up-skilling of referrers, to conduct better ophthalmic diagnosis and condition management in primary care; and
- Offer a better value service for the NHS through more efficient use of resources.

3.2 Service description/care pathway

3.2.1 Service overview

- a. To provide a **Consultant led ophthalmology service in the community** where patients are

- seen either by a consultant, ophthalmology registrar, GPwSI, optometrist with special interest, Ophthalmic nurse practitioner or Orthoptist, but working under and with direct access to a consultant
- b. There must be 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;
 - c. The service will be provided for **adults and children** registered with Hounslow GPs
 - d. The service will **triage** all the ophthalmology referrals from Hounslow GPs and direct them to community or hospital according to clinical appropriateness.
 - e. **Support transfer of patients with low risk ophthalmic conditions** from an acute led secondary care hospital setting to a community setting
 - f. Assessment, investigation and treatment of patients with eye conditions within the scope of the Service;
 - g. For routine cases patients will be seen/offered first appointment within **4 weeks of receiving the referral.**
 - h. Appropriate procedures including **minor surgery** (where these can be safely carried out in the community)
 - i. Improving knowledge of health professionals around the management of eye diseases through the development and implementation of **education programmes for GPs, optometrists** and other practitioners on the agreed clinical pathway.
 - j. To improve the quality of GP/optician referrals such that cases that can be safely managed in primary care are not referred to community or secondary care service
 - k. Help develop and maintain clinical guidelines on local primary care management of common ophthalmological conditions
 - l. An **advice line for referrers** providing timely advice to support better diagnosis in primary care and improved referral quality;
 - m. The service will be delivered in the community locations, **preferably at least from 3 different sites.**
 - n. To improve the **education of patients** around self-management of their conditions.
 - o. Sign posting to third sector organisations for additional support where appropriate
 - p. To improve communication and smooth the patient journey between specialist and primary care
 - q. To provide better value for money due to a more cost effective use of resources
 - r. To improve patient satisfaction through delivering a quick, accessible and quality service
 - s. Use of **SystemOne** (or a system interoperable with SystemOne), to transfer all information for patients, appointment booking and referrals management

- t. Engagement with local data sharing as detailed in the CWHHE memorandum of understanding for data sharing within S1.

Please note- As part of future service development and improvement, provision of Optical Coherence Tomography (OCT) will be considered in the community. Adequate resource allocation to develop these additional pathway will be explored between the Provider and CCG

