

# Referral Guidelines and Clinical Thresholds for use in the Management of Common Ophthalmic Conditions (Primary and Secondary Care)

**May 2014**

**This commissioning policy has been endorsed by and applies to patients within:**  
 NHS South Worcestershire Clinical Commissioning Group (CCG)  
 NHS Redditch & Bromsgrove Clinical Commissioning Group (CCG)  
 NHS Wyre Forest Clinical Commissioning Group (CCG)

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### Review and Amendment Log

Version No	Type of Change	Date	Description of change

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## **SUMMARY**

NHS Redditch & Bromsgrove Clinical Commissioning Group, NHS South Worcestershire Clinical Commissioning Group and NHS Wyre Forest Clinical Commissioning Group (also termed “the Commissioner” in this document) does not routinely fund ophthalmic treatments unless the patient meets with the criteria outlined in this document, which has been agreed as part of the Ophthalmology Service Specification document.

## **1. Definitions**

- 1.1 **Exceptional clinical circumstances** are clinical circumstances pertaining to a particular patient, which can properly be described as exceptional. This will usually involve a comparison with other patients with the same clinical condition and at the same stage of development of that clinical condition and refer to features of the particular patient which make that patient out of the ordinary, unusual or special compared to other patients in that cohort. It can also refer to a clinical condition which is so rare that the clinical condition can, in itself, be considered exceptional. That will only usually be the case if the NHS commissioning body has no policy which provides for the treatment to be provided to patients with that rare medical condition.
- 1.2 A **Similar Patient** refers to the existence of a patient within the patient population who is likely to be in the same or similar clinical circumstances as the requesting patient and who could reasonably be expected to benefit from the requested treatment to the same or a similar degree. When the treatment meets the regional criteria for supra-CCG policy making, then the similar patient may be in another CCG with which the Primary Care Trust collaborates. The existence of one or more similar patients indicates that a policy position is required of the Primary Care Trust.
- 1.3 An **individual funding request (IFR)** is a request received from a provider or a patient with explicit support from a clinician, which seeks funding for a single identified patient for a specific treatment.
- 1.4 An **in-year service development** is any aspect of healthcare, other than one which is the subject of a successful individual funding request, which the Primary Care Trust agrees to fund outside of the annual commissioning round. Unplanned investment decisions should only be made in exceptional circumstances because, unless they can be funded through disinvestment, they will have to be funded as a result of either delaying or aborting other planned developments.

## **2. Scope of policy:**

- 2.1 This policy should be considered in line with all other Worcestershire Commissioning Policies. Copies of these Commissioning Policies are available on the following website address:  
<http://www.redditchandbromsgroveccg.nhs.uk/about-us/strategies-policies-and-procedures/commissioning-ifr/>
- 2.2 These guidelines provide guidance to primary care practitioners (GP's and Community Optometrists) and secondary care clinicians when managing patients with certain common ophthalmic conditions in both primary care and secondary care.

The exception to this is NHS Redditch & Bromsgrove CCG, who have procured a Primary Eye Care Service to manage certain eye conditions in primary care. Therefore, optometric/ophthalmic referrals in Redditch & Bromsgrove are subject to different arrangements. Please refer to the Redditch & Bromsgrove Primary Eye Care Service Specification for further information, which is attached for ease of reference (Appendix 4).

2.3 Attached to this document is a summary of the guidelines specifically covering the following common ophthalmic treatments:

- Cataract surgery
- Eyelid surgery (blepharoplasty)
- Minor skin surgery around the eye area
- Treatment of myopia
- Anti-vascular endothelial growth factor (Anti-VEGF) treatment in NICE approved indications
- Anti-vascular endothelial growth factor (Anti-VEGF) treatment in non-NICE approved indications
- Photodynamic therapy (PDT) for the treatment of age-related macular degeneration

This is supported by a more detailed breakdown of the clinical conditions and threshold for appropriate management across each treatment pathway.

2.4 The policy applies to ALL service providers within primary\* and secondary care who have a responsibility for managing patients with ophthalmic conditions.

Service providers within primary care must consider the clinical thresholds identified within these guidelines before considering referral into secondary care for either specialist ophthalmic advice and/or possible surgical intervention. It is anticipated that GP's, optometrists and/or clinicians at The Practice will not refer patients into secondary care where it is clear that the eligibility criteria are not met. GP's, optometrists and clinicians at The Practice will also be responsible for assessing the patient's readiness and willingness to be referred into secondary care for possible treatment/surgery.

Service providers within secondary care must also consider the clinical thresholds and commissioning statements identified within these guidelines before embarking upon any form of treatment/surgical intervention.

### **3. Background:**

3.1. NHS principles have been applied in the agreement of this policy.

3.2 Besides funding healthcare interventions that tackle ill health and save lives there is a growing demand for a range of ophthalmic procedures, some of which are considered to be low priority when it comes to allocating limited NHS resources. However, the Commissioners recognise that in some cases the purpose of a low priority procedure will be to meet an appropriate and justifiable clinical need. This policy sets out eligibility criteria for funding treatment in such cases.

### **4. Commissioning Policy**

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\* With the exception of NHS Redditch & Bromsgrove CCG

4.1 NHS Redditch & Bromsgrove Clinical Commissioning Group, NHS South Worcestershire Clinical Commissioning Group and NHS Wyre Forest Clinical Commissioning Group (termed “the Commissioners”) consider all lives of all patients whom it serves to be of equal value and, in making decisions about funding treatment for patients, will seek not to discriminate on the grounds of sex, age, sexual orientation, ethnicity, educational level, employment, marital status, religion or disability except where a difference in the treatment options made available to patients is directly related to the patient’s clinical condition or is related to the anticipated benefits to be derived from a proposed form of treatment.

#### 4.2 **Primary Eyecare Assessment and Referral Service (PEARS)**

Both NHS Wyre Forest CCG and NHS South Worcestershire CCG have reviewed the PEARS schemes across their populations. The PEARS scheme , was originally developed through the Countywide Ophthalmology Group and uses community optometrists to provide a primary care based assessment, treatment and referral service to patients with minor eye conditions. A definitive list of those conditions that will be managed by PEARS approved optometrists is included in these referral guidelines. Following assessment by the optometrist, it may be clinically necessary for the patient to be referred into secondary care based ophthalmic services for further assessment/treatment. Optometrists making the onward referral should be mindful of the content of these guidelines, particularly in relation to procedures where there are referral criteria and/or clinical thresholds for treatment.

NOTE: The PEARS service is not commissioned to receive referrals for patients who are not part of the registered practice populations for NHS South Worcestershire CCG or NHS Wyre Forest CCG.

#### 4.3 **The Practice**

NHS Redditch & Bromsgrove CCG do not currently commission the PEARS service for their population. However, they do commission a community based consultant ophthalmology led service (The Practice). Patients access this service via direct referrals from GPs or Optometrists. All referrals are triaged and those patients who are clinically appropriate will be treated via this service. Some patients will be referred directly on to secondary care either at the point of triage or following assessment/treatment. Clinicians from The Practice making onward referrals to Secondary Care must be mindful of the content of these guidelines, particularly in relation to procedures where there are referral criteria and/or clinical thresholds for treatment.

NOTE: The Practice is not commissioned to receive referrals for patients who are not part of the registered population for NHS Redditch & Bromsgrove CCG.

#### 4.4 **Evaluation and Compliance**

Whilst the onus will be on the referring clinician to ensure the patient meets the criteria for referral into secondary care, the secondary care provider will be responsible for ensuring eligibility for surgery/treatment. Compliance with the referral guidelines and clinical thresholds will be assessed through annual audit of the procedures identified within this document. Non-compliance may result in the Commissioners withholding payment for any activity considered to be outside of the approved criteria.

**TABLE 1 - SUMMARY OF CLINICAL MANAGEMENT ARRANGEMENTS**

Referral Guidelines and Clinical Thresholds for use in the Management of Common Ophthalmic Conditions:

Category A	Category B	Category C	Category D
Conditions to be managed in GP practices as part of the core contract	Conditions to be managed in Primary Care/Optomety under core contract	Conditions to be managed within an Enhanced Contract (e.g. PEARS, Post Operative Cataract Service, The Practice* etc)	Conditions to be managed in Secondary Care/The Practice*.
Aesthetic conditions affecting eyes/peri orbital area: <ul style="list-style-type: none"> <li>• Xanthelasma</li> <li>• Skin Tags</li> <li>• Benign Growths, tags, moles, warts</li> <li>• Lipomata (Fatty Deposits)</li> <li>• Sebaceous Cysts</li> <li>• Blepharoplasty for cosmetic reasons</li> </ul>	Dry Age Related Macular Degeneration (AMD), following confirmed diagnosis in Secondary Care	Floaters and Flashers	Cataracts
Chalazion, refer to secondary care if:	Asymptomatic Epiretinal Membranes	Blepharitis in Adults	Corneal Diseases

Category A	Category B	Category C	Category D
<b>Conditions to be managed in GP practices as part of the core contract</b>	<b>Conditions to be managed in Primary Care/Optometry under core contract</b>	<b>Conditions to be managed within an Enhanced Contract (e.g. PEARS, Post Operative Cataract Service, The Practice* etc)</b>	<b>Conditions to be managed in Secondary Care/The Practice*.</b>
<ul style="list-style-type: none"> <li>Symptoms remain after 6 months; AND</li> <li>Clinical need for surgical incision and curettage</li> </ul>			
Conjunctivitis (Bacterial; Viral; Allergic)	Asymptomatic lesions identified using OCT screening	Dry Eye	Corneal Foreign Body not removed by simple irrigation
Ectropion	Conjunctival lesions (Pinguecula/naevus)	Meibomian Gland Dysfunction (MGD) in Adults	Corneal Ulcers
Watery Eyes in Adults	Correction of Squint – Adult	Recurrent Corneal Erosion Syndrome	Entropion Epiphora
Hordeolum	Clinically significant Field Loss vision noted at a field test which is not repeatable at a test undertaken 12 months later	Trichiasis	Keratitis
Minor Non Occlusive Childhood Ptosis	Myopic peripheral lesions without symptoms		Plastics or Suspected Malignancy

Category A	Category B	Category C	Category D
Conditions to be managed in GP practices as part of the core contract	Conditions to be managed in Primary Care/Optomety under core contract	Conditions to be managed within an Enhanced Contract (e.g. PEARS, Post Operative Cataract Service, The Practice* etc)	Conditions to be managed in Secondary Care/The Practice*.
Pterygium for cosmetic reasons	Optic Nerve head drusen		Posterior Capsular Opacification (PCO)
Sub Conjunctival Haemorrhage (SCH)	:		Vitreo-Retinal Conditions – (Acute Onset of) PVD*, Macular Hole, PDR, RD  Sudden painless loss of vision*

Conditions in **Category A to C** should be treated by appropriate clinicians, as part of their agreed contract; all general practice are expected to have access to an optometry service in primary care.

