SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	01
Service	Community Ophthalmology Service
Commissioner Lead	[redacted]
Provider Lead	[redacted] & [redacted]
Period	01 April 2024 – 31 March 2026
Date of Review	March 2024

1. Population Needs

1.1 National/local context and evidence base

Effective and high quality primary eye care services have a key role in monitoring and preventing eye disease, avoiding the need for more invasive and costly treatments in the long run. Ensuring good vision and eye health can have an influence of a person's quality of life and also in maintaining independence.

Optometrist's asses sight and prescribe glasses or contact lenses as required; they are also skilled in the monitoring of many eye conditions. However, the General Optometry Service (GOS) contract does not accommodate treatment or management of eye conditions and as a result patients who require further investigation or monitoring are in most cases referred onto secondary care. The development of primary care ophthalmology services recognises that for patients who are managed in a community setting, there are significant quality benefits associated with avoiding the need to attend a hospital appointment such as, sooner appointments, reduced anxiety and convenience of location. There are additional benefits associated with increased secondary care capacity and a cost saving by avoiding unnecessary secondary care appointments.

Local Context

In 2010, NHS Nottingham City CCG introduced pilot community ophthalmology services in order to maximize the opportunity to prevent unnecessary referrals to secondary care by offering referral triage and community based assessment, management and treatment. All optometrist referrals are now sent via the patient's GP and booked using Choose and Book into the Clinical Assessment Service (CAS). Following the introduction of triage and assessment, the community services have developed to offer stable glaucoma monitoring and low vision aids.

The following community-based ophthalmology services are provided within NHS Nottingham City ICP:

- Community Triage (GOS18 and GP referral)
- Community Assessment (delivered by optometrists with enhanced qualifications)
- Community Low Vision Aid Service
- Community COAG & OHT Service (Chronic Open Angle Glaucoma & Ocular Hypertension)

The pilot Low Vision Service was developed to increase the accessibility and provision of visual aids for patients with low visual acuity within the community. Provision of specialist visual aids will improve quality of life and wellbeing and also reduce the risk of falls

A review was undertaken in 2013 (see document 2), which highlighted the successes of current pilot services, including a significant reduction in the number of secondary care appointments. Data indicated that 43% of referrals are triaged to the community optometrist assessment for enhanced testing, management and monitoring. Patients are referred on to secondary care only if consultant intervention is required.

The Community Ophthalmology Service will provide an integrated and cohesive approach to delivery of the triage, community assessment, low vision aid and COAG & OHT services. The Service will offer responsive, accessible and high quality ophthalmology assessment and monitoring outside of the secondary care services, with robust clinical oversight and formalised arrangements for continuous quality improvement.

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**	

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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 provider will ensure the service is accessible and flexible to meet the needs of patients as outlined in the 'Everybody Counts: Planning for Patients 2013/14. http://www.england.nhs.uk/wp-content/uploads/2012/12/everyonecounts-planning.pdf
• The service will be monitored to ensure people receive a positive experience of care, including the use of the NHS Friends and Family test.

2.2 Local defined outcomes

• Reduce avoidable secondary care outpatient appointments
• Increase in the number of patients with low visual acuity who are provided with suitable low visual aids and signposting to appropriate support services in the community.
• Improved quality of referrals from primary care (through feedback to referrers) and improved referrals on to secondary care (through completion of initial assessment)
• Providing care that is local to patients, improving accessibility and reducing anxiety.
• Provide a robust and joined up approach to delivery of Community Ophthalmology services
• Minimise effect of glaucoma on patient's sight through clinical effective long term monitoring.

3. Scope

3.1 Aims and objectives of service

The aim of the Community Ophthalmology Service is to manage patients with ophthalmic conditions in a primary care setting where it is appropriate to do so. The Service will ensure that patients are transferred to secondary or specialist care only when specialist treatment is required, which will offer value for money and result in reduced patient anxiety.

The Community Ophthalmology Service will provide the following community services:
• Community Triage (GOS18 and GP referral) (see section 3.2i)
• Community Assessment (delivered by optometrists with enhanced qualifications) (see section 3.2ii)
• Community COAG & OHT Service (Chronic Open Angle Glaucoma & Ocular Hypertension) (see section 3.2iii)
• Community Low Vision Aid Service (see section 3.2iv)

The Service will be provided by qualified clinical practitioners with Ophthalmic Consultant overview. The Service will provide continuous improvement in quality through formalised arrangements for peer review and audit. The provider will work closely with the secondary care provider and will be expected to develop pathways for the transition of care between primary and secondary care and direct access to diagnostic tests as appropriate.

Objectives

- Reduction in secondary care first and follow up appointments for patients with ophthalmic conditions that could be appropriately assessed, treated or monitored in primary care.
- Provide multiple community-based clinic locations that are accessible to patients
- Reduce known barriers to access, including language and sight barriers
- Offer community assessment within 2 weeks of referral with appointments that are flexible (including options at weekends and after 5pm)
- Provide a responsive and clinically robust triage of all ophthalmology referrals with protocols and pathways to guide decision making
- Improve the quality of optometrist GOS18 referrals through feedback to referrers
- Ensure consistency in approach to assessment, treatment and management of patients who are referred to the Service

- Provision of Consultant first assessments for patients with chronic open angle glaucoma (COAG) and ocular hypertension (OHT) diagnosis and monitoring service
- Provide a named clinical and operational lead who will be responsible for the overall management and co-ordination of the Community Ophthalmology Service