3.2.2 Referral criteria and sources

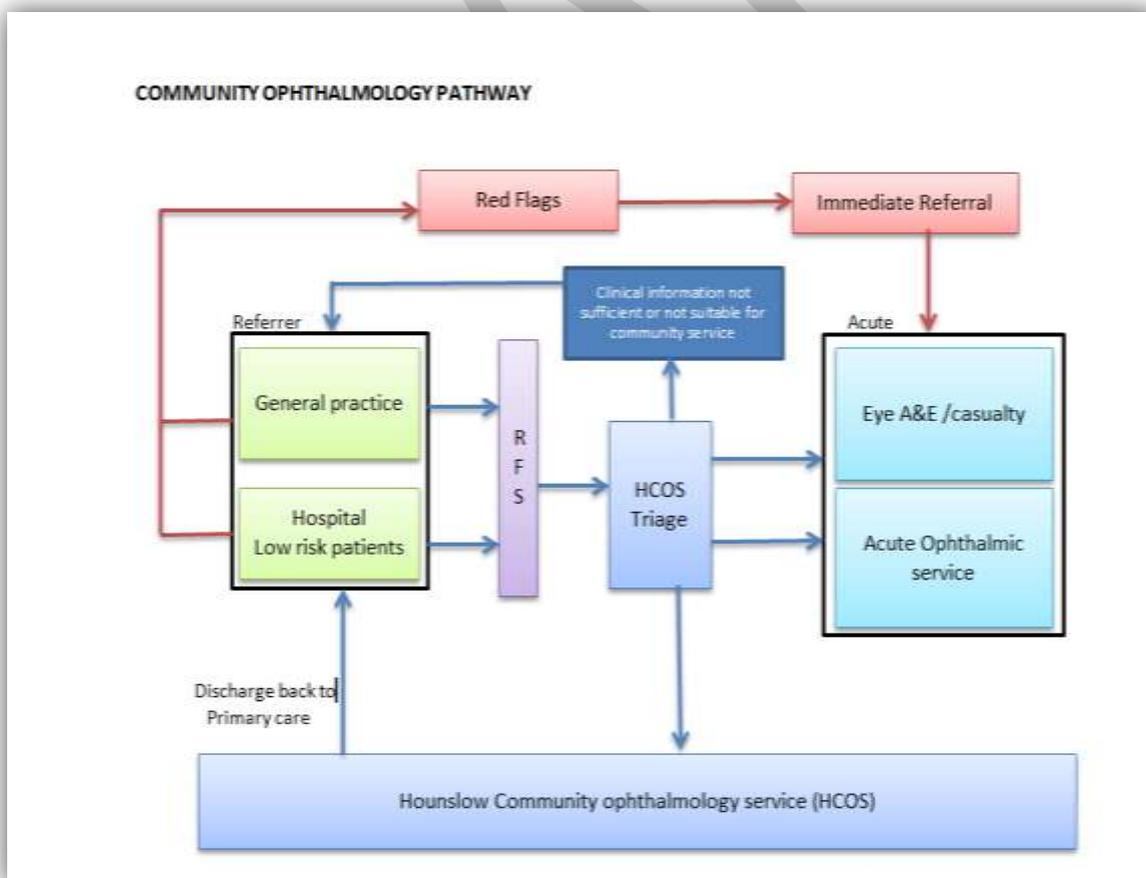
- Referrals will be accepted from patient GPs, for patients registered with a Hounslow GP
- Hospital Eye Services will also be able to refer in to the Service, where for example a patient with a long term condition requires on-going monitoring and review;

3.2.3 Referral route

Referrals will be accepted via Hounslow Referral facilitation services only, except Red flag conditions which should be sent directly to secondary care eye A&E/Casualty. A direct referral received by the Provider will be returned to the referrer via e referral system (SystemOne).

Any onward referral into secondary care for patients requiring specialist hospital intervention will be via Hounslow Referral facilitation services only.

GPs and other referrers will be kept informed of their patient's progress through the system and the final outcome in line with patient consent requirements, especially if HCOS identify red flags which had been missed earlier.



3.2.4 Clinical Triage

The clinical triage must be overseen by a consultant ophthalmologist and support all patients to receive the right care from the start of their care pathway. The clinical triage function will clinically assess all referrals that the Provider has identified as meeting the minimum data set requirements

Referrals will be triaged within 2 working days of receiving the referrals. The Provider will develop an educational feedback process for the referrers (GP/optometrist) with the information from triage.

The outcomes of clinical triage will include:

- Reviewing and accepting routine referrals for assessment, diagnosis and treatment - to be offered within four weeks;
- Directing referrals back to their GP (or other agreed referrer) for further work up and management where referral information is inadequate and appropriate clinical assessment cannot be made. Referrals from GPs must be screened to ensure appropriateness for acceptance in the Service. Where there are patterns of regular inappropriate referrals from a referrer, necessary training and communication should be implemented;
- Where red flags have been missed prior to referral requiring urgent referral to eye casualty from triage this should always be communicated to the referrer
- Directing referrals to a range of other primary care eye services as appropriate (including optometry);
- Ensuring that patients are directed appropriately to receive the right care first time;
- Undertake a telephone assessment / consultation where clinically appropriate; and
- Directing patients to hospital eye services where clinically appropriate.

3.2.5 Assessment, diagnosis and treatment in Community Ophthalmology Service

A list of conditions deemed relevant to be seen within the Service is provided at Annex 1. All outpatient ophthalmic conditions and treatments suitable for a community setting can be provided in the community Service.

Emergency conditions and 2 week wait referrals are not within the scope of this service.