It is acknowledged that under exceptional circumstances and if clinically appropriate, some **Category A, B or C** patients can be referred to secondary care under specific clinical circumstances. For more information, please review the Table 2 within this document.

If a patient self-presents in secondary care, or PEARS or The Practice, who is diagnosed with a **Category A** condition, they should be referred back to their GP, because it is important that patients are treated in appropriate settings and do not take up secondary care appointment slots when they can be managed in primary care.

Please be aware that PEARS and The Practice can only provide a service for adult patients (i.e. patients who are aged 18 and over). Therefore any paediatric conditions requiring onward referral for review/treatment/management should be considered within Secondary Care.

**TABLE 2 - DETAIL OF CLINICAL MANAGEMENT ARRANGEMENTS**

Item No	Condition	Management Category	Guidance
1.	<b>Dry Age Related Macular Degeneration (AMD)</b>	Optometrist/GP	<p>Patients will be identified in Primary Care via General Ophthalmic Services sight tests. Some patients may need to be referred to Secondary Care for diagnosis where there is reduced visual acuity or the patient has visual symptoms as dry ARMD can be seen but cause no symptoms. Patients may be discharged back to Primary Care after diagnosis.</p> <p>Patients to be referred back to Secondary Care if symptoms present (e.g. sudden/acute onset of visual distortion) and may require urgent referral into the Wet ARMD pathway</p>
2.	<b>Wet Age Related Macular Degeneration (WAMD)</b>  <b>(Anti-Vascular Endothelial Growth Factor (VeGF) Treatment)</b>	Pears/GP/Secondary Care	<b>Refer to Secondary Care</b> in line with the National Institute for Health and Clinical Excellence (NICE) Technology Appraisal documents
3.	<b>Wet Age Related Macular Degeneration (WAMD)</b>	Secondary Care	The Commissioners approve the use of treatments that are formally endorsed by the National Institute for Health and Clinical Excellence (NICE) via Technology Appraisal Guidance documents.
4.	<b>Other Ophthalmic Conditions where Anti-Vascular Endothelial Growth Factor (VeGF)</b>	Secondary Care	The Commissioners do not approve the NHS funding of anti-VEGF treatment, unless there is either Worcestershire Area Prescribing Committee approval for use or a published NICE Technology Appraisal that endorses said treatment

Item No	Condition	Management Category	Guidance
	<b>Treatment is considered</b>		
5.	<b>Conjunctivitis (Bacterial; Viral; Allergic )</b>	GP/PEARS/The Practice	<b>Refer to Secondary Care</b> if the patient needs drug therapy to treat the condition, i.e., the condition has been identified as being non responsive to conservative treatment)
6.	<b>Meibomian Gland Dysfunction (MGD) in ADULTS</b>	PEARS/The Practice	<b>Refer to Secondary Care</b> if symptoms are still present after 6 months and there is a clinical need for surgical treatment.
7.	<b>Keratitis</b>	Secondary Care	<b>Refer to Secondary Care</b> as this condition is sight threatening.
8.	<p><b>Blepharitis in Adults</b></p> <p>OPCS-4 Codes (for use within secondary care):</p> <p>C131, C132, C133, C134, C138, C139, C161, C162, C163, C164, C165, C168, C169</p>	Pears/The Practice	<p>See item 24 below for patients with cosmetic blepharitis</p> <p><b>Refer to Secondary Care</b> if there is a clinical need for surgical incision and curettage for one of the following indications:</p> <ul style="list-style-type: none"> <li>• To treat periorbital sequelae of thyroid disease, nerve palsy, blepharochalasis, floppy eyelid syndrome and chronic inflammatory skin conditions.</li> <li>• To relieve symptoms of blepharospasm or significant dermatitis on the upper eyelid caused by redundant tissue.</li> <li>• Following skin grafting for eyelid reconstruction.</li> </ul> <p>For all other individuals who do not meet the above criteria, the following criteria needs consideration before a <b>referral to Secondary Care</b> is made:</p>

Item No	Condition	Management Category	Guidance
			<ul style="list-style-type: none"> <li>• There is documented patient complaints of interference with vision or visual field related activities such as difficulty reading or driving due to upper eye lid skin drooping, looking through the eyelids or seeing the upper eye lid skin; <b>AND</b></li> <li>• There is redundant skin overhanging the upper eye lid margin and resting on the eyelashes when gazing straight ahead; <b>AND</b></li> <li>• There is evidence from visual field testing that eyelids impinge on visual fields reducing field to 120° laterally and/or 20° or less superiorly.</li> </ul>
9.	<b>Chalazion</b>	GP	<p>Condition normally spontaneously resolved in 6 months, if treated appropriately (warm flannel bathing).</p> <p><b>Refer to Secondary Care</b> if symptoms are still present after 6 months and only if surgical intervention is required (to treat a clinical condition rather than to improve the appearance)</p>
10.	<b>Posterior Capsular Opacification (PCO)</b>	Secondary Care	This condition requires assessment by Ophthalmic surgeon and, if appropriate, treatment via the one stop YAG laser treatment clinic with no requirement for formal monitoring post treatment.
11.	<b>Sub Conjunctival Haemorrhage (SCH)</b>	GP	This is a self limiting condition that can be managed by the GP if the posterior edge is identified so that it can be checked for bleeds.
12.	<b>Trichiasis/pseudotrachiasis</b>	Pears/The Practice	Abnormally located eyelashes that grow back toward the eye, touching the cornea or conjunctiva.

Item No	Condition	Management Category	Guidance
			<p>If the patient does not have the conditions noted below, patients can be treated conservatively by removing the affected lashes.</p> <p><b>Refer to Secondary Care</b> for management if the patient has one of the following conditions:</p> <ul style="list-style-type: none"> <li>• Cicatrizing disease</li> <li>• Ocular Cicatricial Pemphigoid (OCP)</li> <li>• Stevens-Johnson Syndrome (SJS) etc.</li> <li>• Recurrence of condition following conservative treatment</li> </ul>
13.	<b>Corneal Ulcer</b>	PEARS/The Practice/Secondary Care	<p><u>Sterile corneal ulcers may be managed under PEARs/The Practice. All suspect or confirmed non-sterile corneal ulcers require Urgent Referral to Secondary Care as noted below:</u></p> <p><b>Urgent Referral to Secondary Care is required if:</b></p> <p>There are potentially diverse clinical reasons for this condition (herpetic, auto-immune, bacterial), therefore, the patient must be assessed, scraped for microbiology and treated by an Ophthalmologist</p>
14.	<b>Ectropion</b>	GP	<p>This condition (eyelid turning outward) can normally be managed in primary care.</p> <p><b>Refer to Secondary Care</b> only if surgical intervention is required (to treat a clinical condition rather than to improve the appearance)</p>

Item No	Condition	Management Category	Guidance
15.	Entropion	Secondary Care	<b>Urgent Referral (to oculoplastics required):</b>  This condition (eyelid turning inward) requires surgery.
16.	Corneal Foreign Body	Secondary Care	<b>Urgent Referral required:</b> <ul style="list-style-type: none"> <li>• Treatment requires sterile setting and there may be a need (if the object was metallic) to remove the rust ring no later than 24 hours post removal of the object.</li> <li>• The eye cannot be irrigated in primary care</li> </ul>
17.	Hordeolum (stye)	GP/PEARS/The Practice	Appropriate treatment is: <ol style="list-style-type: none"> <li>1. Remove affected lash</li> <li>2. Apply short course of warm flannel massage and Fucithalmic</li> </ol>
16.	Dry Eye	Pears/GP/The Practice	This condition is deemed to be non-sight threatening.  <b>Refer to Secondary Care</b> if the patient is diagnosed with a Rheumatic co-morbidity or the condition itself is deemed to be sight threatening.
17.	Recurrent Corneal Erosion Syndrome	Pears	<b>Treatment protocol pending, Worcestershire Acute Trust to lead.</b>
18.	<b>Sudden painless loss of vision:</b>  <b>Central Retinal Artery</b>	The Practice/Secondary Care	To exclude Giant cell arteritis (GCA) then investigate the embolic source.  <b>Refer URGENTLY to Secondary Care</b> if the patient presents with CRAO within

Item No	Condition	Management Category	Guidance
	<p><b>Occlusion (CRAO)</b></p> <p><b>Branch Retinal Artery Occlusion (BRAO)</b></p> <p><b>Nonarteritic Anterior Ischemic Optic Neuropathy (NAAION)</b></p>		<p>24 hours so that emergency decompression of the eye can be undertaken.</p> <p><b>For NAAION: Refer URGENTLY to Secondary Care</b> if Giant Cell Arteritis (GCA) is confirmed so the patient can have an emergency ESR.</p> <p>Patient discharged back to primary care for management with high dose steroids.</p> <p>Patient will also need temporal artery biopsy via vascular surgery.</p>
19.	<p><b>Cataracts</b></p> <p>OPCS-4 Codes (for use within secondary care):</p> <p>C711, C712, C713, C718, C719, C721, C722, C723, C728, C729, C731, C732, C733, C734, C738, C739, C741, C742, C743, C748, C749, C751, C752, C753, C754, C758, C759</p> <p>HRG's: BZ01Z, BZ02Z, BZ03Z</p>	Secondary Care	<p><b>Refer to Secondary Care</b> if condition is sight threatening and the condition is within the Commissioners' "Cataract Extraction Surgery" commissioning policy for treatment.</p> <p><i>"NHS Redditch &amp; Bromsgrove Clinical Commissioning Group, NHS South Worcestershire Clinical Commissioning Group and NHS Wyre Forest Clinical Commissioning Group (also termed "the Commissioner" in this document) will routinely fund cataract extraction surgery on either 1st or 2nd eyes which have been diagnosed with a best corrected visual acuity of 6/12 or worse (in the affected eye)."</i></p> <p>NOTE: Patients needing second eye surgery (if clinically eligible, i.e. the second eye is in line with commissioner policy to be discharged back to Primary Care (Optometrists) for management of the <b>first eye</b> with an agreed treatment plan/date for second eye surgery.</p>

