NHS England
NHS Improvement

SCHEDULE 2 – THE SERVICES

A. Service Specification

Model Structure provided from NHS Standard contract 2019/20 Particulars.

This community post-operative assessment service specification is for delivery by primary care optometrists and necessary to support the Londonwide low complexity day case cataract surgery hub pathway.

Service Specification No.	
Service	Post-operative cataract assessment service delivered by primary care optometrists within the cataract surgery hub pathway.
Commissioner Lead	London/ICS/CCG
Provider Lead	
Period	
Date of Review	

1. Population Need

This service specification outlines a post-operative cataract assessment service (referred to hereafter as the Service) within the London Cataract Surgery Hub pathway. It is delivered by primary care optometrists in community optical practices with the electronic return of outcome data to the surgical provider.

1.1. National/local context and evidence base

This Londonwide service specification has been adapted from the COVID-19 eye care restoration service specification developed by National Eye Care Restoration and Transformation programme, part of the NHSE&I National Outpatient Transformation Programme (NOTP). It is recommended for Londonwide implementation across each integrated care system (ICS) or group of CCGs.

1.2. The Service builds on recommendations from the Get It Right First Time (GIRFT) ophthalmology report (2019), the Colleges Joint Vision 2020, and the Clinical Council for Eye Health Commissioning (CCEHC) Systems and Assurance Framework (SAFE) for integrated eye care pathways, in the context of COVID-19. Along with the CUES pathway, it establishes the foundations for longer term transformation.

1.3. The Service supports a safe, integrated and sustainable system-wide cataract surgery hub pathway for COVID-19 restoration and the prevention of avoidable sight loss.

1.4. The Service is designed to deliver:

- a reduction in traditional face-to-face ophthalmology outpatient appointments, minimising patient travel and time in hospital settings.
- more eye care delivered close to home.
- reduced risk of COVID-19 transmission whilst ensuring all people have access to eye care to meet their needs.
- improved quality of outcome data to Trust and National Ophthalmology Database (NOD).

1.5. Primary care optometrists within optical practice teams have a significant role to play in managing low risk patients in the community, thereby supporting hospital ophthalmology in their response to the pandemic.

1.6. Ophthalmology capacity is under pressure to restore services for moderate-risk and high-risk patients with an increased backlog of patients to be seen following lockdown. Delays and lack of capacity have implications for patient safety, and implementation of these and similar services are now a priority to release capacity.

1.7. **NICE cataract guidance** NG77 Post-operative assessment.
This Service supports NICE Recommendation 1.9.1. Commissioners and service providers should ensure that the following are in place:

- Processes that identify complications after surgery and ensure that there is prompt access to specialist ophthalmology services.
- Processes to ensure that the UK Minimum Cataract Dataset for National Audit is completed.

1.8. **GIRFT ophthalmology recommendation 3:** Use commissioned primary care optometry services to review patients who have had uncomplicated /routine cataract surgery and have no serious ocular comorbidity.

This Service meets the requirements of the following GIRFT actions:

- 3A - Providers and commissioners to work with optometrists to implement pathways so that at least 80% of uncomplicated cataract patients without ocular comorbidity e.g. glaucoma or diabetic retinopathy can receive follow-up and discharge via primary care optometrists, with payment dependent on receipt of post-op data.
- 3B - Baseline data on post-operative assessments, including whether patients were assessed in hospital or at a primary care optometrist, to be routinely collected.
- 3D - Providers, commissioners and primary care to agree clear governance and data sharing requirements, both from primary care to hospitals and vice versa before any new pathway goes live.
- 3E - Providers, commissioners and primary care to ensure that post-operative visual acuity and refractive data is submitted to the NOD or other suitable data collection mechanism.

1.9. **Patient safety -** Serious post-operative complications following cataract surgery are infrequent. Where they do occur, they commonly become apparent shortly after surgery (days to weeks). Patients are therefore provided with information about possible complications, their symptoms and direct contact details of relevant hospital staff, so that if they do experience complications, they can quickly speak to the right person. Currently, most uncomplicated cataract surgery patients are reviewed in an outpatient setting by optometrists or nurses, rather than by surgical team members.

1.10. Where patients have significant ocular co-morbidity or are expected to require more complex procedures, surgery and post-surgery review will remain under hospital ophthalmology responsibility. Only patients assessed by ophthalmologist review as low or low to moderate risk will be treated by the cataract surgery hubs.