3.2.6 Referrer advice line

The Provider(s) will offer direct telephone and email advice, from a specialist within the Service, on a daily basis for referrers. The Provider will be required to ensure email queries are responded within two working days for enquiries. Telephone services shall not start with the digits 087, 090 or 091 or consists of a personal number, unless the service is provided free to the caller. The advice and guidance support will support better diagnosis, condition management and improved referral quality in primary care

3.2.7 Response time and detail and prioritisation

Once the referral has been received the service will initiate contact with patients within 72 hours (three working days) and offer them an appointment within four weeks of the referral being received.

A choice of appointment days and times will be offered and patients will have the option of booking appointments outside the four week period for eventualities such as holidays. If a patient cannot book a further appointment for valid reasons, the appointment may be left open for a maximum of one month.

For any onward referral to hospital eye services, a full statement should be provided and made available to the receiving hospital/service within one working day, this must include as a minimum:

- All diagnostic results already undertaken;
- Patient notes under appropriate information sharing arrangements; and
- Confirmation of informed patient choice offered to the patient.

Following the patient's appointment within the Service a report will be sent to the patient and their GP, including a diagnosis and care plan that is agreed with the patient. This will be sent within two working days of the appointment.

3.2.8 Transfer of information

The service will use SystemOne (or a system interoperable with SystemOne), including the use of electronic patient records.

All letters to patients, GPs and optometrists will be clearly legible, and sent electronically where possible. Where necessary they will be posted within two working days of the appointment. These will contain as a minimum:

- Patient's name, date of birth and NHS number;
- Named clinician in charge;
- Primary and, where appropriate, secondary diagnosis and/ or procedure;
- Referral to other service;
- Diagnostic tests;
- Full management plan and follow up arrangements and suggestions for further treatments, which could if necessary be added by the GP should the patient fail to respond to initial therapy;
- A medication update for the patient stating dose, frequency and duration of course of newly prescribed drugs, suggested review dates and notification if any medications are stopped;
- Contact details for the Service for ease of communication and query.; and
- Where possible copies of clinical protocols/guidelines.

3.2.9 Cancellation

If a patient cancels their appointment with more than 24 hours' notice they will be offered another appointment.

If a patient cancels twice on consecutive appointments they are liable to be discharged back to their GP except in exceptional circumstances. A warning will be given after the first cancellation.

If a patient cannot book a further appointment for valid reasons, the appointment may be left open for a maximum of one month.

3.2.10 Did Not Attends (DNAs)

If a patient does not attend their new or follow up appointment they will be sent a letter asking them to book a new appointment in two weeks. If the new appointment is not taken they will be discharged back to their GP, except in exceptional circumstances.

Once discharged, if a patient telephones the service they will be advised to return to their GP for another referral if they still require treatment.

In exceptional circumstances, a patient may be offered another appointment once discharged.

DNA rates must be provided at monthly intervals to each CCG as part of the monitoring arrangements.

3.2.11 Discharge criteria and planning

Patients will only be discharged from the Service when it is clinically appropriate to do so. They will either be discharged back to the care of their own GP, or to hospital eye services. In either case, a full report will be prepared and sent to the relevant clinician.

3.2.12 Days / Hours of operation

Services must be offered between a minimum 08:00 and 18:30 Monday to Friday and outside of these core working hours to provide a more accessible and convenient service for patients. Opening hours should include at least two evenings per week and/or weekend opening. Flexibility with regard to locations, days, times and sessions held (e.g. extended hours) should reflect modern working commitments and should encourage maximum levels of attendance. Opening hours should follow patterns in demand to keep waiting times consistent.

The Provider will offer patients appropriate information as to which services to access should a treatment complication arise before their allocated appointment time, or should an emergency appointment be required outside these normal hours. In the first instance, this will be redirection to appropriate urgent care services (e.g., 24h A&E).

The Provider will not:

- Replace routine eye examinations or prescriptions for spectacles/contact lenses and a full eye exam will not be required as part of the assessment or treatment or management. Where a routine eye examination is required, the ophthalmic professional will redirect the patient to their usual community optometrist.
- Include a diabetic eye screening service.
- Treat conditions which are funded by NHS England relating to NHS Prescribed Specialised Commissioning. Separate arrangements will need to be made for patients who meet this criterion.

