SERVICE SPECIFICATION

Service Specification No.	**02/GMS/0031**
Service	**Community Ophthalmology Services**
Commissioner Lead	**CCP for General Medical & Surgical**
Provider Lead	
Period	**1 April 2013 to 31 March 2014**

1. Purpose

1.1 Aims

The aim of the service is to manage patients within the community, where appropriate, ensuring that patients are transferred to secondary or specialist care only when treatment needs require secondary or specialist care services.

It will do so by providing a high quality community eye service founded on the principles of good practice and clinical governance.

The service will seek to improve the patient's experience by:

- providing a local service for patients, reducing journey times;
- improving access and choice and reducing waiting times;
- reducing unnecessary and inappropriate referrals to secondary or specialist care;
- working closely with GPs, optometrists and secondary or specialist care colleagues to provide a seamless service and continuity of care;
- facilitating the development of 'one stop' patient consultations combining assessment, treatment, self-care instruction and discharge where appropriate;
- formulating a service delivery framework which meets the requirements of local Practice Based Commissioning ("PbC") consortia.

1.2 Evidence Base

The development of community based ophthalmology services is fully supported by the Department of Health in their 'Commissioning Toolkit for Community Based Eye Care Services'. This document recognises that there will be a growing demand for eye care services over the next decade owing to demographic changes and in particular an ageing population. The toolkit supports the development of community based eye services and promotes the benefits to patients with a range of eye conditions who could be safely and appropriately managed within the community.

In January 2007 the Government announced the results of the General Ophthalmic Services Review. The review recognised the potential to develop more accessible, tailored eye care services for patients by making greater use of the skills that exist among eye care professionals who work in primary and secondary care settings, to help diagnose and

manage a range of eye conditions.

The development of community ophthalmology services will meet the current NHS strategy to increase access to care closer to home, respond to the growing need for community services in order to relieve the burden on the acute sector and provide quality of care to patients who require this element of ophthalmic care. Ophthalmology services available locally, either in the community, hospital or GP practice, will reduce the need for patients to travel to county towns and acute hospitals for care which could appropriately be offered in the primary care setting.

The service is designed to meet the requirements of the National Service Framework for Older People and the National Service Framework for Long Term Conditions. In addition NICE have recently published 'Guidance for the Diagnosis and Management of Chronic Open Angle Glaucoma and Ocular Hypertension (April 2009)'. It is the Commissioners intention to develop the current service specification, in consultation with providers, in order to ensure that the service is fully compliant with this NICE guidance in due course.

The population is ageing which will lead to an inevitable increase in eye disease; in particular as eye disease is frequently chronic in nature and as such requires lifelong follow up. In addition people are being referred with the earliest signs of glaucoma as diagnostic tests become more sophisticated and easier to apply. These factors place increasing burdens on secondary care services where eye conditions have traditionally been managed.

Chronic open angle glaucoma (COAG) is a common and potentially blinding condition, usually asymptomatic until advanced, but causes 10% of UK blindness registrations. It is estimated that 2% of the population over the age of 40 years will suffer from some kind of glaucoma (UK Prevalence – Glaucoma Association).

Evidence from other NHS Trusts across the country demonstrates that providing services on a local tariff can make significant savings; especially in light of the predicted increase in demand over the next decade.

1.3 General Overview

It is recognised that patients with a range of eye conditions may be effectively managed in a community setting, as part of an appropriate care pathway which ensures referral to specialist care when necessary.

A comprehensive Community Eye Service will provide a full local pathway for patients who require:

- Acute Assessments (new Patients)
- Routine Assessments (new Patients)
- Glaucoma Follow up
- Other Ophthalmic Follow up

1.4 Objectives

The service objectives are to provide a convenient, accessible service for patients which is closer to home.

1.5 Expected Outcomes

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 key outcomes of this service would be:

- streamlined and fully integrated ophthalmic patient pathways
- improved patient experience
- reduced impact on GPs and secondary care services resulting from NICE guidance and an the ageing population

Information on monitoring requirements is given in Appendix B.