1.11. **Data Systems** are available for the optometrist to submit the refraction and visual acuity data securely directly into Trust Electronic Patient Records using Medisoft or OpenEyes or similar online portals. There should be local agreements within each ICS on which data transfer options are used depending on Trust systems. This information will need to be shared with other ICS areas as surgery hubs may treat patients from outside their area to help clear long waiting lists.

Until online portals are available, optometrists may send data via secure NHS email to a dedicated email. Trust teams will need to put in place processes to ensure these data are transferred to the patients record and submitted to NOD. All optical practices must have access to secure NHS mail to transfer and receive patient information.

1.12. **National outpatient transformation programme**

NHSE/I regional teams will work with ICSs/CCGs and optical practices to support the availability of appropriate and adequate levels of service to:

- safely deliver cataract post-operative assessment care in the community.
- reduce pressures on ophthalmology departments within secondary care.
- maintain local access to quality eyecare services for local populations.

1.13. **Other key publications**

- NHS England High Impact Intervention Ophthalmology and Eyes Wise
- RCOphth The Way Forward
- Council for Eye Health Commissioning (CCEHC) Systems and Assurance Frameworks (SAFE)

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**	
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	**X**
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**

.2.2. System defined outcomes

Wider Service benefits:

- Accessible, safe, high quality service with reduction in duplication and unwarranted variation across London ICS/CCGs.
- Better use of the primary care workforce (recognising the optometrist as a key practitioner) and estate.
- Release of hospital workforce for more complex ophthalmic care and potential for front-line COVID-19 response.
- Improved connectivity and information sharing.
- Improved collaborative working, clinical relationships.
- Improved experience and outcomes for patients.

Specific Service benefits:

- Supporting the reduction in number of patients waiting for cataract surgery.
- Development of a coordinated pathway across primary and hospital care for patients receiving their care in surgery hubs.
- Provide a safe, high quality primary eye care service for patients with care closer to home and in a lower risk setting.
- Reduce coronavirus infection risk by minimising patient travel.
- Provide accurate data about outcomes across multiple providers.
- Provide outcome data to providers to enable quality improvement.

2.3. The Service will contribute to the evidence base to support the NHS E&I Eye Care Restoration and Transformation programme to further transform services with assessment of long-term cost effectiveness.