3.2.13 Patient consent

The Provider will be required to have processes in place to evidence that valid consent, including from those who have communication or language support needs, is obtained by suitably qualified staff for all treatments/procedures. This will also include evidencing that where a patient lacks the mental capacity to give consent, the principles of the Mental Capacity Act 2005 Code of Practice have been adhered to.

3.2.14 Protected characteristics and accessible information standards – TBC

3.2.15 Medicine Management

The Provider should work to optimise medicines use to improve health outcomes by enabling timely, safe and effective medicines related care, tailored to the needs of individual patients throughout the local health economy.

Where possible, patients should be referred back to their GPs for medication except for treatment that must start immediately i.e. within 7 working days.

The Provider should have a comprehensive policy on the ordering, safe storage, handling, prescribing and dispensing of medicines approved by their Drug and Therapeutics Committee (or equivalent). If not covered under the general medicines policy the following areas must have separately approved policies:

- The use and disposal of patients own medicines;
- Self-administration of medicines by patients;
- Use of unlicensed medicines and medicines used for unlicensed indications; and
- Interacting with the pharmaceutical industry.

Prescribers should adhere to the NWL Integrated Formulary and should not seek to avoid restrictions by asking GPs to prescribe non-formulary medicines. Antibiotics should, in the main, be prescribed from the NWL preferred list.

Should the service require routine use of medicines outside of the NWL Integrated Formulary, provision must be made for initial and on-going supply from the service.

The Provider should submit a list of proposed medicines to be used within the service for agreement with commissioners.

Where there is a choice of medicines which would be equally suitable for the patient, the most cost-effective choice should be prescribed/ recommended. This includes prescribing/recommending medicines by generic name except where this is clinically inappropriate.

The Provider should prescribe in accordance with all relevant local, national and professional guidance including National Service Frameworks, NICE Technology Appraisal Guidance and relevant Health Service Circulars and Guidance, Executive Letters and Audit Commission reports.

The Provider will demonstrate compliance with any relevant Central Alerting System alerts, Patient Safety Alerts and MHRA safety alerts and notices.

The Provider will have a process in place to report Adverse Drug Reactions via the 'Yellow Card' system.

The agreed tariff should be inclusive of medication required immediately (i.e. within 7 working days) and those not included in NWL Integrated Formulary.

Proposed mechanisms for supply of these medicines should be detailed by the Provider for agreement with the Commissioner e.g., Medicines will be stocked and administered/supplied on site, and/or HPFP10 prescriptions used.

If the patient requires any medicine before the Provider can guarantee that the practice will receive

full prescribing information, it is the responsibility of the Provider to supply.

It is the responsibility of the Provider to prescribe a medicine on an on-going basis if:

- It is unlicensed;
- It is included in the 'Red List' of medicines where responsibility for prescribing remains with the consultant; or
- Where a GP feels they do not have sufficient experience of the medicine to take clinical responsibility for prescribing it.

Ideally, informed consent for the use of licensed medicines outside of their licensed indications should be obtained from patients before the prescription is written. Where there is a substantial body of evidence to support the use of a licensed medicine outside of its licence, the GP may be asked to prescribe.

When a medicine requires specialist monitoring, the GP may be asked to prescribe only if the following conditions are met before shared care takes place:

- The patient's condition is stable; and
- The agreement of the patient's GP is sought prior to the transfer of prescribing; and
- The GP is sufficiently informed and able to monitor treatment, identify medicine interactions and adjust the dose of any medicines as/if required by shared care; and
- Resources are available to ensure (where required) the safe administration of any specialist medication in the community e.g., IV therapy. This would usually be agreed with the community nursing services.

All individual consultations are required to include a discussion of 'how to use prescribed medicines and devices'. This should be supported by the provision of information leaflets as appropriate. The Provider will ensure that any potential issues of medicine adherence (medicine taking) are considered and addressed.

When the patient is discharged from the service (or after episodes of care as appropriate) information should be provided to the GP including:

- Details of any medicines that have been stopped, the reason why the medicine has been prescribed and the intended duration of any new medicine;
- Any adverse reactions or allergies;
- Appropriate contact details where the GPs can communicate any issues; and
- Any special arrangements made with Community Pharmacists or Community Nurses to supply/administer medicines.

