SCHEDULE 2 – THE SERVICES

A. Service Specifications

Model Structure provided from NHS Standard contract 2020/21 Particulars

This service specification outlines a service to support the restoration of eye care provision following the COVID-19 national lockdown phase, and to sustain the recovery and long-term transformation of eye care, across England.

Service Specification No.	
Service	COVID-19 Eye Care Restoration Service (CECRS)
Commissioner Lead	Regional Lead CCG / ICS Lead / NHSEI / Trust
Provider Lead	
Period	September 2020 -
Date of Review	

1. Population Needs
The service specification has been developed under the NHS England and Improvement (NHSE&I) National Eye Care Restoration and Transformation programme, part of the NHSE&I National Outpatient Transformation Programme (NOTP). It is recommended for implementation across an integrated care system (ICS) and has been agreed by key stakeholders including the Royal College of Ophthalmologists (RCOphth), the College of Optometrists, Getting it Right First Time (GIRFT), Local Optical Committee Support Unit (LOCSU), Clinical Council for Eye Health Commissioning (CCEHC), and the Royal National Institute of Blind People (RNIB). It builds on recommendations from GIRFT and the Colleges, and the design principles of the COVID-19 Urgent Eyecare Service (CUES), to deliver the CCEHC SAFE Frameworks for integrated eye care pathways in the context of COVID-19 and to establish the foundations for longer term transformation for sustainability. **This service is designed to provide safe, integrated and sustainable system-wide clinical care pathways for urgent and emergency eye care, cataracts, glaucoma and medical retina to support COVID-19 recovery and restoration and the prevention of avoidable visual impairment. It will deliver:** • **a reduction in traditional face-to-face (F2F) hospital ophthalmic outpatient appointments, minimising patient travel and time in hospital settings** • **more eye care delivered close to home and remotely** • **more personalised care with shared decision-making and support for self-management** • **ophthalmology advice and guidance routinely available to primary care optometrists**

- **reduced risk of COVID-19 transmission whilst ensuring all people have access to eye care to meet their needs.**

Context

A 40% increase in demand for eye services is predicted from 2018 – 2038 (Royal College Ophthalmologists 2018) and the overall economic burden of sight loss is estimated to be £28bn in the UK.

Ophthalmology is the highest volume outpatient speciality and in 2018/19 (NHS Digital) accounted for:

- 7.8million attendances
- 1.97 million 1st outpatient attendances
- 10% of all outpatient appointments
- Cataract, glaucoma, medical retina and urgent care together account for 60-70% of all ophthalmology activity.

The strong association of many eye conditions with age and diabetes combined with the development of new treatments has caused ophthalmology to be particularly affected by rising demand. Glaucoma and medical retina conditions are the main causes of certifiable sight loss and need regular timely assessment and treatment to prevent permanent loss of vision. Prior to the COVID-19 pandemic, there were long-standing capacity issues in ophthalmology causing harm through delays to follow up (BOSU/RCOphth 2017). During the initial COVID-19 response, hospital eye services (HES) were limited to emergency and urgent patients only and ongoing COVID-19 infection control procedures continue to affect capacity. This has aggravated the problem and ophthalmology now has a growing backlog of new and follow-up appointments compounded by "hidden" patient need, where patients have not attended eye services or present with more advanced eye disease. NHS systems need to take action to restore and recover ophthalmology services urgently as part of Phase 3 COVID-19 response to prevent further patient harm.

The NHS Long Term Plan (LTP) sets out ambitions to provide digitally supported care, more joined-up services and personalised healthcare, which could reduce traditional F2F outpatient appointments by a third (30million) over the next 5 years across England. Ophthalmology has significant opportunities to deliver these ambitions as many conditions can be managed remotely through decisions based on clinical data and imaging, and the primary care optometric workforce providing many traditionally hospital-based services in the community.

The GIRFT report for Ophthalmology states that *'Our focus overall has been on rethinking the way ophthalmology services are delivered, looking at how to make the best use of all available resources, including primary care, to deliver the right care in the right place at the right time.'*

The College of Optometrists' and Royal College of Ophthalmologists' Joint Vision 2020 builds on these publications by identifying three key principles for service restoration and redesign:

'1. *To balance risk of significant visual loss due to delayed eye care against the risk of acquiring COVD-19 infection as a result of a face-to-face clinical assessment;*
2. That direct patient contact should take place with a clinician capable of making appropriate management decisions including, where required, support by a senior decision maker e.g. an optometrist with higher qualifications or the independent prescribing (IP) certificate, or the HES;

3. That all pathways are underpinned by the highest standards of joint optometry and ophthalmology clinical governance, applied equitably to all who are providing care.'