Figure 1 - London Cataract Surgery Hub Pathway

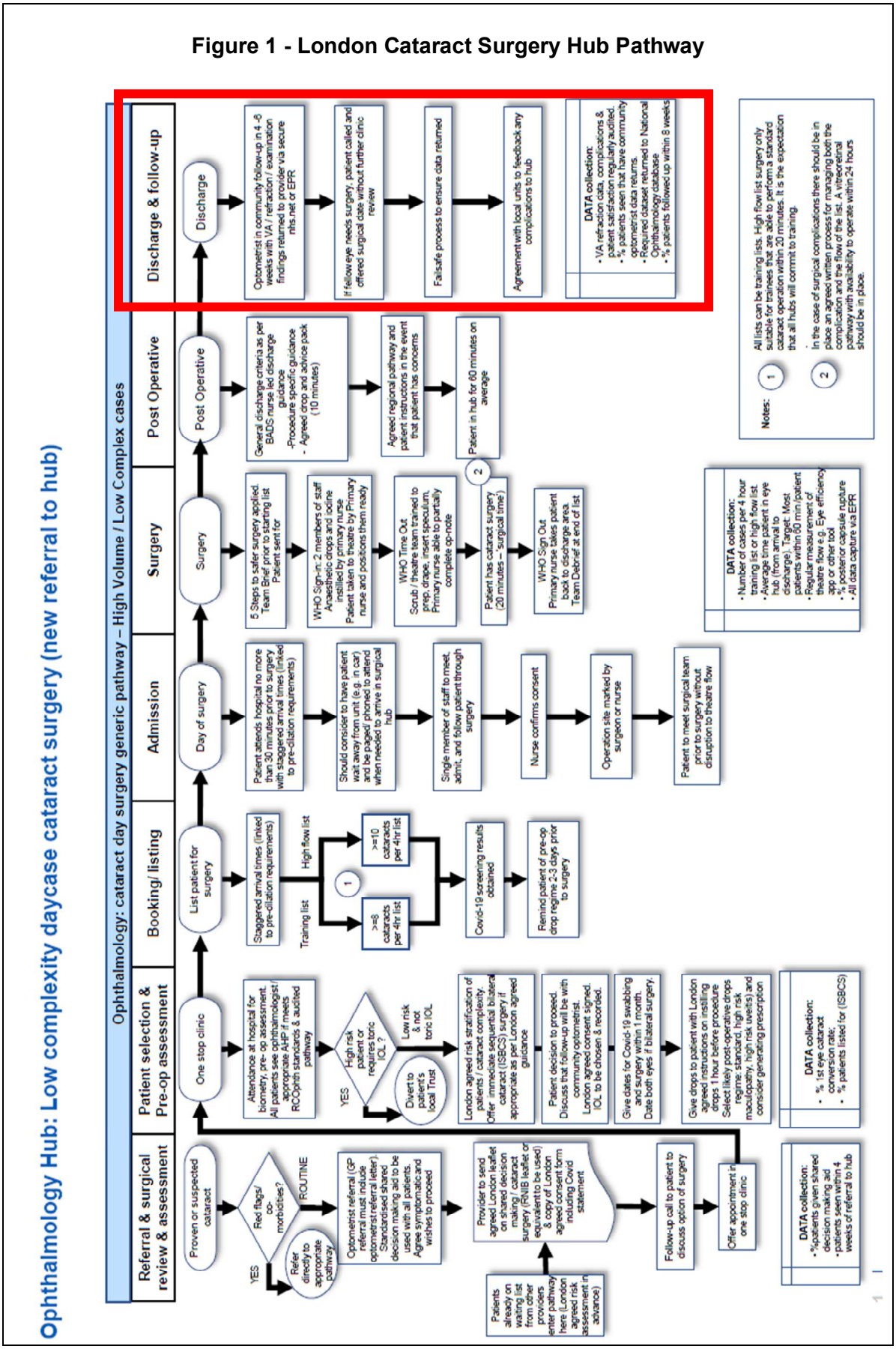
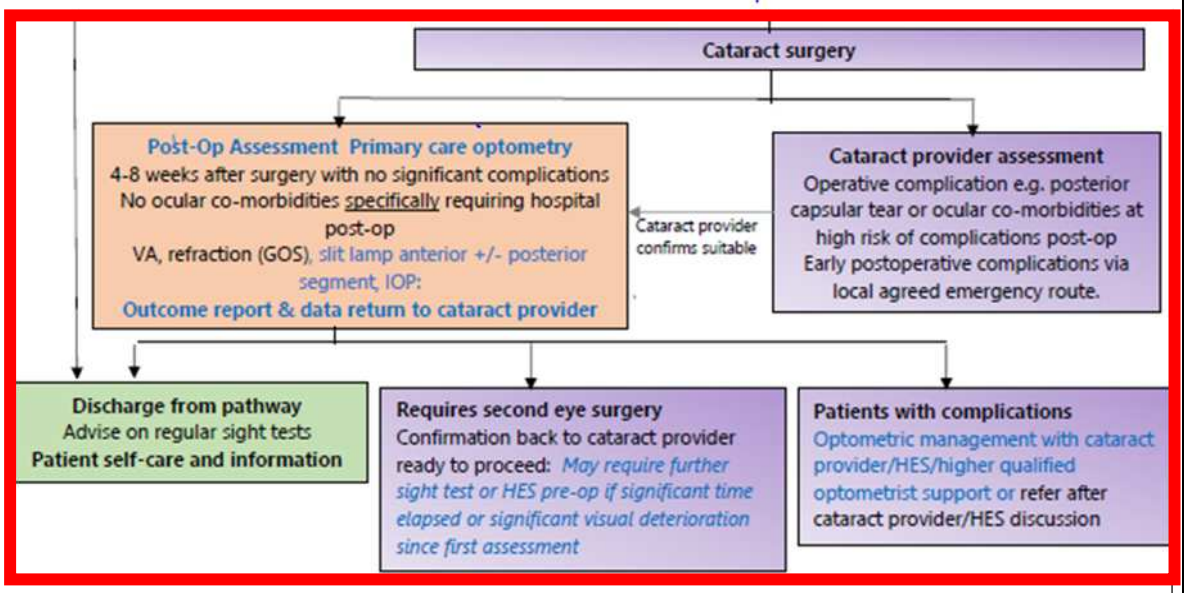