3.2 Service description/care pathway

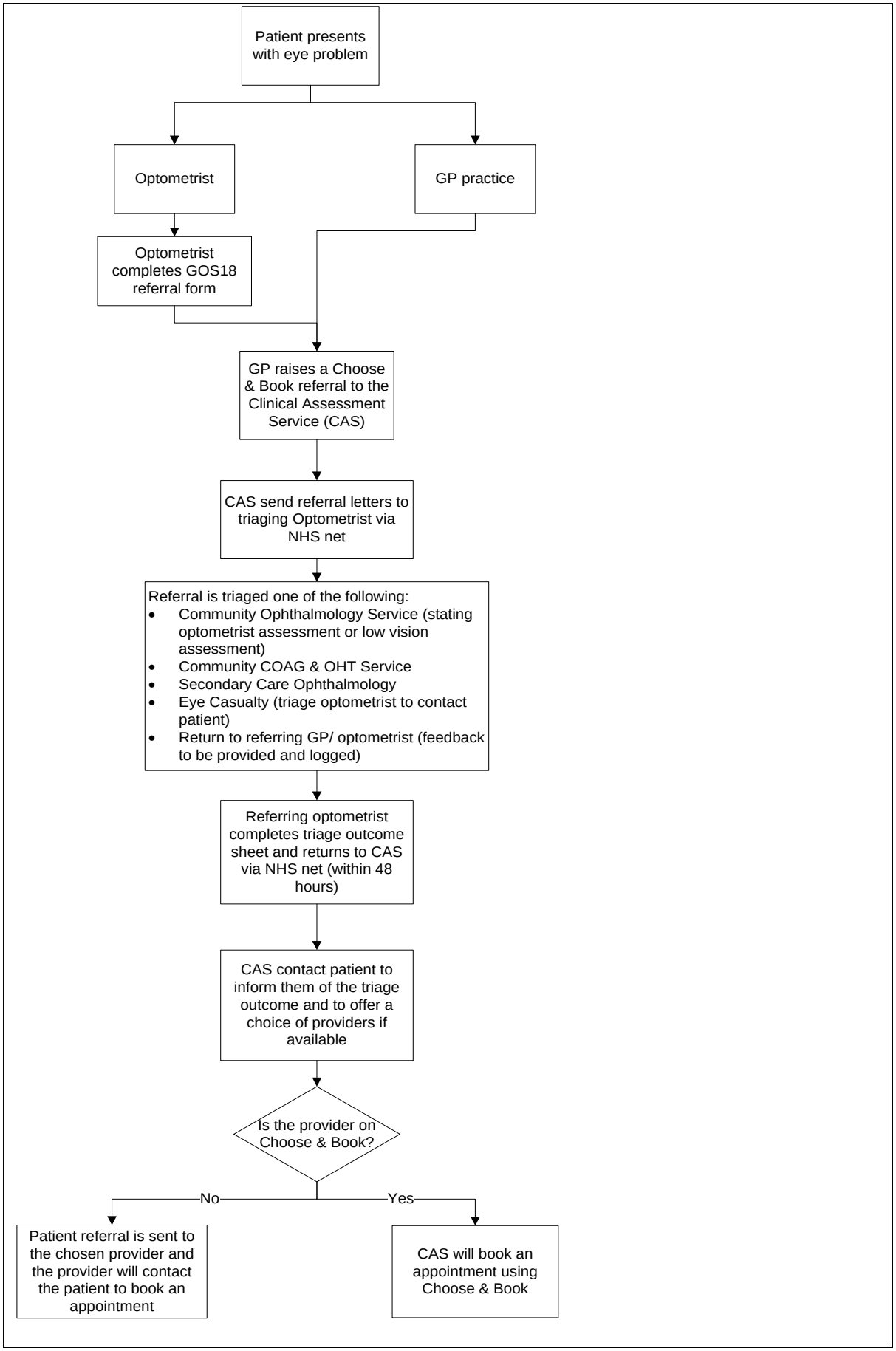
All optometrist referrals are sent via the patient's GP and booked electronically using the Choose and Book referral system into the Clinical Assessment Service (CAS). CAS provide initial contact with the patient to accept referrals and record patient referral information. CAS will facilitate the transfer of patient referral letters to the triage services and inform the patient of their triage outcome. The Provider will be required to have in place a secure and responsive protocol with CAS to agree the process for receipt of referrals for triage and notification of triage outcomes.

3.2i Community Ophthalmology Referral Triage

Provide triage of all adult ophthalmology referrals letters (both GOS18 and GP letters) in order to determine the most suitable service to meet the needs of the patient. Triage will be provided by appropriately qualified optometrist (see section 4.3).

- The Provider will have in place a protocol with CAS to agree the timely electronic transfer of referral letters with outcomes communicated to CAS within 48 hours to ensure a minimal delay to the patient's pathway of care.
- The provider will ensure all referrals and patient information can be transferred using a secure electronic system (e.g. NHS net or Choose & Book)
- Referrals will be triaged to one of the following outcomes; community ophthalmology assessment, community COAG & OHT assessment, community low vision assessment, secondary care ophthalmology or return to referrer
- Referrals returned to the GP or referring Optometrist will be accompanied by explanation and further advice
- The Clinical Assessment Service will contact the patient to inform them of the triage outcome and to offer a choice of provider or clinic location as appropriate
- The provider will ensure that if red flag symptoms are identified during triage or assessment, the patient is signposted or referred onwards to specialist services within appropriate timeframes. The triage clinician will be responsible for communicating a red flag outcome to the patient and recommending appropriate action
- Referrals that are triaged as 'red flag' will be accompanied by a letter of explanation and further advice to the referrer
- The provider will offer clinical advice around the management of ophthalmology conditions as requested by GPs or referring optometrists
- Triaging optometrists will also provide community assessment clinics