Prescribing decisions and recommendations will only be made by suitably qualified medical independent prescribers or optometrists holding the College of Optometrists' Diploma of Ocular Therapeutics in Independent Prescribing with appropriate clinical governance arrangements in place.

The Provider will be required to monitor and audit internal prescribing as good practice and provide a report to the Commissioner every six months

3.2.16 Training and Support to Referrers

The service provider will provide on-going support and education for referring GPs and optometrists in order to ensure that best management practice is shared. The provider will develop and regularly update the referral guidelines to ensure the best clinical practice.

The Provider will develop an educational feedback process for the referrers (GP/optometrist) with the

information from triage.

A consultant telephone and email advice service should be provided to support the referrers. Open educational meetings for all GPs, optometrist, nurses and other community staff to attend will be organised including seminars, lectures and case studies.

Offer in-clinic training for GPs, optometrists, including aspects of diagnosis and treatment to improve skills. The number of sessions offered would depend on how many clinics are run by the provider.

The Provider will fully engage with Health Education North West London and other acute trusts to enable and facilitate clinical supervision and training of SpRs and other appropriate ophthalmology trainee grades/practitioners.

3.3 Population covered/acceptance criteria

The service will be available for patients who are registered with a GP in Hounslow, who have been assessed by their GP or Optometrist as suitable to attend.

The service will be for both, adult and children.

3.4 Any exclusion criteria and thresholds

The service is not available to:

- Patients not registered with Hounslow GPs
- Patients requiring treatment that should be provided under a standard GMS or PMS or GOS contract
- Patients with suspected cancer (should continue to be referred direct to the hospital under the 'two week rule' on appropriate referral documentation);
- Referrals for Diabetic retinal screening service
- Emergency eye conditions requiring intervention at hospital setting;
- Any patient that has received eye surgery at a Hospital Eye Service within the previous 6 weeks.

3.5 Interdependence with other services/providers

Providers shall ensure that all performers of services to patients should be familiar with the wider healthcare community and be able to make referrals to other services, including specialist services, as and when required. Sign posting to third sector organisations for further support where appropriate should also be included within the Service offering.

Partners will include

- All General practices in Hounslow
- Optical practices in Hounslow
- Patient Forums;
- All secondary care providers of Hounslow;
- Local authority
- Hounslow Referral Facilitation Service

The Provider will be required to link seamlessly through effective and prompt communication with, and signposting to, both specialist and primary care ophthalmology services 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).

It is the responsibility of the Provider to ensure that all appropriate details are communicated to the necessary recipients and appropriate notes are made in the patient's records.

The Provider(s) will be required to work proactively with primary care referrers and local hospital eye services to ensure that the desired activity transfer from hospital eye services to the Community Ophthalmology Service is achieved. This includes working with local Hospital trusts to put in place effective arrangements for transferring follow-up care from hospital eye services to the community service.

The Provider will be required to work together with commissioners on future integration work covered under the Whole Systems Integrated Care programme of work across North West London.

3.6 Staffing

3.6.1 Staffing qualification

The service shall have an appropriate staffing structure in terms of skill, experience and numbers.

The Provider shall 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.

The Provider shall ensure that all clinical staff meets 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 Minimum 2 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); and
- Orthoptists
- Optometrists wishing to provide eye care services in the community under the scheme should have and maintain the necessary accreditation. The development of optometric skills should be considered utilizing the College of Optometrists postgraduate qualifications

The provider must keep a record of the immunisation status of all clinical and reception staff,

including but not limited to:

- Occupational Health Assessment against Tuberculosis;
- Measles; Varicella (Chicken pox);
- Rubella (German measles); and
- Influenza (seasonal – each autumn).

3.6.2 Registration

The Provider will have procedures in place for ensuring that all clinical staff, including doctors, nurses and allied health professionals, are registered with the relevant UK professional and regulatory bodies.