2. Scope

2.1 Service Description

The service shall be an outpatient service, community based and provide care and treatment for adult patients presenting with a range of eye conditions. The service will include medical management as appropriate and in line with the care pathway.

The service does not include the delivery of those services which would form part of core GMS/PMS Primary Care Services, APMS or General Ophthalmic Services (GOS).

The specification of this service is beyond the scope of essential services, the GMS Quality and Outcomes Framework or those funded under other Enhanced Service provision. No part of the specification by commission, omission or implication defines or redefines essential, mandatory or additional services.

The service is specifically intended to address conditions that do not require surgery or specialist care.

Tier One is for more complex cases whereby it requires specialist skills or technology.

Tier One conditions shall be assessed and treated by an ophthalmic consultant, an

accredited GP with Special Interests (GPwSI) in ophthalmology or optometrists with relevant postgraduate qualifications and experience.

Examples of conditions included as part of the service, although not exhaustive or definitive are provided in Appendix D of the Service Specification.

Appendix D of the Service Specification also provides a listing of the conditions or patient categories not suitable for care and treatment within the service beyond an initial assessment and/or diagnosis (as appropriate). These categories are subject to revision by the Commissioners at any time.

Glaucoma
There are three elements to the provision of glaucoma services, diagnosis / treatment, refinement and management.

> Diagnosis / Treatment – this should be within the realms of the Community Ophthalmology service referring to the NICE guidance where defined pressures (dependent upon age), are referred to secondary care.
>
> Refinement – Community Optometrists should provide this service with referral to the Community Ophthalmology Service upon defined thresholds.
>
> Management – for the stable or low risk patients, these should be managed within the community optometrists

Any Shared Care arrangement should be between the Community Ophthalmology Service and Secondary Care. The glaucoma element of the service requires further redefining adn will be shared with providers once agreed.

2.2 Accessibility/acceptability

The service will be provided to patients who are registered with GP practices within Dorset; including Bournemouth and Poole. For Dorset, in the first instance, the service will be provided in West Dorset and Weymouth and Portland, with full roll out across the patch once evaluated.

Access to service providers will be via referrals from:

- GPs
- Optometrists
- NHS Minor Injuries Units (MIU)
- NHS Walk In Centres
- Hospital Eye Services

Patients requiring routine assessment will have their referral booked through Choose and Book. These patients should be seen within 4 weeks, but should not exceed the timescales as set locally. Where urgent local assessment is not feasible, e.g. outside of clinic hours, patients must be referred to an appropriate Hospital Eye Service.

Patients who are currently under the care of a local Hospital Eye Service may be transferred to the Community Ophthalmology Services by their consultant, e.g. for continuing glaucoma follow up.

2.3 Whole System Relationships

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.

2.4 Interdependencies

Providers shall be required to link seamlessly with both specialist and primary care ophthalmology services.

2.5 Relevant Clinical Networks and Screening Programmes

Providers shall ensure that appropriate links are established with Consultant Ophthalmologists and community optometrists in Dorset.

2.6 Sub-contractors

In order to make best use of local resources, some or part of the service may be subcontracted, e.g. to local optometrists, GPwSIs etc.

Providers shall ensure that any GP or optometrist, engaged or employed, to perform services, in accordance with the Service Specification, are included on a PCTs Performers List.

Providers shall not sub-contract any of its rights or duties under this service specification in relation to clinical matters unless;

- in all cases, it has taken reasonable steps to satisfy itself that it is reasonable in all the circumstances and that the person is qualified and competent to provide the service; and,
- it has notified the Commissioners in writing of its intention to sub-contract as soon as reasonably practicable before the date on which the proposed sub-contract is intended to come into force and has received consent to its proposals from the Commissioners.