GOS18 Triage Process Map:


Patient presents with eye problem
Optometrist
GP practice
Optometrist completes GOS18 referral form
GP raises a Choose & Book referral to the Clinical Assessment Service (CAS)
CAS send referral letters to triaging Optometrist via NHS net
Referral is triaged one of the following:
Community Ophthalmology Service (stating optometrist assessment or low vision assessment)
Community COAG & OHT Service
Secondary Care Ophthalmology
Eye Casualty (triage optometrist to contact patient)
Return to referring GP/ optometrist (feedback to be provided and logged)
Referring optometrist completes triage outcome sheet and returns to CAS via NHS net (within 48 hours)
CAS contact patient to inform them of the triage outcome and to offer a choice of providers if available
Is the provider on Choose & Book?
No
Yes
Patient referral is sent to the chosen provider and the provider will contact the patient to book an appointment
CAS will book an appointment using Choose & Book

3.2ii Community Ophthalmology Assessment (excluding COAG & OHT)

The Service will offer assessment, treatment and long term monitoring of minor eye conditions by an appropriately qualified optometrist (see section 4.3).

- The community ophthalmology assessment will assess symptoms, take history and carry out examinations in order to diagnose and manage the problem for which the patient has been referred
- Optometrists who deliver the Service will also provide triage
- Patients who are referred via a GOS18 by their optometrist will not usually require a routine eye examination, however patients who are referred directly by their GP may need to be advised to access a sight test
- It is anticipated that the majority of patients will be appropriately managed within their initial assessment but some eye conditions will require follow up appointment and chronic conditions may be kept under review
- The Service will be provided from multiple community-based locations, with premises that are suitable to meet the accessibility requirements of all patients
- The Service will provide an assessment by a specialist optometrist (see section 4.3). The assessment offered will be beyond the scope of the essential services as outlined in the General Optometry Service contract
- Assessment and monitoring/ management of patients must be in accordance with the College of Optometrists Clinical Management Guidelines[1] (see section 4.2)

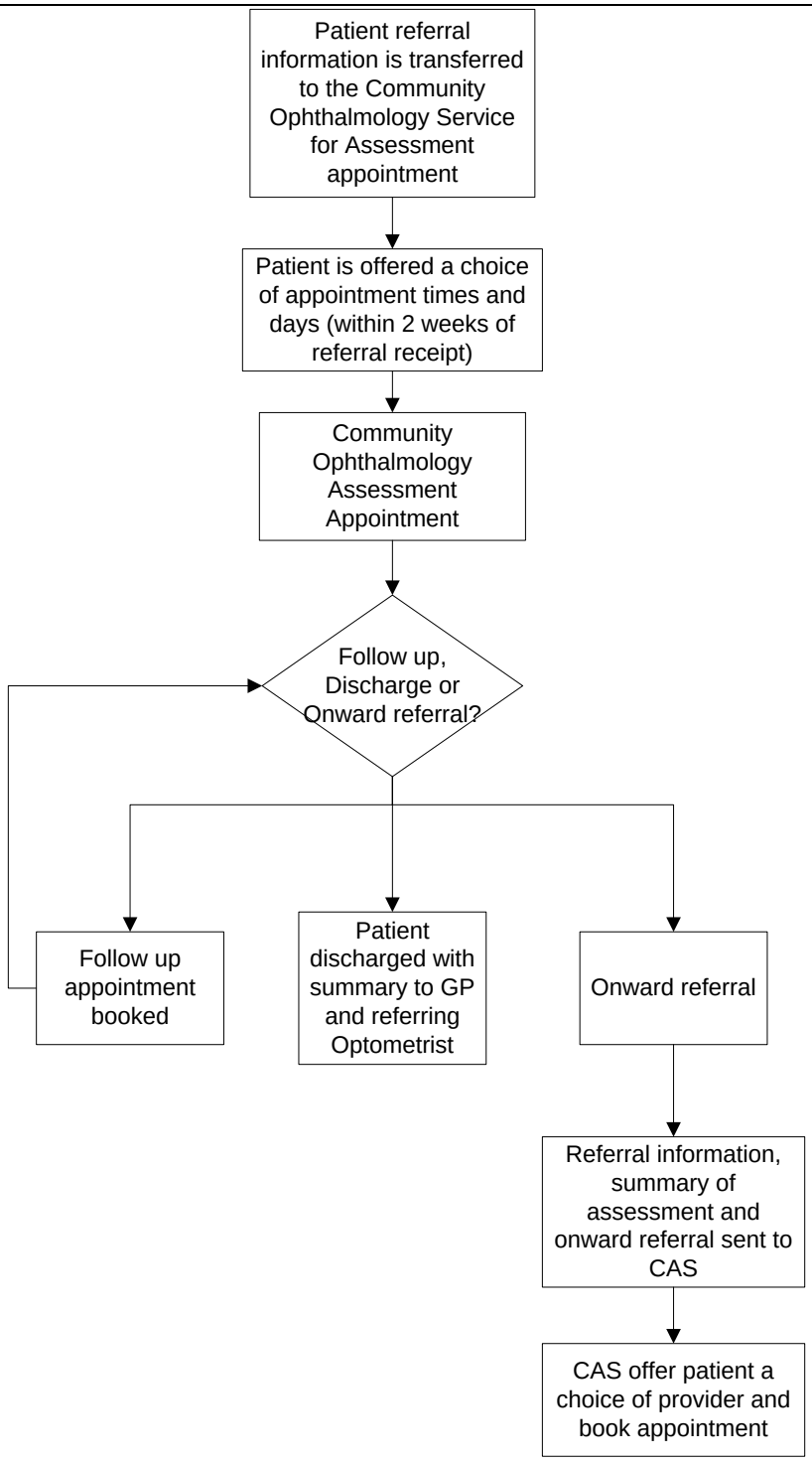
Outcomes resulting from the consultation will be one of the following:

- Follow up in order to carry out repeat diagnostic tests, using specialist equipment as appropriate, including Goldmann Applanation Tonometry (IOP and VF referral refinement)
- Management of the condition through patient advice, recommendation or prescription of medication (with follow-up consultation if required)
- A tentative diagnosis with onward referral to secondary care, indicating whether an urgent or non-urgent appointment is required
- No abnormal findings or no further treatment required; patient is discharged an offered reassurance and advised about when to return for routine sight test
- The examining optometrist recommends an NHS or private sight test (the patient will be given the option to return for to their referring optometrist if appropriate)
- The provider will have in place a protocol with CAS to facilitate the onward referral of patients to secondary care services and to ensure a choice of provider is discussed.

Discharge and onward referral

- Patient will be discharged from the Service following successful diagnosis and treatment or onward referral to another service. This will be in accordance with national and local guidance as outlined in section 4.2
- A patient outcome summary will be sent to the patient's registered GP and the referring optometrist following discharge or onward referral.

[1] http://www.college-optometrists.org/en/professional-standards/clinical_management_guidelines/guidelines_by_condition.cfm



3.2iii Community COAG & OHT Service

The Service will provide assessment and long term monitoring for patients with established and stable glaucoma who require monitoring at programmed intervals.

- Initial diagnostic assessment is undertaken by a Consultant Ophthalmologist (Glaucoma specialist) in order to establish a diagnosis of Chronic Open Angled Glaucoma (COAG) and Occular Hypertension (OHT). A treatment plan will be put in place with recommended monitoring intervals.

- Long term monitoring will be provided by a suitably qualified optometrist with clinical oversight by a Consultant (see NICE guidance in section 4.2), all of which are beyond the scope of NHS essential optometric services
- The Service will be delivered in line with national and local guidance (see section 4.2)
- Patients with suspected optic nerve damage or repeatable visual field defect, or both, will be provided with a definitive diagnosis and management plan by a consultant ophthalmologist

3.2iiia Diagnosis

Patients suitable for the Community COAG & OHT Service will be identified during referral letter triage or following IOP and visual fields testing (referral refinement) within a community assessment. The following clinical presentations will be suitable for community assessment and monitoring:

- an IOP >21mmHg
- field defects
- difference in IOP between the two eyes of >5mmHg
- suspect optic disc appearance with any IOP
- Patients will also be referred into the service from secondary care providers following full recovery from surgery or laser trabeculoplasty.

Diagnosis of OHT and suspect COAG and the preliminary identification of COAG will take place by a Consultant Ophthalmologist (Glaucoma specialist), in order that they will be trained in case detection, referral refinement and be able to identify abnormalities based on relevant clinical tests and assessments.

Clinicians providing the community COAG & OHT service will understand the principles of diagnosis of OHT and COAG and be able to perform and interpret all of the following:

- medical and ocular history
- differential diagnosis
- Examination of the posterior segment using a slit lamp binocular indirect ophthalmoscopy
- IOP measurement using Goldman applanation tonometry (slit lamp mounted)
- Central corneal thickness measurement
- Peripheral anterior chamber configuration and depth assessments using gonioscopy
- Visual field measurement using standard automated perimetry (central threshold test)
- Optic nerve assessment, with dilatation, using stereoscopic slit lamp biomicroscopy with fundus examination
- Alternative methods of assessment if clinical circumstances rule out the use of standard methods of assessment, for example Van Herick's peripheral anterior chamber depth assessment as an alternative to gonioscopy
- Optic nerve head imaging (either OCT, HRT or GDX) for baseline documentation

Clinicians will recommend a treatment and monitoring plan for each patient with monitoring intervals for those with OHT or suspected COAG according to their risk of conversion to COAG and those with COAG according to their risk of progression to sight loss in line with guidance in NICE clinical guideline 85. Diagnosed patients with early or moderate COAG and at risk of significant visual loss in their lifetime will be offered treatment with a prostaglandin analogue.

3.2iiib Monitoring

Long term monitoring will be provided by a suitably qualified optometrist with the ability to detect a change in clinical status and who will be working under the supervision of a Consultant Glaucoma Ophthalmologist (see section 4.2).

The Service will provide treatment and ongoing monitoring of patients with the following diagnosis:

- diagnosed ocular hypertension
- diagnosed suspect COAG
- diagnosed COAG

Patients will be monitored at appropriate intervals in line with the patient's management plan and with NICE clinical guideline 85 (see section 4.2). Clinicians involved in the monitoring of people with OHT, suspected COAG and COAG will be trained to make management decisions on all of the following:

- Risk factors for conversion to COAG
- Coexisting pathology
- Risk of sight loss
- Monitoring and clinical status change detection
- Pharmacology of IOP-lowering medications
- Treatment changes for COAG, COAG suspect status and OHT

The Service will have in place a robust call and recall system to ensure that patients are notified of their next monitoring appointment.