The CUES developed during the pandemic to fill service gaps has demonstrated that effective, integrated eye care pathways, based on communication and collaborative leadership across primary and secondary care, can deliver high quality services which avoid the need for hospital attendance. Building on the principles of CUES and the Colleges' joint vision, the new local eye care restoration should include:

- Risk stratification and prioritisation along pathways
- Remote consultation and prescribing along pathways
- Virtual diagnostic review of images and records along pathways
- Referral filtering in primary care
- Accessible advice and guidance from ophthalmology / higher qualified optometrist to optical practices and non-medical professionals
- Co-management between hospital and primary care where advice, guidance and virtual review is insufficient
- Improved use of primary care optometrists and the non-medical workforce (nurses, orthoptists, opticians and optometrists) including those with higher qualifications, independent prescribing and advanced practitioners
- Direction of patients to the most appropriate clinician / clinic in primary, community or secondary care.

Other key publications

NICE Cataract NG77

NICE Glaucoma NG81 guidance

NICE AMD NG82 guidance

HSIB Lack of timely monitoring of patients with glaucoma

NHS England High Impact Intervention Ophthalmology and Eyes Wise

RCOphth Commissioning Guidance and Covid recovery guidance

RCOphth The Way Forward

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	
Domain 2	**Enhancing quality of life for people with long-term conditions**	**X**
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	
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 Local defined outcomes

The expected benefits of the service include:

- Lower levels of avoidable visual impairment rates per 100,000 population
- Increased overall capacity better geared to eye health need
- Reduction in the number of ophthalmology hospital outpatient attendances
- Reduction in the number of face-to-face appointments
- Reduced ophthalmology new patient waiting times
- Reduced ophthalmology follow-up delays and associated harm events
- Reduction in the number of eye-related GP appointments
- Better use of the primary care workforce (recognising the optometrist as first contact practitioner) and estate
- Release of hospital workforce for more complex ophthalmic care
- Streamlined pathways with reduced duplication of care
- Emphasis on prevention and personalised care (including shared decision-making and self-management)
- Improved referral quality with a reduction in first visit discharge rates
- Improved connectivity and information sharing, including with the referrer
- Care closer to home and improved patient convenience
- Accessible, safe, high quality service with reduction in unwarranted variation across England
- Improved collaborative working, clinical relationships and system effectiveness
- Improved patient experience and feedback
- Better outcomes for patients.

The service will also 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.

3. Scope

3.1 Aims and objectives of service

System-wide recovery from COVID-19 and deliver the objectives of the NHS long Term Plan, specifically:

- Remote first' approach based on clinical triage, assessment, treatment and advice by telephone, video or online to reduce the need for F2F contact and travel where appropriate.
- Virtual diagnostic pathways, with management decisions based on clinical data and images collected in the community, in optical practices or diagnostic hubs.
- Digitalisation of care providing secure two-way communication and interoperability between hospital, community and primary care providers.
- Robust infection prevention and control procedures in place across whole pathway to minimise the risk of COVID-19 transmission.

- Integrated care pathway balancing clinical need and risk of harm from sight loss against COVID-19 risk- seeing the maximum possible number of patients at 'cold' sites in the community whilst hospital capacity is focussed on higher risk and complex care.
- F2F 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 optometric and ophthalmic clinical leadership and clinical governance for all pathways.
- An overall reduction in hospital referrals and - where referrals are made – improved referral information, processes and reliable feedback to referrers.
- Full utilisation of the knowledge and skills of the optical workforce (optometrists, dispensing opticians and contact lens opticians) as primary health care providers / first contact practitioners.
- Access from primary care optometrists to specialist ophthalmic / optometrist / non-medical clinician advice and guidance to support clinical decision-making and treatment including remote prescribing.
- Improved convenience and access to timely eye care for patients.
- High quality remote service to people who cannot leave home unaided or are most clinically vulnerable to COVID-19.
- Personalised care with an emphasis on shared decision-making and patient self-management where appropriate.
- 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

3.2.1 Scope / Service Outline

The service will reduce the flow of patients into hospital by broadening the scope of care offered within primary and community care. This will be achieved by primary care optometrists working more closely with the HES to deliver more streamlined pathways of care to local populations. The two key aspects of the service are:

- to utilise the established trained primary care workforce in optical practices to provide the <u>first line response</u> to people presenting with eye care needs: to offer a consultation, to treat/advise the patient without referral or refer to the most appropriate alternative service.
- to provide an alternative to the hospital for people requiring <u>long term eye care</u> either in optical practices or high-volume diagnostic hubs.