Item No	Condition	Management Category	Guidance
20.	<b>Vitreo-Retinal Conditions (Acute Onset of Macular Hole, PDR, RD)</b>	Secondary Care	<b>Refer to Secondary Care</b> if condition is sight threatening
21.	<b>Corneal Diseases</b>	Secondary Care	<b>Refer to Secondary Care</b> if condition is sight threatening
22.	<b>Suspected Malignancy</b>	Secondary Care	<b>Refer to Secondary Care</b> using the 2 week urgent referral for all conditions except for Basal Cell Carcinoma, which is a standard referral.
24.	<b>Aesthetic conditions affecting eyes/peri orbital area</b> <ul style="list-style-type: none"> <li>• Xanthelasma</li> <li>• Skin Tags</li> <li>• Benign Growths, tags, moles, warts</li> <li>• Lipomata (Fatty Deposits)</li> <li>• Sebaceous Cysts</li> <li>• Blepharoplasty for cosmetic reasons</li> </ul>	GP	<p>Already included in the Commissioners' Aesthetic Surgery Policy under "benign skin lesions".</p> <p>No surgical treatment to be provided unless there are clear clinical symptoms significantly affecting the patient's vision/visual field.</p>

Item No	Condition	Management Category	Guidance
25.	<b>Watery eyes in Adults</b>	GP/The Practice	<p>Normally managed using conservative treatments, eye washes etc.</p> <p><b>Refer to Secondary Care/The Practice?</b> if the condition affects the patient's <b>only</b> sighted eye or the condition is associated with dacryocystitis (acute, chronic or recurrent) or cannot be managed in primary care with conservative therapies.</p>
26.	<b>Minor Non Occlusive Ptosis</b>	GP	<p><b><u>Patients aged 8 Years Old or lower:</u></b></p> <p><b>Refer to Secondary Care</b> if</p> <ul style="list-style-type: none"> <li>• The child is under the age of 8; AND</li> <li>• The eyelid droop affects the pupil, which may affect the development of sight in that eye.</li> </ul> <p><b><u>Patients aged over 8 Years Old:</u></b></p> <p>If a child is over the age of 8 and has not been treated, or the condition occurs in a child over the age of 8, then this patient is treated the same as an adult patient.</p> <p><b>Refer to Secondary Care</b> where the eyelid droop significantly affects the patient's visual field when eyelid is in a relaxed state.</p>
27.	<b>Pterygium for cosmetic reasons</b>	GP	<b>Refer to Secondary Care</b> if the patient's visual acuity is significantly reduced or there are changes to topography or the condition causes dellen.
28.	<b>Conjunctival lesions (Pinguecula/naevus</b>	Optometrist/GP/The Practice	<b>Refer to Secondary Care</b> if malignancy is suspected – referral should be made via the standard urgent treatment pathway.

Item No	Condition	Management Category	Guidance
			Patients with benign lesions should be referred to an optometrist for confirmation of diagnosis then discharged back to the GP for ongoing management.
29.	<b>Correction of Squint – Adult</b>	Optometrist/GP	<b>Refer to Secondary Care</b> if there are symptoms, if the condition is purely cosmetic, these patients should remain under the care of their GP/Optometrist
30.	<b>Asymptomatic Epiretinal Membranes</b>	Optometrist/GP	<b>Refer to Secondary Care</b> if the patient's visual acuity is WORSE than 6/9 with or without distortion
31.	<b>Asymptomatic lesions identified using OCT screening</b>	Optometrist/GP	<b>Refer to Secondary Care</b> if malignancy is suspected – referral should be made via the standard urgent treatment pathway.  Patients with benign lesions with no symptoms should be referred to an optometrist for confirmation of diagnosis then discharged back to the GP for ongoing management.
32.	<b>Myopic peripheral lesions without symptoms</b>	Optometrist/GP	This is not part of the National Screening Network so patients with benign lesions with no symptoms should be referred to an optometrist for confirmation of diagnosis then discharged back to the GP for ongoing management.
33.	<b>Field Loss noted at visual field tests which are not repeatable at a test undertaken 12 months later</b>	Optometrist/GP/Th e Practice?	<b>Refer to Secondary Care</b> if the symptoms persist at the second review (i.e. 12 months after the original test at which the issue was noted).
34.	<b>Optic Nerve head drusen</b>	Optometrist/GP/Th e Practice	<b>Refer to Secondary Care</b> if the symptoms occur e.g. peripheral visual field loss and/or reduced visual acuity persist at the second review (i.e. 12 months after the

Item No	Condition	Management Category	Guidance
			original test at which the issue was noted).
35.	<p><b>Myopia (Short Sightedness)</b></p> <p>OPCS-4 Codes (for use within secondary care):</p> <p>C493, C498, C499</p>	Optometrist/GP	The Commissioners do not approve the NHS funding of laser surgery to correct myopia.

## 5. Clinically Exceptional Circumstances

- 5.1 If there is demonstrable evidence of a patient's clinically exceptional circumstances, the referring practitioner should refer to the Commissioner's "Operational Policy for Individual Funding Requests" document for further guidance on the process for consideration.

For a definition of the term "clinically exceptional circumstances", please refer to the **Definitions** section of this document.

## 6. References

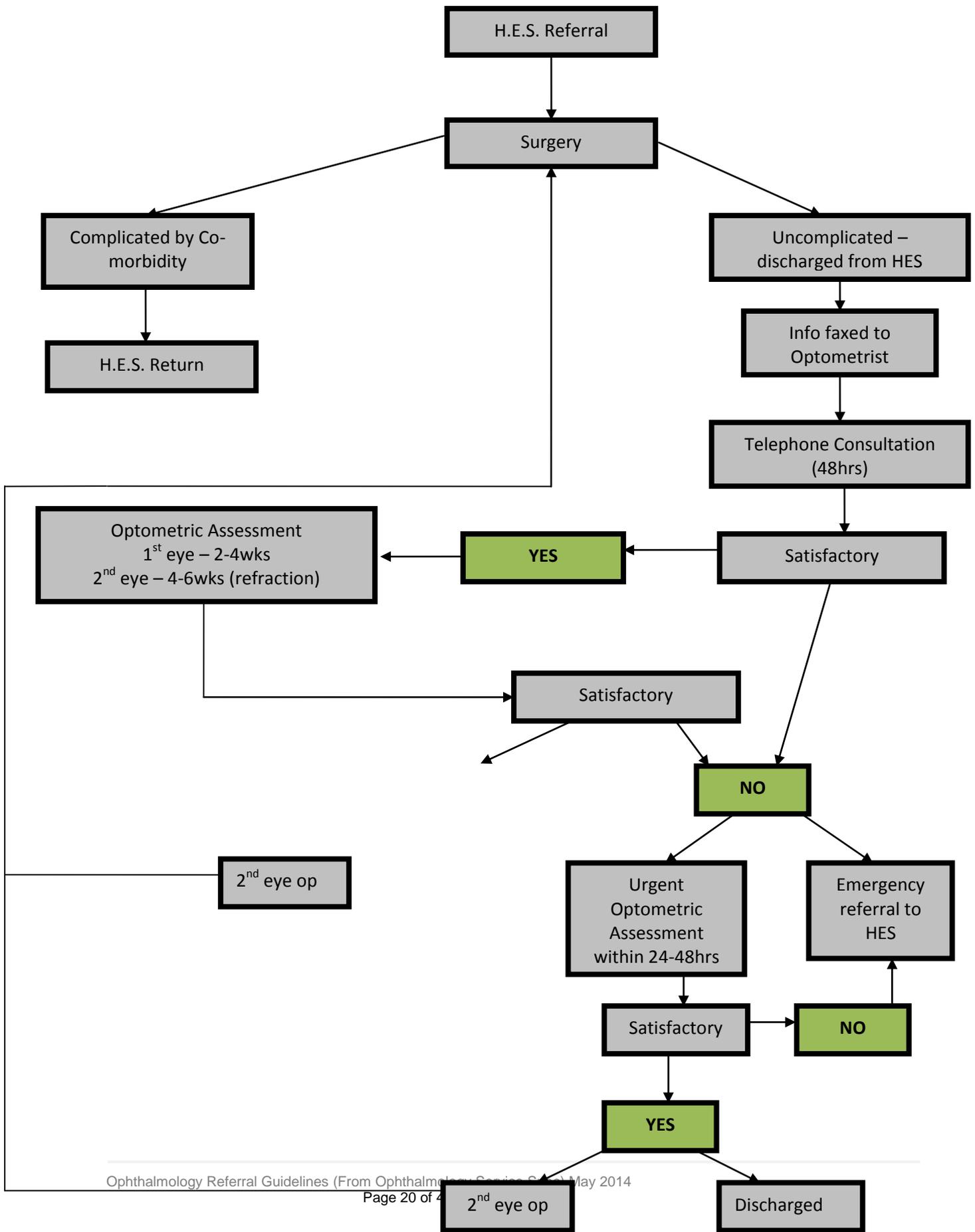
- Hereford Primary Care Trust – Policy on Low Priority Treatments July 2009
- NHS Berkshire - Policy on Low Priority Treatments
- Norfolk PCT - Policy for low priority procedures and thresholds April 2007
- Suffolk PCT - Low Priority Treatment – Policy T28 Upper Eyelid Functional Blepharoplasty Jan 2008
- NHS Surrey – List of low priority procedures and other procedures with restrictions or thresholds *Dec 2009*

## 7. Documents Which Have Informed This Policy

- Worcestershire CCGs: Operational Policy for Individual Funding Requests
- Worcestershire CCGs: Prioritisation Framework for the Commissioning of Healthcare Services
- West Midlands Strategic Group Commissioning Policy 1: Guiding principles and considerations to underpin priority setting and resource allocation within collaborative commissioning arrangements
- West Midlands Strategic Group Commissioning Policy 4: Use of cost-effectiveness, value for money and cost effectiveness thresholds
- West Midlands Strategic Group Commissioning Policy 16: Prior Approval
- West Midlands Strategic Group Commissioning Policy 9: Individual funding requests

**Post Surgery Cataract Pathway**

Appendix 1



**Referral Pathway for Patients with Suspected Wet Age-Related Macular Degeneration (WAMD)**

Emergency referral by GP/Optometrlist/Ophthalmologist to WAMD Fast Track Clinic

**FAST TRACK WMAD CLINIC (new OPA)**

**DIAGNOSTIC STAGE:**

- Full clinical history including confirmation of no known evidence or suspicion of sensitivity to ranibizumab;
- Retinal imaging (stereo fundus fluorescein angiography (FFA) (or indocyanine green angiogram) and optical coherence tomography (OCT) (Stratus OCT 3 equivalent or higher specification));
- Confirmation that patient meets the criteria identified with NICE TA 155 including confirmation of no significant permanent structural damage to the fovea.