Optometrists should be registered with the General Optical Council UK and have one or more of the following qualifications:

- The Foundation Fellowship of the British College of Ophthalmic Opticians (Optometrists)+ (FCOptom);
- The Fellowship/Membership of the College of Optometrists+ (FCOptom/MCOptom);
- The Fellowship Diploma of the British Optical Association (FBOA);
- The Higher or Honours Diploma of the British Optical Association (FBOA:HD)
- The Fellowship in Optometry of the Worshipful Company of Spectacle Makers (FSMC);
- The Higher Diploma on Optometry of the Worshipful Company of Spectacle Makers (SMHD), (Holders of the Honours Diploma of the Company, discontinued in 1950, are described as FSMC(Hons);
- The Fellowship Diploma of the Scottish Association of Opticians (FSAO);
- The Diploma in Ophthalmic Optics of the British College of Ophthalmic Opticians (Optometrists)+ (DOpt); or
- University of Manchester Institute of Science and Technology (MSc).

Providers will have workforce policies, strategies, processes and practices that comply with all relevant employment legislation applicable in the UK and in addition comply with the provisions outlined in:

- Safer Recruitment – A Guide for NHS Employers (May 2005);
- The Code of Practice for the International Recruitment of Healthcare Professionals (December 2004) (the Code of Practice); and
- Standards for Better Health (April 2006).

3.6.3 Disclosure and Barring Service (DBS) Checks

For all staff whose most recent DBS check is more than three years old, the Provider must undertake a new DBS check prior to the staff member commencing work on this contract. Any staff member whose DBS check is less than three years old but whose check was not completed directly by the Provider must renew this prior to commencing work on this contract.

For remaining staff, their DBS check shall be renewed by the Service Provider when their most recent check becomes three years old.

It is the Provider's responsibility to ensure that all staff has had a DBS check and that they have complied fully with the Criminal Records Bureau Code of Practice. Should any offences be recorded

on the DBS disclosure then the Provider shall not allow that person to work on this contract without first obtaining written approval from the authorised representative or his/her representative.

6.6.4 Changes in Staff

Where changes in staff take place, the Provider shall ensure that a DBS check has been conducted. The Provider shall inform the respective CCG of any new appointments or proposed changes to the existing organisational structure, in writing and in advance of the proposed changes becoming effective.

6.6.5 Identification cards

The Provider's staff shall carry and display identification cards at all times. The identification cards must contain as a minimum the Service name, the staff member's name and a colour photograph.

3.7 Patient and Public Involvement and information to be made available to patients

Self-care and patient and carer information

Advice on self-management and patient education leaflets to be made available by the service to be approved by the Commissioner. All patients must be provided with a care-plan.

Providers will offer a comprehensive range of patient information and will direct patients to other resources such as support groups and other third sector organisations in order to educate support and empower them to live with their eye problems. Information will be formatted according to NHS guidelines, and agreed by the respective CCG Communications Department and should be made available in different languages as required (to be identified by the Equality Impact Assessment).

Community Ophthalmology Service information

A set of high quality comprehensive information leaflets on the main eye conditions will be developed and agreed with the CCGs.

In order to involve patients in their care and to help them understand how to manage their condition, patients and their carers shall be given appropriate evidence-based information in an accessible format. The Provider will ensure that patients and carers receive the most appropriate, evidenced based and updated advice and information.

It is expected that each patient's care plan should be reviewed and evaluated with that patient (and/or their carer/family at the patient's consent) at each contact throughout the length of period of care. Patients should be included in the development of and implementation of care plans and be involved in continuous re – evaluation of their needs and what actions to be taken to achieve these requirements.

Patients will be given full information prior to any procedure being undertaken in order to ensure informed consent is obtained. Patients will also be given detailed information regarding the management of their condition following discharge.

The service will also provide advice and guidance to patients up to 28 days after discharge from the services. Patients will be informed that they can telephone, write or email the service and expect a clinical response within one working day. If further advice or guidance is required after this period, patients will be required to re-visit their GP or optometrist.