3.2.2 Care Pathways-

This service specification and associated pathways set out a framework for commissioning and providing local services based on best practice principles at NHS system level. They are

intended to support and enhance rather than replace or disrupt existing successful, integrated care models.

COVID-19 Urgent Eye Care Pathway - CUES

CUES was developed in April 2020 to allow greater involvement of primary care optometrists, and the wider optical practice workforce, in the urgent eye care pathway and to allow safe continuation of services in the face of the COVID-19 pandemic. The CUES framework was intended to enable existing locally commissioned services to migrate to incorporating referral to optometrists with higher skills (including independent prescribing), ophthalmology advice and guidance, remote prescribing and a common IT platform, where these were not yet in place. CUES provides a convenient platform on which to build outpatient restoration and, where CUES or a similar service is not already in place, should be a priority for Local Eye Health Network (LEHNs) and commissioners.
Acceptance criteria - People presenting with recent onset / urgent eye conditions and for advice to support self-management of less complex eye conditions. Presenting symptoms typically include: loss of vision (sudden or transient) / visual distortion / painful eye / flashes and floaters / red eye / double vision.

Qualification – Core competency optometrists. To supplement this, LOCSU with Cardiff University offers a training and accreditation process, to allow optometrists to revisit and evidence their core learning where required.

Cataract

The pathway provides:

- filtering of all cataract referrals by primary care optometrists including shared decision-making so that patients referred for surgery are suitable for, and want to proceed with, surgery, and risk factors are identified to direct to the right surgical provision.
- the postoperative assessment to be performed in optical practices for those who have uncomplicated surgery and no significant comorbidities specifically requiring a hospital post-operative assessment (i.e. the majority of patients). The outcome and the dataset required to complete the National Ophthalmology Database (NOD) national cataract audit will be reported back to the surgeon, as recommended by NICE NG 77.

The GIRFT report highlighted a significant variation in the surgical conversion rate (the % of patients referred for cataract surgery who underwent an operation) with a national mean conversion rate of 71% and many providers under 50%. Existing pre-operative cataract assessment services (e.g. Eye 2009;23:309-13; Ophthalmic and Physiological Optics 2013;36:545-557) and the High Impact Intervention have shown the conversion rate can be significantly improved by referral filtering from around 60% to above 90%. Patients with low risk post-operative issues can be managed by their optometrist with support as necessary from the hospital. The pathway can be developed locally to support direct listing.

Patients should be referred in line with NICE guidance NG77 1.2.2 which states “Do not restrict access to cataract surgery on the basis of visual acuity.”

Acceptance criteria – Pre-operative: people identified through a sight test with a significant cataract affecting their vision and daily life and who would like to be considered for surgery. Do not include those with cataract who are primarily being referred for other co-pathology e.g. glaucoma or age-related macular degeneration (AMD).

Post-operative: people who have had cataract surgery with no significant complications who are considered suitable for postoperative management in primary care.

Qualification – Core competency optometrists. To supplement this, LOCSU with Cardiff University offers a training and accreditation process, to allow optometrists to revisit and evidence their core learning. In addition, local training or regular clinical governance updates may be agreed between the local eye care governance leads and stakeholders, to improve understanding of local surgical requirements and continuous learning and for all clinical professionals.

Glaucoma – New patient pathway

The pathway will improve referral quality, reduce the number of avoidable referrals and help ensure all referrals to HES for glaucoma meet NICE NG81 recommendations on investigations and case-finding.

Referral filtering pathways:

- first level – repeat measures or enhanced case-finding in primary care optical practices will allow optometrists to repeat tests to confirm abnormal test results detected by a sight test and refine the decision to refer. NICE NG81 1.1.1 recommends that Goldmann-type applanation tonometry* and standard automated perimetry are offered to patients prior to referral for further investigation and diagnosis. Any first level filtering should as a minimum ensure intraocular pressure (IOP) measuring using Goldmann-type applanation tonometry* (NG81 1.1.8) and be in line with the other recommendations in NG81 1.1.1.
- second level – referral enhancement or referral refinement - initial evidence of abnormality found during case-finding is validated by an enhanced assessment. This can be provided in a virtual model (decisions taken by the HES based on clinical data and images) or by autonomous decision-making non-medical professionals with enhanced skills and higher qualifications as necessary, with access to advice and guidance or a virtual opinion from ophthalmology if required. Data capture, assessments and risk stratification can take place in a number of settings: primary care optometry, community eye service and community diagnostic hub setting, as well as high throughput HES data capture clinics, depending on local circumstances. Referral refinement is specifically defined by NICE and requires gonioscopy assessment.
- Optometrists with appropriate skills and higher qualifications can diagnose and agree the management plan for patients with suspect glaucoma and ocular hypertension, but diagnosis and the management plan for glaucoma requires consultant ophthalmologist input.