**TREATMENT STAGE 1**  
 Loading injections 1 - 3

**TREATMENT STAGE ONE: LOADING INJECTIONS:**

- To be undertaken at 4 week intervals
- OCT to be undertaken prior to injection

Clinic attendance at Review Medical Retina Clinic (WRH)

**CLINICAL REVIEW:**

- Full ocular assessment
- ETDRS (LogMAR) BCVA history and examination
- OCT
- FFA examination

**TREATMENT STAGE 2**  
 Maintenance injections at 4 weekly intervals or as clinically required (approx 4 further injections in Year One and 8 in Year Two)

**TREATMENT STAGE TWO:**

- Intra-vitreous injections at 4 weekly intervals (minimum) if :
  - There is persistent evidence of lesion activity;
  - The lesion continues to respond to repeated treatment;
  - There are no contra-indications to continuing treatment
- ETDRS (LogMAR) BCVA history and examination, OCT and FFA examination to be undertaken prior to continuing treatment

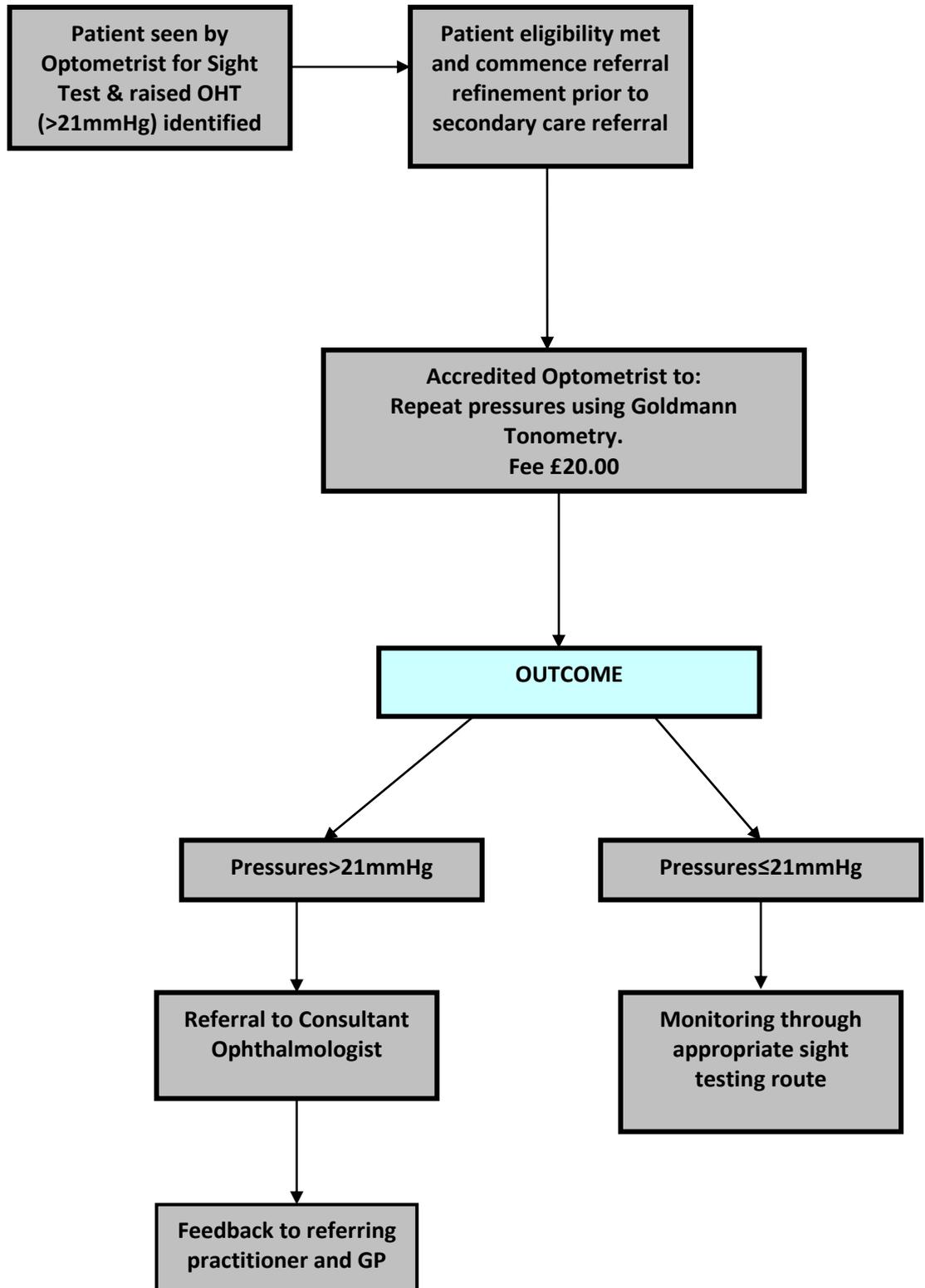
**TREATMENT DISCONTINUED**

Patient on active monitoring through Ophthalmology or discharged

**TREATMENT DISCONTINUED:**

- No evidence of active disease; or
- One or more adverse event related to drug or injection procedure.

## IOP Referral Refinement Pathway



<b>Service</b>	Primary Care Eye Service
<b>Clinical Area</b>	Community Based
<b>Commissioner Lead</b>	NHS Worcestershire on behalf of Redditch and Bromsgrove Clinical Commissioning Group (RBCCG)
<b>Provider Lead</b>	N/A
<b>Period</b>	The term of this agreement shall be for a three-year period commencing on a mutually agreed date.

## 1. Purpose

### 1.1 Aims

#### Overall Aims

- Making the most appropriate use of secondary care; the new service will reduce the number of unnecessary and inappropriate referrals into secondary care;
- Deliver a high quality Primary Care Eye Service in line with agreed Key Performance Indicators (KPI's);
- Improve patient choice and convenience; Redditch and Bromsgrove patients will have the option to be treated for ophthalmology within the local community, closer to home;
- Provides an alternative choice for those patients who have 'low risk' glaucoma (currently treated in an acute setting) and develops transfer protocols to enable patients to move seamlessly into the community based setting;
- Additionally provides two way referral service so that 'low risk' glaucoma patients are referred back to acute hospital care for specialist investigation or treatment, as necessary;
- For those patients requiring cataract surgery, provides pre operative and post operative appointments within the community clinic;
- Facilitating the development of a "one-stop-shop clinic" for patient consultations, combining assessment, treatment and self-care instruction and discharge where appropriated;
- Provides a patient focused service, improving patient choice and enhancing the patient experience;
- Faster access to diagnostics and treatment for patients. As a result, significantly reducing waiting times for ophthalmology outpatient appointments across the whole health economy; as well as referral to treatment and referral to test times;
- Improve education and training structures for GPs and Nurses across RBCCG;
- Promotes the development of specialisation in primary care;

- To develop a service that dovetails with and compliments the existing local services;
- To deliver a service compliant with NICE guidance (including any specific equipment requirements), in partnership with the Commissioner;

## 1.2 Evidence Base

### Drivers for Change – National Drivers

- The clear direction of travel for the future provision of chronic disease services set out by the Department of Health (DoH) in the February 2006 White Paper ‘Our health, Our care, Our say, a new direction for community health services’. This has set out targets in relation to the number of acute based services that should be transferred, or reprovided, in primary care settings wherever possible. There is good evidence from the DoH to suggest that removing services traditionally deliver in secondary care settings and placing them in the community improves access, reduces demand for secondary care services and consequently reduces overall waiting times for outpatient and inpatient hospital care;
- The First Report of the National Eye Care Services Steering Group (2004) evaluated and recommended a number of care pathways be developed in community settings;
- More people are being referred with earliest signs of eye disease as diagnostic tests become more sophisticated and easier to apply. This is resulting in a higher number of people requiring ongoing monitoring;
- The population is ageing and this will lead to an inevitable increase in the prevalence of eye disease. These increasing levels within an ageing population have led to recognition of a rising cost of their care, including complications and the need to provide services in a locally accessible venue;
- The desire to improve local quality outcomes, ease of access, convenience, choice and continuity for patients.

### Key reference points for providers include:

- Action on Cataracts (Department of Health: February 2000) – which describe the action required prior to referral and also within an intermediate service;
- NICE guidelines;
- The Royal College of Ophthalmologists;
- The Royal College of Optometrists;
- The British Orthoptic Society;
- Glaucoma Clinical Care Pathway and Dataset (Do Once and Share: Glaucoma – NHS Connecting for Health, June 2006).

## 1.3 General Overview

- The service does not include the delivery of those services which form part of the essential and additional primary care services;
- Patients will be seen and treated, where possible, in a single “one-stop-shop” visit;
- NICE and NPSA guidelines and alerts will be followed with practices changing to

accommodate updates as required;

- 20% of appointment times should be delivered outside of traditional working hours which are Monday – Friday 9am – 5pm;
- The new service should place the patient at the centre of care; the environment, staffing and delivery of the service must support this vision;
- Suspected cancer patients or patients with complex needs/multiple morbidities will continue to be seen within secondary care;
- Providing an option for a Primary Care Eye Service to be delivered closer to the patient's home, with appropriate access to secondary care, clinical support, and investigations. Ensuring the future provision is of the highest quality and patient focused through collaborative and multi-disciplinary working across Redditch and Bromsgrove.

#### **1.4 Objectives**

The Any Qualified Provider process will give RBCCG the opportunity to identify and accredit suitably qualified providers of eye care services for the registered population of Redditch and Bromsgrove. The selection process will incorporate key requirements associated with quality and will also take into account value for money.

- provide much needed capacity and choice within the area and supply access to community based services within the Redditch and Bromsgrove area;
- reduce pressure on acute eye hospital services;
- the service should work with local social and economically deprived communities, black minority and ethnic (BME) communities to improve the uptake of these services;

As a minimum, the Service Provider must:

- ensure that clinicians providing Triage and Primary Care Eye Services fulfil The Royal College of Ophthalmologists and Association of Optometrists guidelines on qualifications;
- meet with the Healthcare Commission Standards for Better Health in the delivery of a Primary Care Eye Service;
- support the education and training needs of the staff providing the service;
- ensure that they are compliant with all statutory employment legislation.