In order to ensure fully informed consent is obtained the service will provide the following information as a minimum requirement:

- Patient information leaflet giving details of the Provider, days and times of sessions, how to make appointments and contact details
- Patient information leaflet detailing any pre-appointment actions that need to be undertaken by the patient;
- Patient information leaflet explaining in non-medical terms any procedure that is appropriate for the patient to undergo and any prevention/aftercare information; and
- Patient information leaflets for any of the conditions listed in section 2.1.

All information leaflets must be approved by Hounslow CCG before commencement of the service.

The Provider will also ensure that the service adheres to the NHS Hounslow CCG complaints policy. The service will provide information of how to access the complaints process. Staff should be trained in the handling of complaints and there must be a nominated member of staff to handle complaints must be in place.

Information will be made available, upon request, in different formats such as braille, large print and in languages other than English.

3.8 Equipment

The Provider will be responsible for the purchase, maintenance and replacement as necessary of relevant equipment required to provide the service. All associated software must be compatible with secondary care software, or be in a comparable transferable format, to avoid any requirement for duplication of tests, should a patient require onward referral to secondary care.

Essential equipment to be provided by the Provider should include, as a minimum:

- Visual acuity Snellen chart – Distance and Near (to include non-English e.g., Landolt C/ Tumbling E and learning difficulties, Bailey Lovie/LogMar/VAR chart for low vision patients);
- Ishihara Colour vision plates and The City University Colour Vision Test (or equivalent to enable detection of tritan anomalies);
- Appropriate topical medications for ophthalmic examination, including single dose units of topical anaesthetic, mydriatics, cycloplegics and fluorescein;
- Direct and indirect ophthalmoscopy equipment;
- Slit lamp biomicroscope with at least 40 x magnification with Goldmann Tonometer (or Perkins for domiciliary visits or patients with postural problems);
- Fundi oculi lenses – Volk lens and three mirror gonioscopy lens;
- Visual field analyser (suprathreshold or Damato 60 point for domiciliary visits);
- Additional equipment as may be required in line with any new regulations and best practice guidelines; and

The Provider will also use SystmOne clinical software (or a system interoperable with SystmOne), for appointments, record keeping, reporting and communications with GP practices. 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 staff working within the service will have achieved competency in both assessment and procedure management including a clear understanding of

possible complications.

All equipment should be in full working order and fit for purpose. Portable appliances and fixed installation electrical testing certificates are required.

If sharps are used, all staff should know the procedure to follow after a sharps injury; the laminated sharps injury flow chart is to be displayed on the premises.

3.9 IM&T

The Provider shall 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
- Have a SystmOne IT system, or suitably highly granular interoperability with a SystmOne enabled IT system to facilitate; Two 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

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 in 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 25 birthday for children.

4. APPLICABLE SERVICE STANDARDS

4.1 Applicable national standards (e.g. NICE)

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

- 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; and
- Data Protection Act 1998.

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

The Provider shall comply with the standards and recommendations in guidance issues by all relevant professional bodies.

4.3 Applicable local standards

TBC

6. LOCATION OF PROVIDER PREMISES

The service will be delivered in the community locations, **preferably at least from 3 different sites**

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 CQC 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 Provider will ensure that premises are accessible to patients with physical disabilities or wheelchair users and must comply with the Equality Act 2010.

As required by applicable clinical guidelines, regulations and best practice, service 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;
- A storage area;
- Wheelchair / pram access;
- Network capability to support service delivery;
- Appropriate ventilation;
- 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;
- Flooring in all areas where patients have access should be impervious and forms a coved skirting to enable disinfection.
- Patients' seating is to be fabric-free to ensure adequate disinfection. Some chairs in the waiting area are to have arm rests to enable the elderly to rise easily.
- Signage in line with guidance from RNIB; and

- 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 the provision of the ophthalmology service under this Contract, the Hounslow 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 CCGs. An Ophthalmic Contract Compliance Visit will be carried out on an annual basis at all points of service providing ophthalmology services under the Contract to ensure that patient safety is not being compromised.