3. Service Delivery

3.1 Service Model

Clinical Processes

Patients referred into the Community Ophthalmology Services will be assessed, treated and discharged in line with current legislation and guidance. A number of conditions, such

as glaucoma, which require regular follow up, will be managed according to clinical appropriateness.

Patients shall be referred without delay to appropriate Hospital Eye Services if there is significant progression or deterioration in the patient's condition or if they fall within the exclusion criteria.

Service design and delivery will reflect evidence-based practice and adhere to any current or future national or local clinical guidelines and protocols and such additional guidelines as set by the Commissioners. Specific attention is drawn to 'Diagnosis and management of open angle glaucoma and ocular hypertension' (NICE April 2009).

All referrals will be screened for suitability, and those that require specialist intervention or surgery, or that fall within the exclusion criteria shall be referred on directly. Urgent cases shall be prioritized in accordance with evidence-based policies in order that patients are seen within a clinically appropriate time scale and that priority is given to patients according to clinical need.

On screening, diagnostic tests will be identified and organised before consultation where appropriate, facilitating a 'one stop' appointment approach.

The service shall provide appropriate high quality patient information, both verbal and written, and patient education literature at each stage of the care pathway. Providers shall review all published patient information material regularly based on patient feedback.

Providers shall ensure patients are discharged, at the conclusion of each care episode, back into the care of their registered GP. Patients may re-enter the service on re-referral.

It is desirable, but not essential that the service provides telephone consultations and support for general practitioners and/or community optometrists.

Providers of the service shall participate in local audits and reviews of the service governance, protocols and guidelines.

Administrative Processes

The service shall:

- be included on the NHS Choose and Book menu for local referral services and the provider shall have systems in place for receiving, recording and acting upon referrals;

- have efficient processes in place to deal with all administration from the point of referral onwards, including a bookings and appointments system that meets all waiting time targets and other targets required of the Commissioners and NHS services nationally;

- have suitable processes in place to handle and manage variations in demand, e.g. seasonality;

- have procedures in place to deal with patients who do not attend or cancel appointments, e.g. a database of glaucoma patients to ensure recall/follow up;

- have procedures in place to follow up and/or recall patients as appropriate;

- ensure that full, accurate, contemporaneous and legibly written notes and records are kept for all patients;

- send a report outlining the diagnosis, drugs prescribed and proposed management plan to the referring GP and optometrist (as applicable) within five working days after the initial appointment. Where the referral originated directly from an optometrist, the patient's GP must also be sent a copy of the letter. The letter will include feedback reflecting on the appropriateness of the referral (leading to improved future referrals);

- send a discharge report to the referral source, copied to the patients GP, within five working days of the completion of the package of care or when any significant change in treatment is proposed.

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.

Providers shall populate the Directory of Services in Choose and Book and supply a CAB enabled PAS to facilitate CAB bookings into clinical services.

Provider shall ensure that data to support Commissioning support 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.

Standards and Quality

Core Skills/Competencies of team

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 meet the CPD requirements of their professional and regulatory bodies, that they are competent to deliver the service and that their skills are regularly updated.

Providers shall ensure that all clinical staff involved in the assessment and treatment of patients demonstrate a continuing and sustained level of relevant activity, conduct regular audits, are subject to appraisal and take part in supportive educational activities.

Providers shall ensure that clinicians have access to appropriate supervision, mentorship and advice. All clinical staff responsible for the monitoring of patients with glaucoma shall hold an appropriate specialist qualification and have the ability to detect a change in clinical status.

Providers shall 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).

The provider shall 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.

The provider shall ensure that all staff undertake an effective induction and training programme.

Assurance of safety, consistency and quality

The Provider shall have the responsibility for maintaining clinical quality standards within the service and of ensuring that these agreed clinical standards are available to their patients and that these are subject to peer review and clinical audit.