#### **1.5 Expected Outcomes**

- More patients diagnosed and treated within the community;
- Patients have rapid access and minimal delay to diagnosis and treatment for their ophthalmology problems;
- The patient moves appropriately and seamlessly between primary, community and specialist secondary care services;
- Service users including minority ethnic groups feel the service is responsive to their needs;
- Ensure the patient's GP is informed of the outcome of any appointments as outlined within

the national contract;

- Submit data returns to the commissioner as outlined within the information requirement section of the contract. This includes activity, waiting time, DNA's, conditions and treatments delivered, onward referrals and ethnic monitoring data.

The Service Provider will evidence:

- An enhanced level of knowledge and skills to those acquired by non-specialist colleagues;
- Good communication skills;
- Competence in teaching and training health care professionals;
- Commitment to cascade knowledge and skills.

## 2. Scope

### 2.1 Service Description

The Primary Care Eye Service will provide an equitable service for the registered population of Redditch and Bromsgrove with non-complex eye conditions within locality settings (see section 3 for details of Service Model and Patient Care Pathways).

- Follow safe and secure practices, appropriate for the provision of community based services;
- Provide standard NICE compliancy, updating services as new guidance is released;
- Undertake "best practice" management and follow up each patient using a one-stop-shop pathway (e.g. field and HRT tests to be undertaken on day of consultation/follow up review) where possible and updating practices and protocols as national and local guidance and policies (including NHS Worcestershire Policies) are released.
- Support patient's self care and facilitate the education of the person with chronic eye disease (such as glaucoma) about their condition;
- Complete a monthly, quarterly and yearly KPI report to inform audit and evaluation of the service;
- Ensure that the GP is informed about the medication required (to ensure that the medication is prescribed) if the patient requires ongoing treatment;
- Communicate outcomes and treatment required to the patient's own GP and referring clinician (if this was not the patients GP). This will include patients that do not attend;
- Ensure patient details are entered onto a suitable computerised follow up recall management system.

### 2.2 Accessibility/acceptability

The Primary Care Eye Service will be listed on the local Choose and Book menu for NHSW, as such all GP referrals for the new community service should be arranged via the Choose and Book system. Direct referrals can also be received from local optometric practices and as a seamless transfer of care from a local acute provider.

- The service is available to all adults age 16 and over, with the exception of those who fall under the exclusion criteria detailed in Section 4.6;
- Treatment is based on clinical need;
- Patient referrals should be triaged within 3 working days of receipt of referral (including notification to referring GP or optometrist);
- The Service Provider must ensure that patients wait no longer than 4 weeks from point of referral to appointment within the Primary Care Eye Service;
- Urgent patients are seen quickly (within 48 hours);
- A minimum of 20% of hours should be delivered outside of traditional working hours which are Monday – Friday 9am-5pm;
- Clear and accessible patient information should be provided in a variety of formats inclusive of guidance on services provided; and health promotion for common ophthalmology conditions.

### **2.3 Whole System Relationships**

The Service Provider **MUST** work collaboratively with RBCCG, NHSW commissioners, acute trust / secondary care and General Practice. Where ever necessary, the service provider must demonstrate effective links with other statutory providers and voluntary sector organisations.

### **2.4 Interdependencies With Other Services**

The expectation of RBCCG is to ensure that all services are delivered to patients in a streamlined, cohesive fashion, whereby any Patient Care Pathways (identified within section 3.2) requiring the involvement of one or more additional Providers, is delivered in a collaborative and organised fashion with minimal disruption to the Patient. The expectation is that the service provider will be able to plan for and manage any of the risks arising from these interdependencies.

The service can take over the long term management of 'low risk' glaucoma patients from the acute sector as required. Inter-provider protocols will need to be developed and agreed before this can occur.

The Ophthalmology Service is dependent on RBCCG GPs, secondary care ophthalmology departments and optometric providers, in relation to referral pathways, adherence to local protocols and follow-up of patients. The provider will be required to develop effective data transfer protocols as part of any agree inter-provider referral pathway agreements (for example, where the provider aims to provide pre and post operative care for cataract patients) to ensure continuity of care.

### **2.5 Relevant Clinical Networks and Screening Programmes**

The Service Provider must demonstrate effective links with NHS Worcestershire's Retinopathy Screening Programme to ensure the services within the Primary Care Eye Service are maximised appropriately.

The provider will liaise with local commissioners and GPs to market and raise awareness about services, referral mechanisms and treatment protocols prior to and once the service has commenced.

The community service will liaise with secondary care providers and other community providers from related disciplines to agree local protocols and pathways.

## 2.6 Prior to Service Commencement

The following considerations need to be in place prior to the service commencing:

- Registration with Care Quality Commission. Any conditions applied to that registration which require improvements to the service must be delivered prior to commencement of the service;
- All staff (clinical, management and administrative) will have completed a full induction and are conversant with the relevant services, policies and operational protocols. This induction training should include (but not limited to) equality and diversity, complaints management, information governance, fire, child and adult protection;
- Provide evidence of the competency of all staff in the clinical conditions included in this specification, including working with vulnerable persons;
- Provide evidence of robust risk management, complaints, infection control and untoward incidents reporting mechanisms;
- Ensure that staff providing the service have appropriate personal indemnity and assurances in place to cover claims made against them as described within the nation contract. Proof of cover **MUST** be provided to the commissioner prior to service commencing;
- Ensure CRB checks are completed and professional registration is in place for all staff;
- Any GPSI employed, must be accredited by NHSW, or Equivalent accreditation body, Evidence of accreditation must be provided;
- Ensure availability of suitably qualified staff to deliver the service;
- General health and safety requirements must be met before commencement of the service.

## 2.7 Sub-contractors

RBCCG is aware of the potential requirement for the Service Provider to reach sub-contractual agreements with operational staff in order to effectively deliver the required elements within the Service Specification. However, the provider is to remain the accountable body for all aspects of the service specification. The provider must inform and have written agreement with the commissioner for any sub-contracts planned or in place.

Providers will ensure that any GP or optometrist engaged or employed to perform service, in accordance with the service specification, are included on a PCT Performers List (or future equivalent).

## 3 Service Delivery

### 3.1 Service Model

#### 1. Primary Care Eye Triage System

The Service Provider will establish a central triage or referral refinement service, suitable for referral of all GOS18 (or equivalent form as agreed between Service Provider and Commissioner) referrals from referring GPs and Community Optometrists.

On triage, diagnostic tests required will be identified and organised before the consultation where appropriate, facilitating a "one-stop-shop" appointment approach.

Patients will be offered the choice of referral into the triage service at point of GP referral.

Optometrists will continue to refer directly into secondary care for certain conditions / presentations which fall outside of the agreed referral criteria.

The Service Provider will establish a dedicated telephone line for patients and their carers to access support and advice during normal working hours.

## **2. Primary Care Eye Service**

The Service Provider will offer a service from a minimum of 2 community based locations (within Bromsgrove and Redditch).

The Service will appropriately manage patient pathways as agreed between the Service Provider and Commissioner (see section 3.2 for details of Patient Care Pathways).

The provider will ensure that diagnostic results are reported back to the referring GP and where urgent, are acted upon without delay for the appropriate intervention of follow-up.

The provider will make arrangements to carry out patient satisfaction surveys on a quarterly basis in relation to the service, share results with the commissioner and develop and implement plans to show improved results year on year. The provider will also co-operate with such surveys that may be carried out by the commissioner. The provider shall have regard to any Department of Health guidance relating to patient satisfaction surveys. The provider will be expected to demonstrate evidence of having used the patient experience of using the service to make improvements to service delivery.

- The provider to ensure staff are appropriately qualified, indemnified and revalidate where appropriate;
- The provider will carry out all CRB checks where necessary;
- The service provider will support staff in their professional development through regular training, supervision and appraisals;
- The service provider will provide all staff with cultural awareness and disability awareness training;
- The service should have a full set of Human Resources policies and documents.

The provider will be required to purchase, maintain and replace as necessary all relevant equipment required to provide the service. As a minimum this is expected to include (but not limited to):

- An effective data management system including a system which is capable of effective and safe data transfer for patients on agreed inter-provider pathways;
- Humphrey visual field machine (or equivalent threshold visual field screener) and printer;
- Illuminated Snellen Chart or electronic screen chart equivalent;
- Focimeter and compensatory lens set for field testing;
- Slit lamp;
- Applanation tonometer – Goldman – type for slit lamp, and hand – held (e.g. Perkins or Tonopen);
- Direct and indirect Ophthalmoscopes and indirect (20Diopter or equivalent) lens;
- Amsler charts and Ishihara colour vision charts;
- Diagnostic drugs (mainly dilatin, topical anaesthetic and fluorescein drops);
- Slitlamp biomicroscopy lenses;
- Gonioscopy lenses;
- Automated pachymeter (e.g. Pach-Mate).