7. ACTIVITY

7.1 Indicative Activity Assumptions

		Year 1	Year 2	Year 3
Number of Attends	First Attends	6,455	6,649	6,848
	Follow Up Attends	2,351	2,422	2,495
	Procedures	247	254	262
	Total	9,053	9,325	9,605

QUALITY AND PERFORMANCE INDICATORS

	Description of KPI	Minimum Performance Standard	Method/Timing of Monitoring	Breach
1.	All routine referrals to service triaged as per agreed local referral Management process	All referrals appropriately recorded and assessed at triage within 2 working days	MONTHLY Anonymised record of all referrals received time to triage and next steps decision recorded for 100% referrals received	Less than 98% of referrals in any one month
2.	Onward referrals to Secondary Care for any procedure is accompanied by completed PPWT form	100%	MONTHLY Monthly provision of MDS for patients treated Review against NWL PPWT procedures list	Below 100%
3.	Provision of Minor Surgery in HCOS (List of minor surgery TBC)	98% appropriate minor surgical cases treated within COS without further treatment required in Acute	MONTHLY	Below 98%
4.	Turnaround time for sending letters after assessing/treating patient	100% within 2 working days	MONTHLY	Less than 98% of referrals in any one month
5.	Waiting Times of routine cases-Percentage of patients seen and treated within 4 weeks of receipt of the referral	95% treated within 4 weeks	MONTHLY	Less than 85% of referrals in any one month
6.	Percentage of DNA s by new and FU (against total period of appointment)	9%	MONTHLY	DNA rate greater than 9%

	Description of KPI	Minimum Performance Standard	Method/Timing of Monitoring	Breach
7.	Consultant attendance at Community clinics	Lead Consultant to attend a minimum (TBC) of clinical sessions per week provided as part of contract. Provider will need to have appropriate cover arrangements in place for absence/sickness etc.	MONTHLY Evidence of weekly Consultant attendance at clinics e.g. Notes of MDT meetings, job plan, attendance records	A week when less (TBC) of clinics attended by consultant (i.e. 1 episode)
8.	Delivery of GP /Primary Care Education Sessions broken down by group sessions, in-clinic training, telephone and email advice broken down by practices	Delivery plan to be agreed between provider and commissioner by service start date	MONTHLY Provision of agenda and attendance record for event Evidence of how topics /actions selected and how are outcomes identified and Audited	Not completing actions and meeting timescales detailed on delivery plan.
9.	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	QUARTERLY Specific question in patient satisfaction survey covering 'choice'.	Less than 95%

	Description of KPI	Minimum Performance Standard	Method/Timing of Monitoring	Breach
10.	Patient satisfaction with the service	90% satisfied with the service Minimum response 40% of patients who attend COS 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	Less than 90% satisfied with the service Less than 40% of patients who attend COS clinic
11.	Breakdown of incidents, SUI, never events and complaints	No occurrences	MONTHLY Submission with the contract Performance report	Occurrence of any of these events
12.	Delivery against all agreed adult and child safe guarding protocols and procedures set out in service specification	100% compliance required	MONTHLY Monthly update on agreed indicators Agreed reporting schedule as part of contract review process	Required level of compliance falls below 100%. Referral to CQG if concerns persist
13.	Infection control standard	85% compliance with infection control audit standard	QUARTERLY	If required level of compliance falls

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

All ophthalmology referrals are sent to the community service, for clinical triage, with the following exceptions:

- a. Referrals that meet the exclusion criteria in section 3.4 of the specification; and
- b. If the Referrer suspects a condition is an emergency it should be referred directly to emergency eye services.

Where the referrer is in doubt, they should use the clinical advice line for guidance on the referral. If advice not available on time, and the referral is not an emergency, the referral should be sent to the

Acute Conditions

- Watery eye
- Dry eye
- Red eye
- Lid lesion
- Blepharitis
- Eyelash problem
- Floaters / flashing lights
- Field defects
- Retinal lesions
- Blurred vision

Chronic Conditions

Glaucoma:

- Screening for suspected glaucoma or ocular hypertension per agreed criteria and NICE guidelines
- Follow up of low risk primary open angle glaucoma per agreed protocol

Cataract:

- The service will work with the commissioner to develop a protocol for Cataract: surgical pathways longer term. In the short term 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

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. *Minor surgery list TBC*

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