The Provider shall:

- demonstrate compliance with all national standards of service quality and clinical governance including the core standards of the Care Quality Commission (CQC), National Patient Safety Agency (NPSA) standards and NICE guidelines relevant to the service;

- be familiar with NHS standards and regulations in relation to the provision of the service and comply with the recommendations as appropriate;

- demonstrate a system of clinical governance which is fully compliant with Core Standard 7a of the Standards for Better Health framework and complement the Clinical Commissioning Groups Clinical Governance Framework, ensuring strong links with the commissioner's clinical governance team;

- ensure that evidence-based best practice underpins all clinical policies where available and that these are reviewed on a regular basis to take account of emerging issues, evidence and NICE guidance where applicable;

- ensure that lines of professional and clinical responsibility and accountability are clearly defined;

- ensure that robust systems are in place to ensure compliance with the national Code of Practice for the Prevention and Control of Health Care Associated Infection. This will include arrangements for the cleaning and sterilisation of equipment and the disposal of clinical waste;

- ensure that all equipment conforms to Health and Safety regulations and nationally accepted standards, is properly maintained and replaced as necessary;

- ensure that there are robust systems in place for the secure storage retention and handling of medical records and are compliant with Records Management: NHS Code of practice 2006;

- comply with all Data Protection and Information Governance standards and ensure that any patient identifiable data is transmitted within a secure NHS network and is appropriately encrypted;

- ensure that there is a robust system of reporting adverse incidents or serious untoward incidents, that all incidents are documented, investigated and followed up with appropriate action and that any lessons learnt from incidents are shared across the organisation and with the commissioners;

- have a system in place to ensure that safety alerts and Medical and Healthcare Products Regulatory Agency (MHRA) notices are circulated to all staff and acted upon where necessary;

- ensure that patients are able to contribute to the planning of their own care and that opportunities for feedback are easily available;

- establish and operate a complaints procedure in line with the current NHS guidance for complaints procedures and the GMS/PMS/GOS contracts, to deal with any complaints relating to any matter reasonably connected with the service provided. Information will be available to service users on how to make a complaint or raise a concern and the options available to them should they not achieve a local resolution;

- ensure that a process is in place for any member of the professional team to raise concerns in a confidential and structured way;

- ensure that all staff are appropriately trained and competent and that team members work within their areas of professional competence and that skills and knowledge are kept up to date;

- keep full, accurate and contemporaneous and legibly written notes and records for all patients;

- ensure that the provider and service complies with the Department of Health guidance on 'Accreditation of GPs and Pharmacists with Special Interests';

- ensure that the provider and its clinicians have appropriate indemnity.

Prescribing

For community eye clinic based in GP practice run by GPwSI

- A robust financial system needs to be set up to ensure all costs incurred in running the community eye clinic are borne against the service and are kept completely separate from that of the GP practice.
- The provider needs to apply for a dedicated prescription pad with a dedicated prescription code to enable prescribing costs incurred to be directly attributed to the service.
- The provider needs to apply for the prescription code through the medicines management team.

For community eye service based in community hospitals

- Prescribing of all medication or consumables used in treatment supplied by hospital and subsequently reclaimed from the provider via the usual pathway.

For Community Eye Services based in private venues run by private providers

- The Provider will need to set out their proposed system for the management of drugs, and issue of prescriptions.
- Details of how to obtain codes and prescription pads will be advised by the Medicines Management Team.

- Patient remains in the community for care but would require the same medication as that of a patient attending eye service clinic in secondary care. Prescribing that takes place in a community eye clinic located either in the community hospital or GP practice, prescriptions will be dispensed in the community pharmacies or in a dispensing practice. All drug costs shall be included in the price of the service, with a minimum course length of 28 days (or as clinically indicated).

- The Provider must advise the patient's GP in good time (to allow for any ongoing treatment (beyond the 28 day prescription)) should this be necessary.

- NICE drugs – any new drugs approved in the future may have an impact. The provider needs to be able to demonstrate that they are working within established cost and clinical effectiveness parameters. The managed entry of new drugs / appropriate implementation of NICE or national guidelines should be considered with the agreed local heath community.