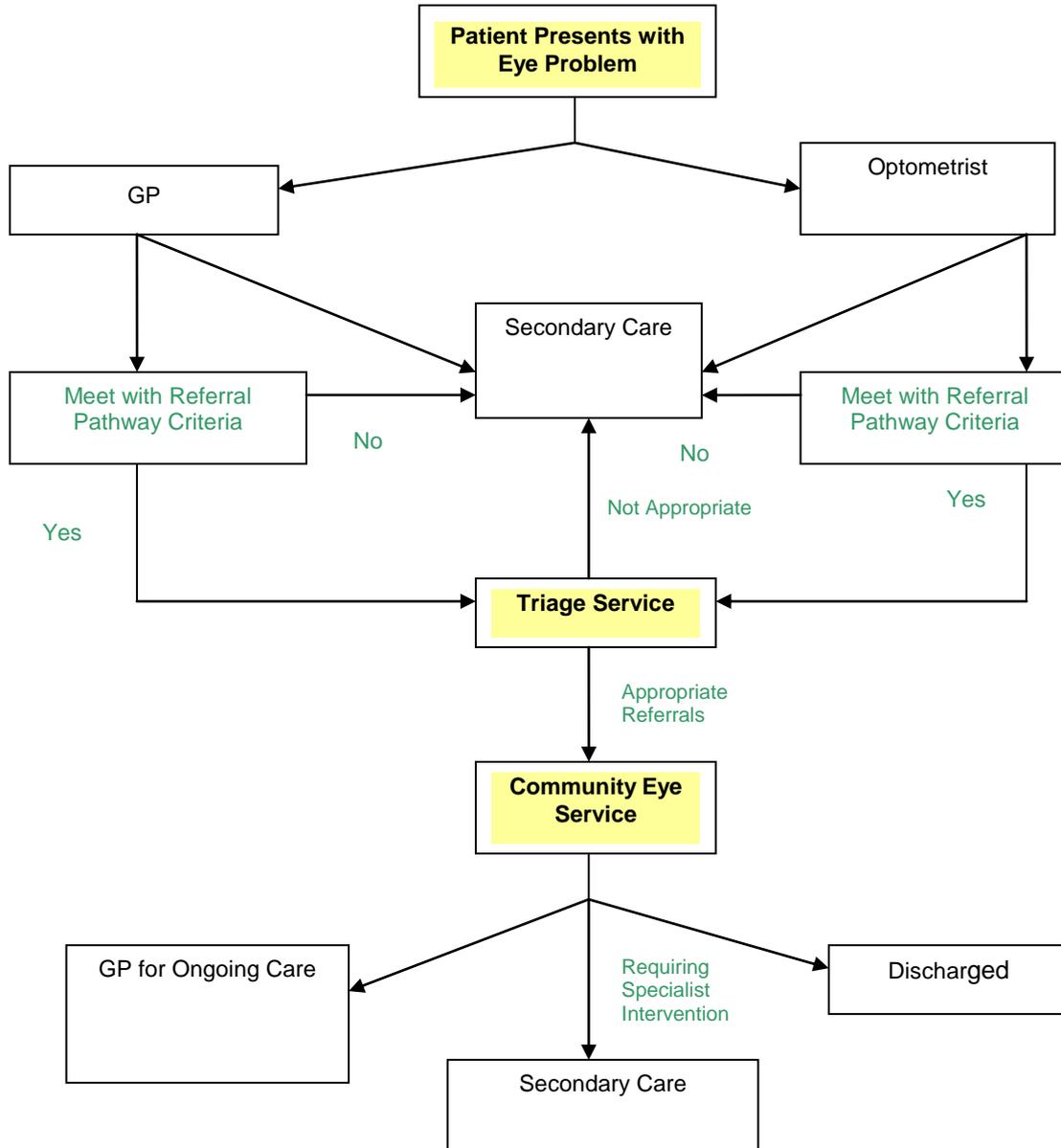
Where cataract pre-op assessments are planned providers will purchase, maintain and replace:

- Pre-assessment equipment i.e. IOLMaster, modern B-scanning equipment with necessary linkup to acute services through agreed inter-provider protocols.

The service will use one of the following arrangements for sterilisation:

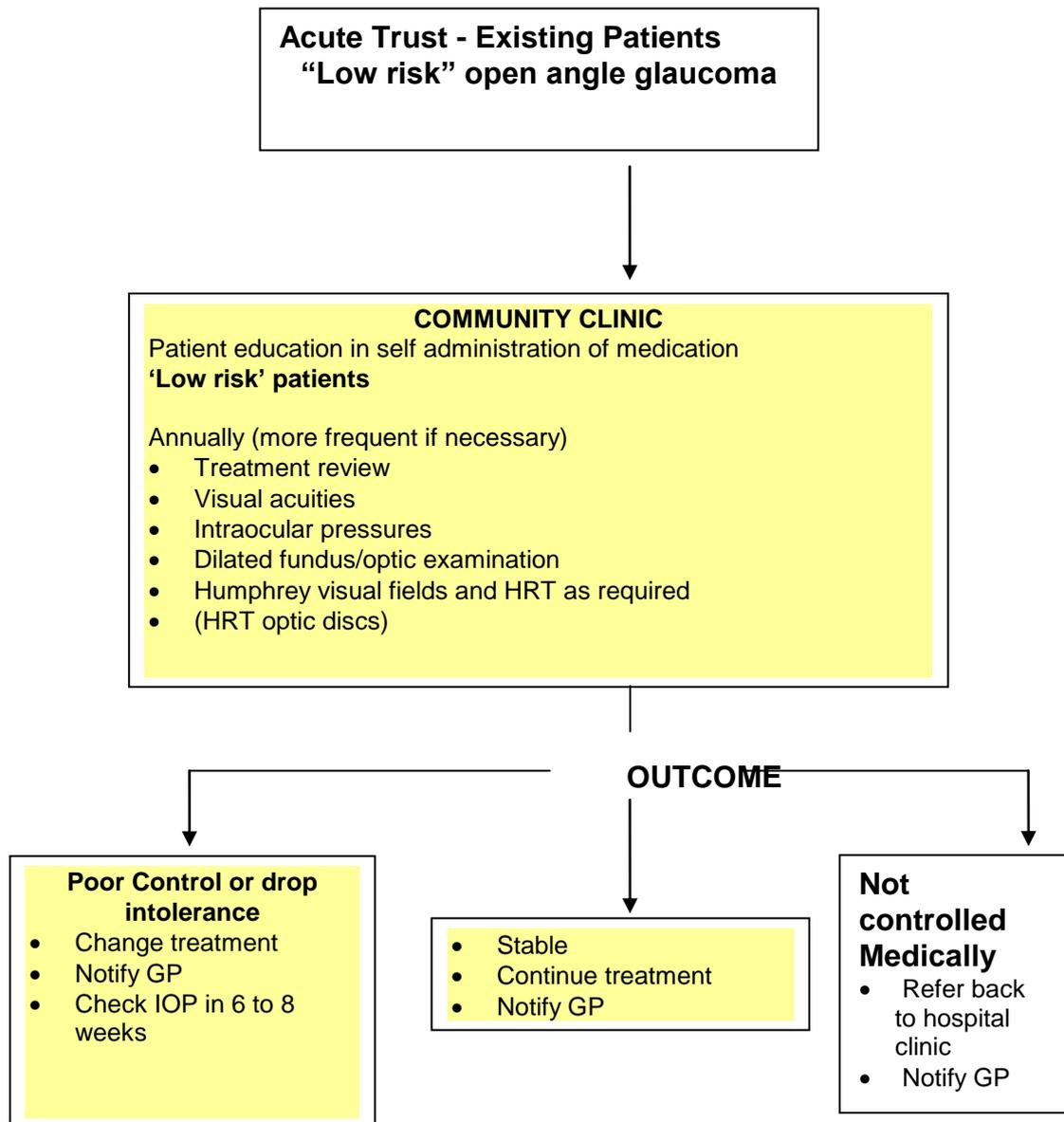
- Sterile packs from a local CSSD;
- Disposable sterile instruments;
- Approved sterilisation procedures that comply with national guidelines. Practice must be updated as guidance changes.

**Flowchart outlining the RBCCG Primary Care Eye Service Model**



### 3.2 Pathways

#### 1. 'Low risk' open angle glaucoma



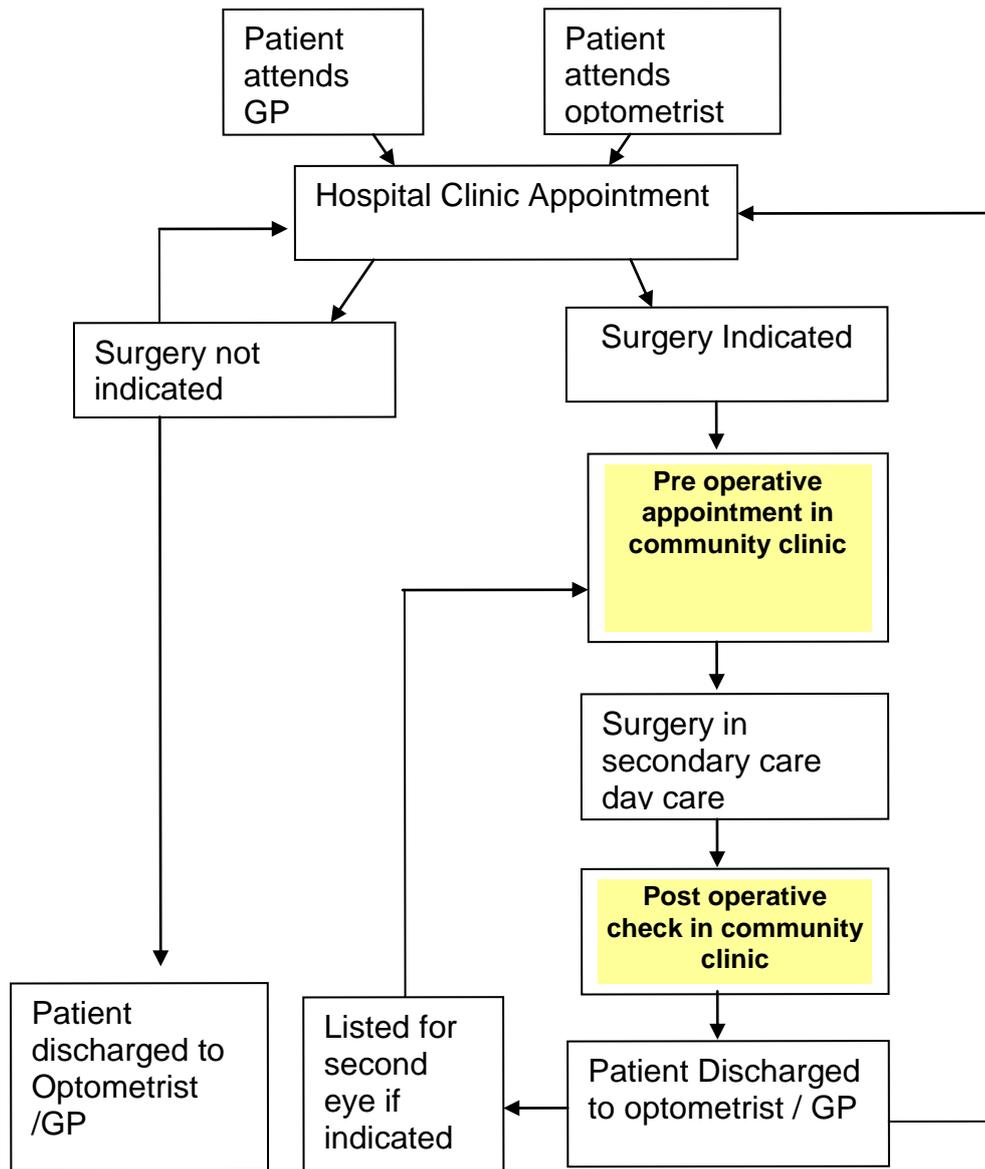
Once diagnosed with 'low risk' glaucoma, lifelong follow up is required and involves a yearly appointment (more frequent if necessary) for an intra ocular pressure reading and visual field test.