Figure 2 - Cataract post-operative assessment - extract from COVID Cataract pathway - National Eye Care Restoration and Transformation programme
(Blue text = non General Ophthalmic Services (GOS) commissioned service)



3. Scope

3.1. Aims and objectives of service

The primary aims and objectives of the Service is to ensure people can access post-operative cataract assessment within primary care, utilising the established trained workforce in optical practices. This supports:

- Integrated care balancing clinical need and risk of harm from sight loss against COVID-19 risk - seeing the maximum possible number of patients at 'green' sites in the community whilst hospital capacity is focussed on higher risk and complex care.
- Face to face consultations only where required and in the most appropriate location by the most appropriate practitioner – Right place, Right time, Right Practitioner.
- A whole-system approach with improved communication (clinician to clinician and clinician to patient), reduction in duplication of care, collaborative optometrist and ophthalmologist leadership, and clinical governance for cataract hub pathways.
- Improved information, processes, and reliable feedback.
- Full utilisation of the knowledge and skills of optometrists.
- Improved convenience and access to timely eye care for patients.
- Continuity of care with people receiving more of their care from their chosen optical practice, including care that would traditionally have been delivered in hospital.

3.2. Service description/care pathway (red boxes in Figures 1 & 2, pp 5 & 6)

3.2.1. The Service provides for the delivery of:

- a post-operative assessment following cataract hub surgery to be performed by optometrists in optical practices for those people who have uncomplicated surgery and no significant comorbidities specifically requiring a hospital post-operative assessment (i.e. most patients).
- a Service protocol (see Appendix)
- the outcome and dataset required to complete the NOD cataract audit is reported to the Hub provider, as recommended by NICE NG77 and GIRFT.
- leadership and governance, audit and reporting, training and learning,
- patients with low risk post-operative issues to be managed by their optometrist with support as necessary from the hub.

3.2.2. **Acceptance criteria**:

- People registered with a London GP who have had cataract hub surgery with no significant complications and considered suitable for post-operative management in primary care.
- See section 3.7: exclusion criteria.

3.2.3. **Qualifications** – Core competency for optometrists.

- Optometrists delivering the cataract post-operative assessment service must be registered with the General Optical Council and must adhere to the professional standards set out by that body.

3.2.4. Accreditation

- Optometrists are required to attend an online process familiarisation meeting to gain accreditation.

3.3. Implementation

- The Service will ideally be commissioned Londonwide using a regional/ ICS footprint with optical practices contracted via a prime provider model with a lead CCG(s)
- The Provider will have overall responsibility for the delivery of the Service including direct management, clinical and quality leadership, financial and activity management, as well as seeking patient experience feedback.
- Across England, many CCGs hold primary eye care service contracts for the delivery of Cataract pre-assessment and Minor Eye Conditions (MECS). This service specification may be added to existing contractual frameworks.

- This Service specification is not intended to interfere with existing/ pending locally agreed arrangements, where planning or delivering this service is working well and the service being provided meets this specification.

3.4. Clinical leadership

- All services require clinical leadership in enabling and assuring the delivery of high-quality care. The Service will therefore require effective clinical leadership using the principles of process training, clinical governance and audit.
- A clinical lead optometrist for the prime provider will oversee the implementation and performance management of the Service and will work in partnership with the ophthalmology clinical lead(s) to agree local pathways; revisions to local ophthalmology guidelines and support responsive service co-developments, as required.

3.5. Service innovation and developments (agreed locally)

- Emergent pandemics are times of high uncertainty, and the commissioner, service providers and local ophthalmology departments will need to work collaboratively to adapt and develop the service to best meet the immediate and intermediate needs of the local health care system.
- Working in an integrated way, discussions between commissioners, primary care optical practices, lead ophthalmologist(s) and lead optometrists can build on this post-operative cataract assessment service and lead to the development other care pathways to support hospital eye services.

3.6. Population covered / geographic coverage/boundaries

- It is expected that the vast majority of users of the Service will be registered with a GP within the same London ICS/CCG.
- For equitable service delivery and patient access, London CCGs and prime providers will agree cross border arrangements to avoid cross border charging. So, if a patient travels outside their CCG area to another London CCG area for a post-operative cataract assessment, this will be allowed within these Service and funding arrangements.