Patients will receive necessary tests in order to ensure clinically effective and safe monitoring of their COAG or OHT (in line with NICE clinical guideline 85). The Service will ensure the following tests and interpretation are carried out during a monitoring appointment as clinically appropriate:

- Slit lamp mounted Goldmann Applanation Tonometry
- Repeat central corneal thickness measurement
- Van Herick's peripheral anterior chamber depth assessment
- Repeat gonioscopy
- Standard automated perimetry (central threshold test) to all patients who have established COAG and those suspected of having visual field defects who are being investigated for possible COAG.
- Patients with diagnosed OHT and those suspected of having COAG whose visual fields have previously been documented by standard automated perimetry as being normal may be monitored using supra-threshold perimetry
- Where a visual field defect has previously been detected, the same visual field measurement strategy for each visual field test will be used
- Stereoscopic slit lamp bio microscopic examination of the optic nerve head with dilated pupils if an adequate view is not possible
- When a change in optic nerve head status is detected, a new optic nerve head image will be obtained to provide a fresh benchmark for future assessments ; ideally, using the same type of instrument used at diagnosis
- A dilated fundus examination should be performed on an annual basis

The Service will ensure that the following equipment is available to carry out the service and that only trained, accredited and competent staff use the equipment to deliver this service:

- Slit lamp and fundus viewing lens
- Goldmann applanation tonometer
- Humphries visual field analyzer capable of producing a printed report
- Digital imaging device (GDX, HRT, OCT)
- Distance test chart
- Appropriate ophthalmic drugs
  - Mydriatic
  - Anesthetic
  - Staining agents

Providers should use single use disposable prisms when delivering the Goldmann applanation tonometry test. Providers will be required to demonstrate infection control procedures in accordance with guidelines from the College of Optometrists and Royal College of Ophthalmologists[2] (see section 4.1i).

3.2iiic Prescribing

[2] http://guidance.college-optometrists.org/guidance-contents/safety-and-quality-domain/infection-control/

Prescribing will be in accordance with this service specification, clinical governance as outlined within NICE clinical guideline 85 (see section 4.2) and the Nottinghamshire Area Prescribing Committee prescribing guidance. The provider will:

- Consider all relevant co-morbidities and potential drug interactions before offering medication
- Where target IOP is not achieved, additional or alternative pharmacological agents are to be offered for OHT or suspected COAG patients.
- Offer alternative pharmacological treatment to patients with OHT / suspected COAG, who are intolerant to current medication
- If target IOP is not achieved, by pharmacological agents, then patients are to be seen by a consultant ophthalmologist to discuss relevant options.
- Offer patients who present with advanced COAG and who are listed for surgery interim treatment with a prostaglandin analogue.
- Encourage patients using pharmacological agents, to continue with the same treatment unless: target IOP is not reached, there is progression of optic nerve head damage, presence / progression of a visual field defect, or they are intolerant to the drug.
- If adherence and eye drop instillation technique are satisfactory offer alternative pharmacological treatment or referral to secondary care for surgery or laser trabeculoplasty
- Consider offering patients with COAG who are intolerant to a prescribed medication alternative pharmacological treatment or a preservative-free preparation, if there is evidence that the patient is allergic to the preservative
- Check medication compliance and eye drop instillation technique, in all patients, especially where target IOP is not reached IOP

The Service will supply medicines via FP10 prescription and it is the responsibility of the provider to order prescription pads. The service will be responsible for ordering its own stocks of diagnostic medications and will ensure appropriate systems are in place to carry out housekeeping tasks, for example fridge temperatures, stock rotation, stock levels and usage. Diagnostic medications will be obtained at the expense of the provider.

The Provider will ensure compliance with national legislation and professional guidance, for example compliance with relevant NPSA alerts. The provide will be able to demonstrate use of appropriate written procedures covering patient safety incidents and near misses in relation to medicines, undertake regular audits, and will report incidents and near misses in accordance with local and national requirements.

The Provider will ensure effective recording and monitoring of prescribing (using agreed prescribing codes) to enable Commissioners to monitor the prescribing budget associated with the Service.

The Service will source information on and signpost patients to appropriate medicine facilities, services and pharmacies. The Service will ensure that an exemption clause is signed by the patient, if exempt from charges.

3.2iiid Discharge and onward referral

The Provider will offer patients with COAG who prefer not to have surgery or who are unsuitable for surgery, for whatever reason, pharmacological treatment or referral to a secondary care provider for laser trabeculoplasty.

Patients with COAG will be recommended appropriate surgery in accordance with the guidance given in NICE clinical guideline 85 (see section *4.2).* Patients who are offered and accept surgical or laser treatment will be onward referred to a secondary care provider via the Clinical Assessment Service (in order for a choice of secondary care provider to be offered). A discharge summary will accompany the onward referral, with a copy to the patient's GP.

Patients with OHT or suspected COAG, who are recommended not to receive treatment, will be discharged from active glaucoma care, after an interval of 3-5 years without change in clinical status (depending on perceived risk of conversion), to community optometric care and advised to seek annual assessment

Patients who DNA two appointments will be discharged from the service and their GP informed.