*Note that, since the NICE guidelines were published, the use of the Ocular Response Analyser (ORA) for IOP measurement is becoming accepted by glaucoma clinicians as a reliable alternative to Goldmann-type applanation tonometry. (https://bjo.bmj.com/content/bjophthalmol/early/2020/09/24/bjophthalmol-2020-317112.full.pdf)

Acceptance criteria - People who are found at sight test to have a suspicious glaucomatous clinical sign (raised IOP, suspicious optic nerve head, glaucomatous visual field defect), usually an opportunistic finding.

Qualification - Skills required for delivery of repeat measures are covered by core competency. To supplement this, LOCSU and Cardiff University offer a training and accreditation process to allow optometrists to revisit and evidence their core learning and practical skills. Any additional training and accreditation for enhanced case-finding should be locally agreed with all stakeholders.

Skills required for delivery of referral enhancement within a consultant-led service with virtual review and decision making are covered by optometrists' core competency but again can be supplemented by the LOCSU and Cardiff University training and accreditation process or local training. Skills required for autonomous decision making within a referral refinement service are covered within College of Optometrists Professional Higher Certificate in Glaucoma or Glaucoma Certificate A or equivalent.

In addition, local training, experience or regular clinical governance updates may be agreed between local eye care governance leads and stakeholders, to ensure understanding of the local glaucoma care requirements and pathway and continuous learning and improvement in the pathway for all clinical professionals. All optometrists undertaking integrated glaucoma pathways must be part of a system wide glaucoma/eye care clinical governance structure. Whichever model is used, there should be reference to NICE guidance, RCOphth commissioning guidance for glaucoma and Joint Colleges' guidance on referral.

Glaucoma – Long Term Care pathway

Where safe and appropriate, low risk patients can be discharged to the general ophthalmic services (GOS) from their optometrist as recommended by NG81 1.1.5, 1.1.7 and 1.4.14. For patients with glaucoma and glaucoma-related conditions who do require monitoring, a risk stratification exercise (RCOphth/UKEGS risk tool) will identify a cohort of patients considered to be of lower complexity and risk of progression potentially suitable for transfer to a primary care optometry or community monitoring service. These patients can be seen in optical practice by an optometrist working to an agreed management plan, with access to the previous clinical data as required from the HES, undertaking investigations and care in line with NICE NG81. This may be through:

- a full virtual service with HES decision making on data collected in the optical practice
- autonomous decision making by an appropriately qualified and experienced optometrist with the option to obtain ophthalmology (or, if appropriate, a more experienced optometrist with higher qualifications) advice or virtual review if there is a change in clinical status.

Alternative provision can be made within community ophthalmology services / diagnostic hubs to meet local capacity requirements. It is crucial to ensure patient information provision and support is available throughout the pathway to provide shared decision-making and that the patient has the information, understanding and skills to self-manage (e.g. drop use) effectively.

Acceptance criteria – Any patient with a diagnosis of ocular hypertension, suspect glaucoma or glaucoma who is considered suitable for community monitoring by their glaucoma consultant and / or service clinical lead. This needs to be an individual patient risk-based decision.

Qualification - Skills required for delivery of monitoring data collection within a consultant-led service with virtual review and decision making are covered by optometrists' core competency.

To supplement this, the Local Optical Committee Support Unit has worked with Cardiff University to develop a training and accreditation process, to allow optometrists to revisit and evidence their core learning. However NICE guidance also requires patients to be assessed to identify issues with side effects from medication, adherence or drop instillation issues, worries or concerns about vision as well as provision of patient education -and support at every visit. Therefore, practitioners providing data collection monitoring require appropriate education and skills to provide this; local training can be agreed with all stakeholders.

Skills required for autonomous management will require a higher qualification in line with NICE guidance depending on the risk and complexity of the patient cohort considered suitable for the service i.e. College of Optometrists Higher Professional Certificate in Glaucoma or Diploma in Glaucoma.

In addition, local training, experience or regular clinical governance updates may be agreed between the local eye care governance leads and stakeholders, to ensure understanding of the local glaucoma care requirements and pathway and continuous learning and improvement in the pathway for all clinical professionals. All optometrists undertaking integrated glaucoma pathways must be part of a system wide glaucoma/eye care clinical governance structure.