3.7. Exclusion criteria

- People identified with Covid-19 symptoms, confirmed Covid-19 infection or in one of the at-risk groups must be managed by remote consultation or referral, as they will not be offered a face-to-face consultation within the service. Optometrists may decide to delay assessment until patient is negative and safe to be seen.

- Patients who are not registered with a London GP and not living in the London region (except for those in the London area who are members of travelling communities, homeless people who are eligible for NHS care).

3.8. Interdependence with other services/providers

- Ophthalmologists
- Trust providers and IT teams
- Optometrists and primary optical practice staff
- Local Optical Committees
- Primary eye care services
- GPs and practice staff

3.9. Data Protection

- All Providers are expected to maintain secure patient records and, when required, cooperate and securely share (e.g. NHS mail, web portal) information with others involved in a patients' clinical care, treatment and support while having regard to the patients' right to confidentiality.

4. Applicable Service Standards

4.1. Service Standards: The Service Provider will ensure all aspects of the Service are delivered where applicable within:

- NICE Cataract Guideline NG77
- The College of Optometrists Guidance for Professional Practice
- https://guidance.college-optometrists.org/home/
- Local guidelines agreed between optometrists and ophthalmology with a list of conditions /urgency /setting for care (NB guidelines to be agreed for the Service and not for each and every local Trust).

4.2. Governance: The Service Provider will demonstrate that there are clear organisational governance systems and structures, with clear lines of accountability and responsibility. The Service Provider will ensure clinical and corporate governance processes are in place to include the following as part of standard reporting:

- Full recording of clinical notes
- Patient confidentiality
- Infection control and PPE requirements
- Quality assurance
- Clear policies to manage risk and procedures to identify and remedy poor professional performance
- Serious incident reporting (jointly, with the hub/ hospital provider where appropriate).

- Clear mechanisms for management of incidents/complaints/SIs, collection of metrics, clinical audit and learning shared across the whole pathway including optometrists and HES (as rapid reporting and learning will be required for a newly implemented service).
- Escalation routes are set out clearly with problems being solved as early as possible.
- Communication and sharing information take place with all partners at the appropriate level.

4.3. Leadership

- The clinical lead optometrist for the prime provider and the clinical lead ophthalmologist(s) will support local implementation of the service pathway. The clinical lead optometrist and the clinical lead ophthalmologist(s) will act as their respective service clinical governance leads.

4.4. Collaborative working

- Governance leads should work with and be supported by their own provider organisation to review and recommend updates to the service specification. Changes to the service specification will be subject to agreement between commissioner and provider via contractual mechanisms. Performance and clinical audit data (4.6) to be shared between providers to manage any safety issues highlighted after implementation.

4.5. Learning

- The Provider will provide updates via a learning forum for all practitioners delivering cataract post-operative assessment care. This will be organised by the clinical leads and could be delivered by senior optometrists, and local ophthalmologists via webinar. The Provider to develop a plan to support learning and anonymised case discussions, feedback on good practice, incidents etc.

4.6. Clinical Audit

- Audit and performance measures to be agreed between optometric and ophthalmology leads and any other regional leads
- Essential data collection via IT delivery module
- Numbers of patients seen
- Patient experience/satisfaction survey
- Every clinical interaction and outcome must be recorded by optical practices
- Adherence to protocol (appendix)
- Compliance with NOD data submission
- Serious Incidents and incidents of inappropriate care
- Other audits as requested by the commissioner

4.7. Other applicable national standards

- Clinical Council for Eye Health Commissioning (CCEHC) System and Assurance Framework for Eye-health (SAFE) – Cataract.(2018). https://www.college-optometrists.org/uploads/assets/34295ade-8fa3-4825-9912a0bd22f97b77/SAFE-Cataract.pdf
- Royal College of Ophthalmologists, The Way Forward – Cataract (2017). https://www.rcophth.ac.uk/wp-content/uploads/2015/10/RCOphth-The-Way-Forward-Cataract-Summary-300117.pdf
- Clinical Council for Eye Health Commissioning (CCEHC) SAFE: Quality Indicators for Commissioning (2018). https://www.college-optometrists.org/uploads/assets/29af6c37-788f-490b-9a371d64146b84e1/SAFE-Quality-Indicators-for-Commissioning.pdf
- Clinical Council for Eye Health Commissioning - Primary Eye Care Framework (2018). https://www.college-optometrists.org/uploads/assets/8a93d228-ac28-4e6e-98af94c62c0f8442/Primary-Eye-Care-Framework-for-first-contact-care.pdf
- LOCSU integrated cataract pathway (2020) https://www.locsu.co.uk/what-we-do/pathways/