3.2iv Low vision assessment providing advice, provision of visual aids and signposting to support organisations**.**

Low vision assessment

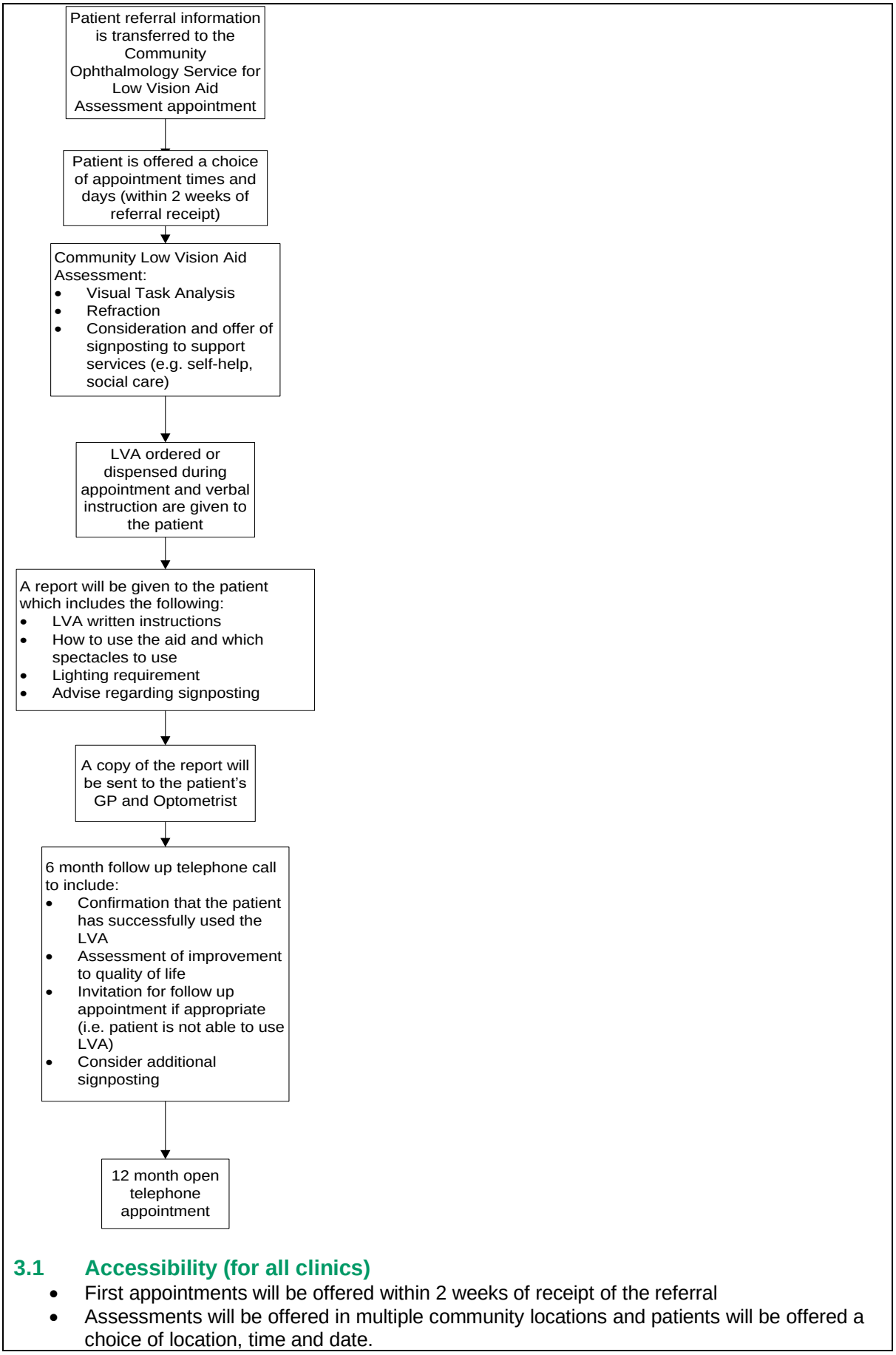
The provider will offer a full low vision assessment and determine whether a magnifying device would be beneficial in maximising the patient's residual vision. The service will offer a wide range of devices to suit patient's needs. However, specialist devices will still only be available from NUH low vision clinic (i.e. distance vision telescopes).

The provider will be able to issue from the following list of devices:

Product		Maximum cost (per product)
Hand Magnifiers – non illuminated		
Coil Hi Power	5204	4x
	5205	6x
Illuminated Hand Magnifiers		
Coil	7270	3x
	7146	5x
	7147	7x
	7148	9x
	7271	11x
Stand Magnifiers – Non illuminated		
Coil Hi Power	5123	3x
		4x
Stand Magnifiers - illuminated		
Coil / Raylite	7400/30	2.8x
	7259/30	3.0x
	7269/30	4.7x
	7289/30	7.5x
Overspecs		
	Various LTF's	
Distance Aids		
	Coil 2x / TV Max	
Flat field magnifier		
	Coil bright magnifier	

The provider will centrally purchase products which are within an agreed pricing and of approved quality (to be advised). The maximum price which can be claimed is listed above.

- Device(s) would be issued on a permanent loan basis and it is anticipated that a maximum of one distance and one reading device would be supplied. Patients will be able to request replacement devices due to breakages or equipment failure.
- Patients will be advised on practical considerations and, where appropriate, offered a referral to the visual impairment specialist at the Nottingham City Council Adult Sensory Team.
- Referrals will be received via GP, Optometrist or patient self-referral.
- Assessment appointments will be offered within 2 weeks of referral and vision aids will be delivered within 3 weeks.
- A 6 month follow up call will be made to check suitability of the device.
- Patients will be offered the option of one further appointment within a 1 year period.
- The provider will collate patient outcome and satisfaction data via a method accessible to patients with sight loss.
- Patients who have not had a standard sight test within 12 months will be advised to attend their normal Optometry practice.



3.1 Accessibility (for all clinics)

- First appointments will be offered within 2 weeks of receipt of the referral
- Assessments will be offered in multiple community locations and patients will be offered a choice of location, time and date.