All routine 'low risk' glaucoma patients will have all their appointments within a community setting and will only attend secondary care for surgical intervention or more detailed

physiological testing.

The Provider must work in partnership with the secondary care consultant ophthalmologist to develop and improve the following Patient Care Pathways:

**2. Pre operative assessment and post operative care for cataracts**



The Service Provider must ensure there are Patient Care Pathways in place for the following common ophthalmic conditions (this is NOT an exhaustive list) to be agreed between service provider and commissioner:

- 3. Glaucoma/Ocular Hypertension (no optic nerve or visual defect)
- 4. Retinal Lesions (not macular)
- 5. Dry eyes

6. Blepharitis
7. Eye pain / eye discomfort (not red eye)
8. Low vision
9. Conjunctivitis – allergic, bacterial, viral or chlamydial
10. Episcleritis
11. Chronic and acute visual dysfunction (diagnostic and appropriate referral)
12. Trichiasis
13. Recurrent Anterior Uveitis
14. Non-emergency flashing lights/floaters

**Referral exceptions:** In the event of an urgent referral, outside of the agreed conditions as detailed above, an onward pathway for management will be agreed between Service Provider and Commissioner. The Service Provider must be compliant with any applicable National Waiting time targets. Exclusions including cancer referrals to be managed in accordance with 2ww cancer process to ensure the patient journey is not compromised.

**Potential Future Service Developments (to be agreed and signed off with commissioner)**

- Minor surgery procedures

#### 4. Referral, Access and Acceptance Criteria

##### 4.1 Geographic Coverage/boundaries

RBCCG is a sub section of NHS Worcestershire. It covers 23 separate GP practices in North Worcestershire and a patient population in excess of 160,000. A high percentage of patient reside in the 2 separate towns of Redditch and Bromsgrove but a significant minority are found along the Western end of the M42 motorway and in rural setting around the 2 towns and to the south of nearby city of Birmingham.

Acute based ophthalmology services are currently provided to RBCCG by Worcestershire Acute Hospitals NHS Trust at the Alexandra Hospital, Redditch, Princess of Wales Community Hospital, Bromsgrove and Worcestershire Royal Hospital (with some attending Kidderminster Hospital). In addition to Worcestershire Acute Trust providers, patients may choose to access ophthalmology services outside of the Worcestershire locality as per choose and book.

##### 4.2 Location(s) of Service Delivery

The Service Provider is required to identify the appropriate levels of capacity and setting to allow for communication, consultation and booking in/reception area;

Sites should be fit for purpose, clear and comfortable and have adequate patient parking. General health and safety requirements must be met before commencement of the service. Sites must have access and be compliant with Disability and Discrimination Act (2005);

The Service Provider must ensure that the service is equitable and accessible to the local population and new comers;

Locations to demonstrate accessibility to main road networks and public transport for those patients where private transport is not an option. To be communicated as necessary and ensure information about physical access available accordingly;

The Service Provider must, as a minimum, provide a service from locations within Redditch and Bromsgrove, with key emphasis on care provided from a community based clinic setting;

The Service Provider must offer a domiciliary option for house bound patients and other patients with barriers to accessing services.

#### **4.3 Days/Hours of Operation**

As necessary in order to meet with the requirements within the Service Specification and as agreed between Service Provider and Commissioner.

A minimum of 20% of hours should be delivered outside of traditional working hours which are Monday – Friday 9am-5pm. Patient satisfaction will be monitored to identify if the hours of operation meet the needs of the service user.

#### **4.4 Referral criteria & Sources**

Referrals into the service will be for non-urgent ophthalmic conditions from GPs, hospital consultants, optometrists and can include the transfer of stable patients from existing eye care services i.e. 'low risk' glaucoma patients.

- The provider will develop proformas and electronic solutions to support the referral and transfer of care process;
- Inappropriate referrals will be returned to the referring clinician with an explanation as to why it is considered to be inappropriate;

The Service will be for patients aged 16 years and over who fit the entry criteria for the clinical conditions and who choose to use the service.

The service will provide advice and guidance to GPs and other referring clinicians to support better primary care management for ophthalmic conditions.

#### **4.5 Referral Route**

Patients will have been offered Patient Choice at point of referral by the referring GP. Triage will form one of the choices available to patients on the Choose and Book system.

The Service Provider must be able to offer capacity for patients to be booked in by GPs/practices using the Choose and Book system.

#### **4.6 Exclusion Criteria**

The following patients will not be treated by the service. Those:

- 15 years of age and under;
- With acute or emergency ophthalmic conditions e.g. iritis, papilloedema, visual floaters within two weeks of onset, corneal foreign bodies, ocular trauma, acute angle closure glaucoma, corneal ulcers, sudden monocular visual loss, optic and retrobulbar neuritis, scleritis, suspected temporal arteritis with visual symptoms;
- Squint/Ocular motility problems;
- Suspected of having cancer;
- Sudden visual field loss;
- With acute neurological symptoms;
- Dysthyroid eye disease;
- Where there is a strong suspicion of wet AMD – e.g. new – onset central visual disturbance, macular haemorrhage, or clear signs of macular oedema or pigment epithelial detachment;

- Requiring urgent A&E care including patients with acute trauma, chemical injury or burns to the eye or lid.

#### **4.7 Response Time and Prioritisation**

The Service Provider must demonstrate the ability to manage referrals in a timely fashion in order for secondary care providers to take over the management of patients where appropriate, not compromising RTT target.

##### **1. Triage**

The Primary Care Eye Service Provider will triage all GOS18 (or equivalent form) referrals made by GPs and community optometrists, ensuring that:

- The Service Provider must ensure that patients are triaged within 3 working days of receipt of referral (including notification to referring GP or optometrist). Inappropriate/urgent referrals to be redirected on day of triage.
- Provider will be expected to reflect a new to follow-up ratio of 1:2.4 in episode costs;

Patients are appropriately prioritised and referred to:

- a. Acute Ophthalmology Services (where necessary)
- b. Primary Care Eye Services
- c. Referring GP provided with advice for case management and education

##### **2. Primary Eye Care**

- The Service Provider must ensure that patients wait no longer than 4 weeks from point of referral to appointment within the Primary Care Eye Service
- Urgent patients are seen quickly (within 48 hours)

#### **Onward Referrals**

Unsuspected cancers – in the event that an unsuspected cancer is found when carrying out or reporting a routine procedure and within 2 hours of discovering the condition, the clinician should ensure that:

- The procedure is reported urgently;
- The patient must be referred onto a 2 week wait cancer pathway;
- A letter to the GP and the referrer (if this was not the GP) outlines the outcome of the report and the referral.

#### **Potentially serious and life-threatening conditions**

In the event that a potentially serious or life-threatening condition is identified, within one working day the clinician should:

- Ensure the examination is reported urgently;
- Contact the appropriate admitting team at the nearest NHS acute hospital to arrange urgent admission and provide copies of the procedure report and any results to the receiving unit;
- A letter to the GP and the referrer (if this was not the GP) providing copies of the procedure report, any results and the outcome of the referral.

#### **Non-urgent condition requiring medical attention**

In the event that a non-urgent medical condition (unrelated to the reason for referral) is identified when carrying out or reporting a routine diagnostic procedure, the clinician should:

- Make onward referral to the patient's GP for follow up.

#### **4.8 Accessibility**

##### **Healthcare Travel Costs Scheme**

- Travel costs will only be reimbursed through the Healthcare Travel Costs Scheme [www.dh.gov.uk/en/Publications and statistics/Publications/PublicationPolicyAndGuidance/DH 116383](http://www.dh.gov.uk/en/Publications%20and%20statistics/Publications/PublicationPolicyAndGuidance/DH_116383)
- Patients will be informed of how to obtain reimbursement through the healthcare travel costs scheme before they attend any appointments;
- Escorts or carers will only be able to claim where the GP or other healthcare professional involved in the claimants care has confirmed that their attendance is necessary.

##### **Patient Transport System (PTS)**

- Patients who have a medical need for ambulance transport will be able to have transport provided by the (PTS). Patients eligible for PTS are those:
  - Whose medical condition is such that they require the skills or support of PTS staff on/after the journey and/or when it would be detrimental to the patient's condition on or recovery if they were to travel by other means;
  - Whose medical condition impacts on their mobility to such an extent that they would be unable to access healthcare and/or it would be detrimental to the patient's conditions or recovery to travel by other means.

#### **4.9 Equality**

The Service Provider will deliver the service with dignity and respect with due regard to both individuality and confidentiality. The service should be appropriate for the requirements of a patient's age, sexual orientation, gender, ethnic origin, religion or disability (performance managed in line with section 9 - Key Information Requirements).

#### **4.10 Interpreting Services**

NHS Worcestershire recognises its role in ensuring that all members of society including non-English speakers and people with visual or hearing loss can have full access to all commissioned services.

To this end the PCT now provides a full range of language and translation services through Applied Language Solutions. The services included are:

- **Face to Face Interpreting;**
- **Instant Telephone Interpreting;**
- **Document Translation;**
- **British Sign Language – via Deaf Direct**

Please note: alternative formats to be made available upon request (e.g. audio, Braille, MP3 etc)

The Service Provider must clearly demonstrate a directly comparable process, in order to meet the diverse requirements of the Redditch and Bromsgrove registered population.

## 5. Discharge Criteria & Planning

The providers will inform the patient's GP by letter when the patient is seen first, initial diagnosis and treatment plan and when the patient is discharged from the service or is referred on to another service. All letters should be sent post discharge as outlined within the standard contract. Standard templates/secure electronic communications should be developed to expedite this process.

A discharge summary will be issued within 5 working days of the consultation taking place.

The discharge letter should contain as a minimum:

- Patient's name, date of birth and NHS number;
- Diagnostic tests;
- Summary of treatment;
- Outcome of treatment;
- Treatment Advise Notice (TAN) in line with local prescribing policies;
- Reason for discharge or planned follow up;
- Referral to other services;
- Treatment plan or recommendations for management.

A copy of this letter should normally be given to the patient as they progress through the service if they have indicated a wish to receive this information.

Details to include patient's status with advice on further management. If a patient requires follow-up, the discharge letter should provide a clinical reason for the next appointment.