COVID-19 guidance

Guidance is subject to regular update, the following websites are regularly updated

- **NHS England:** A new guidance webpage for primary care - contains all COVID-19 resources for primary care, including the optical SOP.
- **UK Government:** https://www.gov.uk/government/topical-events/coronavirus-covid-19-uk-government-response
- **The College of Optometrists -** COVID guidance and updates for practice – https://www.college-optometrists.org/the-college/media-hub/news-listing/coronavirus2019-advice-for-optometrists.html
- **Association of Optometrists guidance relating to COVID -19** https://www.aop.org.uk/coronavirus-updates

4.9. Applicable local standards

Consider inclusion in the development of local referral protocols.

5. Applicable quality requirements and CQUIN goals

5.1. Applicable Quality Requirements (See Schedule 4A-C) None

5.2. Applicable CQUIN goals (See Schedule 4D) None

6. Location of Provider Premises

6.1. Primary Care Optical Practices holding a General Ophthalmic Services contract

Appendix

Cataract Post-operative Assessment for Primary Care Optometrists

Information

- Following surgery, the patient will leave the cataract surgery hub/ hospital with an advice sheet, drops and contact details for how to access care in-hours and out-of-hours for post-operative care.
- All patients with no significant complications during surgery will be asked to attend the optometrist 4-6 weeks after their surgery for a post-operative assessment.
- Service provider to work with cataract surgery hub andclinical leads for each hospital provider to implement a clear, safe discharge process to primary care, so that non-attendance and failsafe reporting are managed.
- If there are any significant complications during surgery, the patient may need to be examined at the hospital eye clinic, timing to be determined by the surgeon.
- Some patients with other ocular co-morbidities may need follow up attendances in addition to their post-operative assessment at the optometrist and this should be arranged by the hospital at an appropriate time interval in the clinic which oversees this condition.
- Patients agreeing to 1st eye surgery only will be discharged at the time of surgery. If they later decide they want the 2nd eye surgery, they will require a new referral.
- For patients agreeing to both eyes surgery there are two options in the hub pathway:
  - Immediate sequential bilateral cataract surgery (same day)
  - Delayed sequential bilateral cataract surgery (eye surgeries within e.g.2-4 weeks). If the 2nd eye is not already dated, the patient can be listed from a phone call if they are content with their 1st eye vision and have no concerns. Some people in this situation may need a VA and autorefraction on the day of surgery as an additional step. Patients having separate cataract surgery will not require a formal sight test (refraction) between the two operations.

Protocol

- The optometrist will undertake a post-operative cataract assessment 4-6 weeks after surgery (usually 1-2 weeks after finishing their post-operative eye drops) to:
  - review patient's post-operative history and any symptoms
  - undertake refraction and assess acuity
  - assess for any post-operative complications
  - return outcome data to the hospital
  - if no complications, the patient can be discharged by the optometrist

Requirements

- History and symptoms
  - Perception of visual improvement
  - Any significant problems/symptoms e.g. pain or discomfort, visual problems
  - Confirm compliance with drops (standard drop regime lasts 4 weeks, dark eyes and diabetic patients may be given a longer course)

- Assessment of any post-operative complications
  - Slit Lamp examination assessment of:
  - Degree of redness
  - Wound
  - Corneal clarity/oedema
  - Degree of iritis/AC activity
  - IOL position
  - Significant posterior capsule opacity
  - Pupil/iris abnormalities
  - Fundoscopy usually undilated
  - Dilated fundoscopy at professional discretion, if vision acuity not satisfactory, or if symptoms warrant (e.g. flashes and floaters) or if posterior segment pathology known or suspected requires detailed assessment
  - Record if dilated on post-op assessment form
  - Measurement of IOP (and method used)

- Submission of unaided vision, refraction and visual acuities (distance and near)

Return of data

- Send post op cataract assessment data back electronically as per local agreement along with any additional information
- Patient satisfaction feedback
- Maintain a copy of the assessment for your own records

Management of postoperative complications

- There must an agreed pathway between the cataract surgery hub and the local eye unit for the management of post-operative complications. This should include a standard operating procedure to support the pathway with regular audit of complications seen in the community.