- The Service will offer a range of appointment time and dates (including options after 5pm and at weekends)
- Patients will be provided with clear information about the service and their pathway of care, including expected monitoring and treatment (in other formats and languages where required)
- It is important that the aspects of service provision are clearly defined between NHS and non-NHS provision. Patients will receive a copy of their prescription and it will be explained that they have the option to visit a different optometrist for the purchase of eye wear.
- Information about the local NHS complaints office will be displayed.
- Translation options will be made available to patients who require them and costs are included within the contract

3.3 Population covered

The service will be available to patients who are registered with an NHS Nottingham City ICP GP The Service will provide non-English speaking patients with access to professional interpreting services and have arrangements in place to support people with communication needs or disabilities. The Service will ensure translated explanatory material is available.

3.4 Any acceptance and exclusion criteria and thresholds

The Service will accept all adult (18 and over) Ophthalmology referrals

The following list is not exhaustive but indicative of the conditions that will be suitable for assessment within the Community Ophthalmology Service (following triage):

Corneal abrasion
Episcleritis
Hordeloum
Ocular rosacea - meibomianitis
Pinguecula
Pterygium
Sub conjunctival hemorrhage
Sub tarsal foreign body
Dry eyes
Trichiasis
Floaters
Ocular motility disorders – adult
Chronic squints – adult
Ocular migraine
Epiphora
Lid twitch
Corneal endothelial dystrophies
Raised IOPs
Lens opacities
Vitreous opacities
Posterior vitreous detachment
Dry AMD
Epiretinal membrane
Visual field anomalies
Myelinated retinal nerve fibres
Contact lens related issues
Peripheral retinoschsis
Pigment dispersion syndrome
Keratoconus
Suspicious disc cupping

All patients will be assessed and managed in accordance with The College of Optometrists Clinical Management Guidelines (see section 4)

Conditions excluded from assessment within the service:

- Diabetic retinopathy
- Patients under the age of 18
- Severe ocular pain requiring immediate attention
- Suspect Retinal detachment
- Retinal artery occlusion
- Chemical injuries
- Penetrating trauma
- Orbital cellulitis
- Temporal arteritis
- Ischaemic optic neuropathy

All 'red flag symptoms' should be referred directly to the nearest eye casualty. The provider is responsible for communicating this to the patient at the time of identifying a red flag (either at triage or community assessment stage). If the patient indicates that they are not willing to attend, this will be communicated to both the referring optometrist and GP.

The following conditions are identified as 'red flags':
External
Chemical Injuries
Unexplained sudden loss of vision
Penetrating injuries
Herpes Zoster (to GP same day) –with Hutchinson's sign next day to hospital
Third nerve palsy
Scleritis
Anterior
Hyphaema
Hypopion
Micobial keratitis with red eye
Periorbital inflammation with pain and swelling
Corneal foreign body
Vitreous
Acute flashes and floaters with tobacco dust
Vitreous hemorrhage
Posterior
CRAO
Retinal breaks and tears
Retinal detachment
Suspected temporal arteritis
Uveitis
Wet maculopathy
Papilloedema
Glaucoma
Acute red eye with raised IOP
Diabetes
Pre-retinal hemorrhage
Rubeosis with VA hand movements or better
Retinal Detachment

3.5 Interdependence with other services/providers

- NHS Nottingham City Clinical Assessment Service
- Nottinghamshire Local Optical Committee
- Adult Sensory Team (Nottingham City Council)
- NHS Nottingham City GPs
- Optometrists

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

- The Provider will be registered with the Care Quality Commission and maintain compliance with the essential standard of safety and quality.
- The College of Optometrists Clinical Management Guidelines
- NICE clinical guideline 85: Diagnosis and management of chronic open angle glaucoma and ocular hypertension (2009)
- The Provider must consider quality and diversity in every aspect of the Service in accordance with the Public Sector Equality Duty of the Equality Act 2010
- Staff delivering the Service will be appropriately qualified, trained and supervised to meet the objectives and requirements of the Service Specification. Staff must ensure that they are aware of, compliant with, and can provide evidence if required to demonstrate compliance with any relevant clinical standards including adherence to relevant NICE guidelines.

4.1i Infection control & hygiene

The provider will demonstrate and sustain infection control and hygiene practice in accordance with The Health and Social Care Act: The Hygiene Code (2008), including:
Management arrangements to include:-

- a designated lead for infection prevention and control and decontamination
- Access to accredited microbiology services.
- Access to an infection control team.
- Evidence of application of evidence based infection prevention and control policies and procedures through a programme of validated audit
- Design, maintenance and effective cleaning of the environment and medical devices.
- Education; ensuring that all staff have attended relevant infection prevention and control training with at least 2 yearly refresher courses. This must include hand hygiene and aseptic non-touch technique. Competency must be evidence.
- Concise and timely communication and documentation
- Safe disposal of clinical waste and sharps
- Appropriate antibiotic / antimicrobial prescribing in line with a correct diagnosis and prescribing guidance

4.1ii Data & Information Sharing

Keeping an up to date electronic register of all patient information requirements
Keeping contemporaneous patient records, which will follow the patient.