- Prescribing should be undertaken within the context of guidance from the Commissioner's Medicines Management Team and Drugs and Therapeutics

Committee (DTC), as appropriate, and in compliance with local drug formularies agreed by the Commissioners.

- Providers will be responsible for funding any pharmaceutical support within their service.

- Providers will be responsible for all safe, secure handling of medicines including policies and procuring pharmaceutical advice and support to meet the needs of the service.

- The service must meet standards for better health in medicines management and for the CQC.

- For any new NICE compliant drugs, entry will be managed across the health community and prescribing should not take place until this process is complete.

- The PCT can support this prescribing process; costs will be attributed to the service.

- It is the provider's responsibility to secure a source of supply of medicines and consumables.

- Prescribing budget monitoring will be undertaken by the medicines management team. Responsibility for the monitoring of drugs prescribed should be as per the DTC guidance for clinical responsibility.

- The Provider shall provide, as part of the service, shared care protocols and define these in conjunction with GPs and appropriate officers of the Commissioners.

3.2 Pathways

See Appendices A1 and A2

4. Referral, Access and Acceptance Criteria

4.1 Geographic coverage/boundaries

The service will be accessible for patients registered with GP practices across Dorset; including Bournemouth and Poole.

4.2 Location(s) of Service Delivery

The service may be provided in any locality, subject to the consent of the Commissioners, in a geographically convenient, easily accessible location which:

- complies with appropriate health and safety legislation;

- has disabled access;
- has appropriate waiting and treatment areas;
- is appropriately furnished and equipped with necessary equipment;
- meets cleanliness and hygiene standards.

4.3 Days/Hours of operation

The Commissioners objective is that the totality of service provision, from Providers, is accessible to patients from Monday to Friday as a minimum. Individual Providers may propose to the Commissioners sessional hours in accordance with their capacity and anticipated demand for services.

4.4 Referral criteria & sources

The service shall be based in a community setting and available for the assessment, care and treatment of adult (16 and over) patients with a range of eye conditions who can safely and appropriately be managed within the community. See Appendix D.

The categories set out in Appendix D are subject to revision by the Commissioners at any time.

There are four key elements to this service:

1. Acute (new patients)

   New acute referrals for assessment and treatment and discharge.

2. Routine assessment (new patients)

   New routine referrals for assessment and treatment and discharge for a range of conditions where surgery is unlikely to be required.

3. Glaucoma follow-up

   Further guidance will be issued regarding this.

4. Other ophthalmic follow-up

   There are a number of conditions that are currently followed up in secondary care that would be appropriate for the community ophthalmology service. Some of these would represent follow up of routine referral the service and some would come from Hospital Eye Service discharge. Examples of these conditions would include:

   - Central and branch retinal vein occlusion
   - Dry macular degeneration

4.5 Referral route

Urgent acute referrals may be made to the Service by telephone. Routine referrals shall be via the Choose and Book process.

4.6 Exclusion Criteria

Hospital Eye Services shall continue to receive referrals directly from GPs where surgery is likely to be indicated, emergency referrals from optometrists, and for a number of other patient groups. See Appendix D.

4.7 Response time and prioritisation

Appointments to be available within nationally and locally set waiting times.

5. Discharge Criteria & Planning

Patients whose course of treatment is complete shall be discharged back into the care of their registered GP.

Patients requiring long term follow-up, e.g. glaucoma, may continue to be reviewed within the service in line with national guidance. Should their condition deteriorate they may be referred to the Hospital Eye Service.

6. Self-Care and Patient and Carer Information

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 information by providers in an accessible format.