- This ensures continuity of care, relevant surgical records, quality assurance, audit, and data returns to the National Ophthalmology Database.

1. Post-operative emergencies that need immediate attention (e.g. endophthalmitis) should be managed by the patient's nearest open eye casualty.

2. Urgent post-operative conditions should be managed by the Hub and its contracted casualty, where practical. If referred elsewhere, referrer must notify the Hub that patient was seen and sent elsewhere.

3. Routine post-operative conditions should be managed by local optometrist providers or by referral to the patient's local eye clinic.

Referral to Eye Clinic

- If further continuation of drops are required – this can be supplied by the optometrist if an optometrist prescriber is available, or alternatively, arrangements should be in place with the hub site for this to be as offered remotely by the hospital, with consideration of the patient experience.
- Patients should be referred back to the Eye Clinic if there are signs of undiagnosed pathology or unexpected abnormalities.
- Referral pathways for emergency, urgent and routine access to be locally agreed depending on local IT options and Trust systems

Post-operative problems requiring referral to hospital

Emergency

- **Endophthalmitis** Infection inside the globe. Presents as painful, red eye with poor vision. Severe iritis usually with hypopyon. Opaque vitreous with poor view of fundus.

Urgent

- **Marked or moderate iritis** Uncomfortable and slight blurring of vision. Ciliary injection marked cells and flare. Sometimes this can be due to rebound uveitis as drops are tapered and stopped. Must also consider possibility in rare cases that this could be the start of endophthalmitis, and patients should be advised to return if the symptoms do not settle quickly.

- **Significant Wound Closure Problems** May be asymptomatic.
  Wound edges may not seal together which presents as a wound gape, a wound plugged with prolapsed iris tissue, or may be Seidel test +ve.
  If severe leakage from eye, IOP will be low and AC shallow.

- **Retinal detachment and retinal tear** Presents as flashes and floaters, and possibly visual field loss or reduction in acuity (if retina detached). May be a PVD but needs referring if shortly after cataract surgery. Higher risk in high myopes, and those with serious operative complications.
- **Raised IOP >28mmHg** Usually occurs in first few days following surgery but can persist longer. If severe may be associated with reduced acuity and corneal oedema.
- **Corneal oedema** Presents as blurred vision and corneal opacity with sometimes visibly increased corneal thickness and Descemet's membrane folds. Mild corneal oedema is common in first few weeks following surgery. Usually resolves over time. Must ensure not caused by raised IOP. Rarely does not recover and requires corneal graft.
- **Drop allergy** Presents as sore, itchy red eye +/- skin rash on lids. Refer if no access to optometrist prescribing, potential for management using remote/ video consultation by hub/ hospital.
- **IOL displacement** Presents as reduced vision, increased astigmatism and monocular diplopia. IOL may be partially or completely displaced from central position across the pupil (up/down or occasionally forwards/backwards). May see part of the IOL in front of pupil/iris, or iris trapped behind part of IOL. Pupil may be distorted. More obvious with dilated pupil.
- **Cystoid macular oedema** Presents as blurred vision, usually delayed onset after surgery. VA reduced, may be Amsler distortion, and swelling or cysts visible at macula. More common in diabetic patients, even if no retinopathy.
- **Deteriorating diabetic retinopathy** Diabetic retinopathy can sometimes deteriorate rapidly after surgery, even to the point of frank maculopathy or new vessels requiring laser treatment.

Routine

- **Very mild anterior uveitis (iritis)** Very occasional cell can occur once stop drops. If asymptomatic and the examination seems satisfactory usually nothing seriously wrong. If more, consider management using remote/ video consultation with hub/ hospital.
- **Posterior capsular opacification** The commonest complication causes reduction in vision and loss of transparency behind the IOL. Usually occurs after several months – years, but occasionally occurs early. Can be treated with simple laser therapy if significant symptoms and opacity. All patients being discharged from care should be warned of the possibility of this complication.

- **Significant Refractive Surprise**. Patient's refraction does not match the predicted outcome, or there is significant unplanned anisometropia. This is an optometrist decision based on the patient's symptoms and unhappiness with the result. Anisometropia in between surgery for first and second eye is common.

London cataract hub site contacts - enquiries:

- Office hours please contact XXXXXXXXXXX
- Out of hours contact XXXXXXXXXX
- Optometrist helpline / email for routine enquiries XXXXXXXXX