The Provider will provide assurance and evidence of this annually by providing the Commissioner with an independent audit report of the IG Toolkit declarations (further information: https://www.igt.hscic.gov.uk/)

Through this mechanism the provider will demonstrate compliance with relevant legal and regulatory standards, including:

- NHS Code of Confidentiality (2003)
- HSCIC 'Guide to Confidentiality' (2013)
- Data Protection Act (1998)
- Access to Health Records Act (1990)
- Freedom of Information Act (2000)
- Environmental Information Regulations (2000)
- Computer Misuse Act (1990)
- NHS Code of Practice for Records Management (2009)
- Human Rights Act (1998)
- Caldicott Guardian Manual (2010)
- Caldicott 2 Review 'To Share or Not to Share' (2013)

The Provider must have a named individual with responsibility for Information Governance in adherence with the NHS IG Toolkit declarations (further information: https://www.igt.hscic.gov.uk/)

The provider will have Information Technology systems compliant with national NHS standards, including access to the NHS network (N3)

4.1iii Prescribing
Ensure that there are policies and procedures in place for obtaining supplies of medicines, receipt, recording, storage (including controlled drugs and refrigerated items), handling, administration and disposal of medicines in accordance with:

- The Medicines Act 1968
- The Misuse of Drugs Act 2001 (amended)
- Health and Safety Regulations
- Essential standards for quality and safety (Care Quality Commission)
- Relevant professional codes of practice in relation to medicines e.g. Health Professionals Council (HPC), General Medical Council guidance on good medical practice and Nursing: Nursing and Midwifery Council (NMC) Standards for medicines management (2008)

The service must ensure that they are aware of any safety alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) http://www.mhra.gov.uk/#page=DynamicListMedicines and the NHS Central Alerting System (CAS) https://www.cas.dh.gov.uk/Home.aspx that apply to any equipment or patient safety concerns associated with this service and that these are acted upon. Details of action taken must be reported back to NHS Nottingham City ICP within the designated timescale.

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

- The College of Optometrists Clinical Management Guidelines

http://www.college-optometrists.org/en/professional-standards/clinical_management_guidelines/

- The College of Optometrists A3 Infection Control. Oct 12
- The Royal College of Ophthalmologists Age-Related Macular Degeneration: Guidelines for Management September 2013
- The College of Optometrists Optometrist Formulary. Medicines Support Unit For Optometrists

(http://www.med-support.org.uk/IntegratedCRD.nsf/MSU_Home?OpenForm)

- Guidance on the referral of Glaucoma suspects by community optometrists Issued by The College of Optometrists and The Royal College of Ophthalmologists December 2010 http://www.locsu.co.uk/uploads/enhanced_pathways_2013/locsu_glaucoma_repeat_readings_and_oht_monitoring_pathway_rev_nov_2013.pdf

The provider will be responsible for:

- Working to a protocol for the delivery of the service (direct and indirect) responding to identified needs of patients
- Providing all premises, staffing and consumables required to carry out the service
- Ensuring that all equipment used is maintained and calibrated in accordance with the manufacturer's guidelines. The cost of this will be met by the provider
- Ensuring that there are adequate back up/contingency plans in place for the continued provision of the service in the event of breakdown of equipment, key staff absence or supply chain problems
- Dealing with any complaints received from patients or referring practices about the service, and reporting the complaint and the response to the CCG.

The service will have in place a Safeguarding policy for children and vulnerable adults, which ensures that the interests and safeguarding of children and vulnerable adults is paramount at all times. This must be in accordance with the standards set out in the Department of Health's publications, Working Together to Safeguard Children (2013) and No Secrets: guidance on protecting vulnerable adults in care (2000) and adhere to local protocols within Nottingham City and Nottinghamshire County.

The Provider must ensure that Safeguarding training is available to all staff and submit an annual assessment of safeguarding to commissioners.

4.3 Applicable local standards

The Service will be provided by appropriately qualified clinical staff, optometrists who provide triage and community assessment appointments will have the following qualifications, training and experience:

- Be registered with the General Optical Council (GOC)
- Have five years post qualification experience and registration with the General Optical Council.
- Undertaken additional qualification
- The provider will facilitate and require staff to undertake 6 monthly peer review; an audit of referrals will be carried out to determine the focus of each peer review.
- The results of the audit review will be shared with commissioners. The provider will undertake annual audit of referral outcomes, including collaborative working with NUH around patients who are onward referred from the community clinic.

Optometrists who undertake a Community Ophthalmology assessment will have access to the following equipment:

Access to the internet
Means of indirect ophthalmoscopy (Volk/headset indirect ophthalmoscope)
Slit lamp
Applanation Tonometer (disposable tonometer prisms)
Findus Camera/ imaging devices
Distance test chart (Snellen/logmar) – including provision of non-English speaking patients
Equipment for epilation
Threshold fields equipment to produce a printed report
Amsler Charts
Colour vision chart
Equipment for FB removal
Appropriate ophthalmic drugs (see section 3.2iiic)
Staining agents
Mydriatic
Cycloplegic
Topical anaesthetics
Focimeter
Frame rule
Retniscope
Ophthalmoscope

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4A-D)

Providers are required to have a robust incident reporting and investigation procedure in place for all clinical and non-clinical incidents. All serious incidents (SI's) should be recorded and reported to the NHS Nottingham City ICP as the contract lead within the timeframes stated in the NHS England's 'Serious Incident Framework March 2013'.

Patient, staff and clinical feedback will be monitored and captured via satisfaction surveys, comments and complaints. The Provider will work closely with patient groups to ensure continued engagement, monitoring and evaluation of the service.

5.2 Applicable CQUIN goals (See Schedule 4E)

N/A

6. Location of Provider Premises

The Provider's Premises are located at:
The service will be provided at multiple locations within the community with the aim of ensuring maximum accessibility for patients. The Provider will be responsible for updating a 'choice menu' of Optometrist sub-contractors, which will be shared with the Clinical Assessment Service and the Commissioners in order to facilitate an informed choice discussion with the patient.

Clifton Opticians
Duffy Optometrists in Wollaton
Brooks & Wardman in City Centre

7. Individual Service User Placement

N/A