### **Did Not Attend (DNA)**

If a patient did not attend their appointment either new or follow details must be sent to the referrer within 5 working days. The service provider to demonstrate they have offered the patient one further appointment of their choice.

## 6. Self-Care and Patient and Carer Information

The production of patient information leaflets will be the responsibility of the Service Provider. The information should be appropriate for the requirements of a patient's age, sex, ethnic origin, religion or disability. The service should make available any literature produced by the patient support groups and display addresses and points of contact. Information should also be made available as easy read for those with learning disabilities and in Braille for those registered as blind.

The Service Provider must offer appropriate education and advice for all newly diagnosed/treated patients upon the management of the agreed ophthalmic conditions. This should be through both direct and indirect contact (e.g. telephone, internet or other means) and must include written information, where appropriate.

The Service Provider to take reasonable steps to ensure that patients are aware of:

- The complaints procedure, taking cognisance of language and communication requirements;
- The role of the PCT and other bodies in relation to complaints about services under the contract and whatever relevant legislation is currently in force;
- The right to assistance with any complaint form via independent advocacy services, as

is statutorily provided.

The Service Provider must establish a Patient Focus Group. The terms of reference for this group should include the ongoing evaluation of the change in service provision for ophthalmology services. The group should meet at least twice yearly to review the findings of the patient satisfaction survey. The Service Provider must demonstrate that any findings are discussed with the commissioners of the service and are actioned if clinically or financially appropriate to do so.

### 7. Continual Service Improvement Plan

The Service Provider must demonstrate that they have a process in place to bi-annually peer review the provision, work process or output of an individual or collective working operating within the Primary Care Eye Service. A report of any review that takes place should be available to the commissioners of the service and clinical governance lead.

The Service Provider must demonstrate the ability to extend the scope of skills and competence of GP's and nurses with the appropriate training and education.

The Service Provider must operate a robust and continuous approach to the improvement of its Patient Care Pathways.

### 8. Baseline Performance Targets

Quality Performance Standard	Quality Performance Indicator	Threshold	Method of Measurement	Consequence of breach	Report Due
Minimum data set (as identified within section 7)			RBCCG Information Analyst		Monthly, ongoing basis
Patient satisfaction survey	10% of population referred into service		RBCCG Information Analyst		Quarterly
Complaints, near misses and SUI's	In line with NHSW policy		RBCCG Information Analyst		Quarterly
Referral acceptance/rejection within 3 working days and onward treatment within Primary Care Eye Service within 4 weeks					Ongoing basis
The Service Provider must demonstrate that they have a process in place to peer review the provision, work process, or output of an individual or collective working operating within the Primary Care Eye Service. A report of any review that takes place should be made available to the					Bi-annually

Commissioners of the Service and Clinical Governance Lead.					
Service Provider must comply with National DH Clinical Governance requirements and as a minimum meet the standards laid down in the National Quality Standards and Standards for Better Health.					Annual inspection – as required
A programme of audits to be made available to the PCT with findings and action plans from said audits					As required
A mechanism needs to be in place to ensure that all staff within the Primary Care Eye Service are appraised on an annual basis. A copy of all appraisals should be made available to the Commissioners of the Service.					Annual
<b>Additional Measures for Block Contracts:-</b>					
<b>Staff turnover rates</b>	n/a	n/a	n/a	n/a	n/a
<b>Sickness levels</b>	n/a	n/a	n/a	n/a	n/a
<b>Agency and bank spend</b>	n/a	n/a	n/a	n/a	n/a
<b>Contacts per FTE</b>	n/a	n/a	n/a	n/a	n/a
<b>9. Activity</b>					
<b>9.1. Activity</b>					
<b>Activity Performance Indicator</b>	<b>Threshold</b>		<b>Method of Measurement</b>		<b>Consequence of breach</b>
Minimum data set (as identified within section 7)					

### Key Information Requirements

- Data requirements will be agreed and set out in the contract, with SUS being the preferred route. The system and process for collating and transmitting the data will be contractually agreed and set up prior to commencement of the service.
- Submission of data will be required to be supplied (at a minimum) as outlined in the table below:

Report	Freq	Deadline	Provided to
Monthly Activity Report Patient-Level Dataset	Monthly	20 <sup>th</sup> working day of month following reporting period	Locality Information Analyst

Monthly activity will be sent to [Samantha.hill3@nhs.net](mailto:Samantha.hill3@nhs.net) as per commissioner process.

- The Service Provider must demonstrate that they are able to diagnose, assess and treat patients with common and acute ophthalmic conditions to a high standard of care. To maintain clinical competency within this field, the Service Provider must ensure that every clinical member of the multi-disciplinary team registered with the GMC or other professional body, reviews a minimum of 30 patients and 5 different ophthalmic conditions per year. If an individual practitioner falls below the threshold of 30 in 2 consecutive years, they will cease to be accredited by the PCT to work within the service without evidence of re-training;
  - Clinic reception, procedure and office areas have access to IT points and access to appropriate EPR;
  - Storage of medical records and information which is relevant to treatment and ongoing care is passed between all parties in accordance with the Caldicott Principles and Data Protection Act (1998);
1. For the contracted period, the Service Provider must produce **monthly management minimum data set** to the PCT ( by practice and by RBCCG) to include:
    - Total number of patients seen in the clinic;
    - Total number of patients seen as a first outpatient appointment;
    - Total number of patients seen as a follow-up appointment;
    - Total number of patients seen at home;
    - The percentage of complete excisions;
    - The number of patients who develop an infection post excision;
    - Total number of DNAs;
    - Total number of rebooked appointments for DNAs;
    - Total number of patients seen by ethnic origin;
    - Total number of patients seen by condition;
    - Total number of patients referred onto secondary care for consultation after being mistakenly triaged to the Primary Care Eye Service;
    - Total number of patients referred for surgery;
    - Total number of adverse events associated with treatment;

- Total number of patients referred into service per practice and/or consortium;
- Average number of weeks waiting for first outpatient appointment within audit period;
- Average number of weeks waiting for follow-up appointment within audit period;
- Total number of Patient Satisfaction Surveys completed;
- Total number of complaints and commendation.

The Service Provider must maintain adequate records of patient attendance and the service provided using an electronic and/or paper based system. Full records of all procedures should be maintained in such a way that aggregated data and details of individual patients are readily accessible if requested by RBCCG or NHSW.

2. For the contracted period, the Service Provider must be able to produce accurate clinical records for each patient referred into the service. Information should include as a minimum:

- Patient name;
- Patient NHS number;
- Patient date of birth;
- Patient ethnicity;
- Sexual orientation;
- Gender;
- Religion;
- Disability;
- Patient practice and/or consortium;
- Name and designation of person providing care;
- Reason for consultation
- The number of DNAs;
- Patient outcome;
- Details of adverse events associated with treatment;
- Date of last hospital appointment (if appropriate);
- Details of referral into Secondary Care.

3. Patient Satisfaction Survey

Result of Patient Satisfaction Survey 10% of population served

## 9.2 Activity Plan

**There are no guaranteed volumes of activity or finance and the risk of there being insufficient activity sits with the provider.**

Providers to adhere to a new to follow up activity ratio of 1:2.4.

Providers are to follow the Best Patient Pathway protocol by ensuring that 90% of patients requiring field tests also have their consultations as a one-stop shop appointment.

Patients with long term conditions transferred from an acute centre will be charged as followed up activity. The plan for transfer will be developed and delivered by the provider in partnership with the acute centre and agreed with the commissioner prior to implementation.

Further expansion of the service will be agreed with the commissioner. Contractual agreement must be confirmed before expansion is implemented. Additional activity delivered before formal contact variation agreed and signed will not be chargeable.

**10. Prices & Costs**

**10.1 Price**

Basis of Contract	Unit of Measurement	Price £	Thresholds	Expected Annual Contract Value £

## Equality Impact Assessment

Organisation

Department  Name of lead person

Piece of work being assessed

Aims of this piece of work

Date of EIA  Other partners/stakeholders involved

Who will be affected by this piece of work?

Single Equality Scheme Strand	Baseline data and research on the population that this piece of work will affect. What is available? Eg population data, service user data. What does it show? Are there any gaps? Use both quantitative data and qualitative data where possible. <b>Include consultation with service users wherever possible</b>	Is there likely to be a differential impact? Yes, no, unknown
<b>Gender</b>	Services are provided on the basis of clinical need alone, which would mean that the gender of the patient should not be a matter of concern within the service provision requirements.	No
<b>Race</b>	There is recognition that some ophthalmic conditions may be more prevalent in specific ethnic groups, however, as the service provision is based on clinical presentation, this should not be an issue.  The service specification also requires patient information (including verbal at consultation) to be provided in a way that is understandable to all patients (i.e. access to interpretation services and British sign language as part of the main service, patient letters and information leaflets to be made available to patients in appropriate languages, including braille).	No
<b>Disability</b>	The service specification requires clinics to be held in environments that can be accessible to all patients (including those with disabilities).	No

<b>Single Equality Scheme Strand</b>	<b>Baseline data and research on the population that this piece of work will affect.</b> What is available? Eg population data, service user data. What does it show? Are there any gaps? Use both quantitative data and qualitative data where possible. <b>Include consultation with service users wherever possible</b>	<b>Is there likely to be a differential impact?</b> Yes, no, unknown
	The service specification also requires patient information (including verbal at consultation) to be provided in a way that is understandable to all patients (i.e. access to interpretation services and British sign language as part of the main service, patient letters and information leaflets to be made available to patients in appropriate languages, including braille).	
<b>Religion/ belief</b>	Services are provided on the basis of clinical need alone. The service specification requires patients to be treated with dignity – which should encompass an understanding of patient’s religion and/or beliefs.	No
<b>Sexual orientation</b>	Services are provided on the basis of clinical need alone.	No
<b>Age</b>	Services are provided on the basis of clinical need alone. However, there is a recognition that some of the conditions treated within the service may be more prevalent in specific age groups (or there is better evidence for treating patients within specific age groups). The decision to treat will be made based on the clinical presentation at consultation and will be the responsibility of the clinician.	No
<b>Social deprivation</b>	Services are provided on the basis of clinical need alone.	No
<b>Carers</b>	Services are provided on the basis of clinical need alone. There is no challenge to the right of a patient to be treated in the presence of their carer should that be considered appropriate at the time of consultation or treatment.	No
<b>Human rights</b>	Will this piece of work affect anyone’s human rights?  No	No