7. Quality and Performance Indicators	*Quality and Performance Indicator(s)*	*Threshold*	*Method of Measurement*	*Consequence of Breach*
Service User Experience	**Quarterly Report - Patient Satisfaction**	**80% patient satisfaction.**	**Patient Questionnaire Complaints / PALS**	**Performance notice issued if persistent poor patient satisfaction.**
Improving Service Users & Carers Experience	**As above**			
Outcomes	**Quarterly Report – Case Review**	**25% of historical cases from quarter**	**As detailed in Appendix B**	**Performance Notice issued and Immediate Review of**

				Service Provision
Reduction in Referrals to HES	**Quarter by quarter reduction in referrals**	**All Referrals**	**Audit**	
Ratio of 1st and Follow up Appointments	**Quarterly report**	**See Appendix B**	**Activity Data**	

The requirement on Providers to report information to the Commissioners on a Quarterly basis will be reviewed by the Commissioners after the first year of the provision of services subject to satisfactory performance.

8. Activity			
Activity Performance Indicators	*Threshold*	*Method of measurement*	*Consequence of breach*
As detailed in Appendix B	**100% of all referrals**	**Data collection**	**Performance Notice issued and Immediate Review of Service Provision**

Activity

NHS Dorset and NHS Bournemouth and Poole, have a combined registered patient population of 708,000.

In 2008-9 there were 14,094 new referrals and 27,355 follow up appointments to outpatient clinics in acute hospitals commissioned by NHS Dorset. The Commissioners are unable to accurately estimate how much of this activity can be transferred to a community ophthalmology service, however, analysis of local data suggests that 44% of new referrals and 58% of follow ups might have been appropriate for a community service.

NHS Bournemouth and Poole, based on an extrapolation of activity undertaken by existing providers of community based ophthalmology services in Poole, to limited localities, estimate that a community ophthalmology service covering the entire patient population of the conurbation would undertake 2,638 first out-patient and 5,187 follow-up appointments.

National prevalence of glaucoma shows that about 2% of people over the age of 40 (RNIB) will suffer from some sort of glaucoma (*RNIB)*. There are 239,457 patients aged 40 or over in NHS Dorset which equates to around 4,787 possible glaucoma sufferers, although actual numbers are higher than the national prevalence.

There is a predicted rise in prevalence of glaucoma by an average of 33 new patients per year. In addition the new NICE glaucoma guidelines will increase the level of referrals, but it is too early to factor in the impact of this.

The provider shall provide adequate service provision under the scheme to enable the assessment and/or treatment of all clinically appropriate patients.

Where activity levels exceed these predicted activity levels by 10% or more, the provider should notify the PCT.

9. Continual Service Improvement Plan

The service will be subject to regular monitoring – see Appendix B.

10. Prices & Costs

10.1 Price

The agreed tariff shall be payable to the Provider for each patient seen for assessment and/or diagnosis of an ophthalmic condition within the scope of the service, attending a first outpatient appointment, or follow up appointment in accordance with the Service Specification. The agreed fees are as follows;

	First Appointment	Follow Up Appointment

Tier One	£80	£40

The Commissioners will review the agreed tariffs following the development to the service specification to comply in full with the NICE Guidelines on Glaucoma and OHP pathways.

These tariffs shall include all costs incurred by the provider and associated with delivery of services.

No payment will be made for patients who fail to attend booked appointments (DNA) or for services which are not included in this specification and for which prior approval has not been sought from the Commissioners.

In all cases the clinician conducting the initial assessment and/or diagnosis, and subsequent monitoring or treatment, must be appropriately qualified and experienced. This shall be an ophthalmic consultant, an accredited GP with special interests in ophthalmology or an optometrist with relevant postgraduate qualifications and experience;

The Commissioners shall only pay to the provider the agreed tariffs in relation to first outpatient appointments and follow up appointments undertaken for patients registered with a GP practicing within the NHS Dorset or NHS Bournemouth and Poole geographical area of responsibility at the date of each appointment attended.

Accompanying documents

Appendix A1: Routine referral and follow up Care Pathway
A2: Acute referral Care Pathway

Appendix B: Monitoring and Performance Management

Appendix C: Definition of Stable Glaucoma

Appendix D: Definition of the Range of Ophthalmic Conditions/Patients included and excluded from the Service