Medical Retina – Wet maculopathy pathway

This pathway allows:

- referral filtering for people with suspected wet AMD or other wet maculopathy (can be part of CUES)
- non-urgent referral for those with non-neovascular maculopathy or sight threatening conditions
- monitoring in the community for people with a diagnosis of late AMD who require regular monitoring and would otherwise need a hospital appointment
- discharge of patients with no sight threatening or treatable pathology, avoiding unnecessary hospital attendances.

In line with the NICE guideline NG82 recommendations, this service aims to improve the efficiency and accuracy of case-finding for AMD (wet active), for both new and review patients, and so improve the speed at which people are diagnosed and treated within the HES. A recent study showed virtual review of retinal referrals including fundus photo and OCT found approximately half did not need referral and only 15% urgent referral, largely for wet active AMD.

By improving referral accuracy and appropriateness, the capacity within hospital clinics can be used more appropriately to manage people most in need of specialist intervention, prevent inappropriate referrals and lead to earlier intervention and improved visual outcomes in true wet AMD cases. The new patient pathway must be designed so that no untoward delays are introduced and the required NICE guideline timescale of 14 days from referral to treatment can be met.

Referral filtering and long-term monitoring are provided either:

- in a virtual model, with decisions taken by the HES based on clinical data and images or
- by autonomous decision-making non-medical professionals with enhanced skills and qualifications with access to advice and guidance or a virtual opinion if required.

Data capture and assessments can take place in a number of settings: primary care optometry, community eye services, a community diagnostic hub setting, as well as high throughput HES data capture clinics (for long-term monitoring), depending on local circumstances. Community and primary care professionals undertaking long-term monitoring need access to the previous clinical data as required from the HES.

Acceptance criteria - People who have symptoms or signs suggestive of wet maculopathy including blurred/reduced central vision, distortion of straight lines, difficulty with specific tasks especially reading and recognizing faces. Patients may self-present, including those with AMD who have identified a change following self-monitoring, or be referred following a sight test or from another health care professional.

Qualification – Assessment of the macula is covered by optometrist core competency. Requirements for additional qualifications, experience or training for optometrists to make autonomous management decisions (both at the initial point of contact and for monitoring of stable patients), will need agreement with the optometrist and ophthalmic pathway clinical leads as well as the lead consultant from the local macular service. LOCSU and WOPEC have an accreditation in development and the College of Optometrists provides a professional certificate in medical retina all of which are desirable but not necessarily essential for autonomous management.

Medical Retina – Diabetic Macular Oedema (DMO)

This pathway delivers referral filtering for people with suspected diabetic macular oedema and a streamlined care pathway for assessment and management. This is delivered through locally commissioned enhanced optical coherence tomography (OCT) assessment as part of the diabetic eye screening programme (DESP) as recommended by DESP/PHE.

Under DESP, a patient with high-risk maculopathy will be referred directly to the HES as usual. Where a patient has suspected maculopathy which is below the threshold for high-risk maculopathy, an OCT will be performed and graded within the DESP structure, with access to secondary graders and a virtual HES opinion as required. Where the DESP does not have access to OCT, this can be delivered in partnership in settings where the OCT and appropriate professionals exist such as primary care optical practices, HES and diagnostic hubs.

Where a patient presents with possible diabetic macular oedema (DMO) to an optometrist and they are not already under the DESP programme, the optometrist can undertake a diabetic macular assessment, either as autonomous decision-maker or with virtual decision-making based on the images from the HES.

Approximately 50% of patients referred from DESP without OCT assessment do not need an appointment in the hospital eye service (RCOphth2017 ; GIRFT 2019). By closing this gap through an OCT assessment, the capacity within hospital clinics can be used more appropriately for earlier intervention and improved visual outcomes for patients who do need treatment for DMO.

Acceptance Criteria – People attending their DESP annual screening and graded as R1M1 or R3sM1. Alternatively, a person with diabetes who is suspected to have DMO following a routine sight test or CUES examination.

Qualification

For DESP delivered services, there is detailed guidance on the requirements for the DESP clinical lead to be responsible for the clinical governance of the OCT pathway and ensure the quality standard is met and for the qualifications of DESP graders (https://www.gov.uk/guidance/nhs-population-screening-diploma-for-health-screeners).

Optometrists who already perform DESP grading do not need to undertake all of the mandatory grader training units except for the "Principles of health screening" unit and any role-specific units identified for their position within the screening programme. Optometrists who have completed a professional certificate in medical retina after October 2017 need only to complete the extra modules of 'Undertake diabetic retinopathy imaging unit' and the assessment element of 3.1 of the 'Detect retinal disease and classify diabetic retinopathy unit'.

Requirements for additional qualifications, experience or training for optometrists to make autonomous management decisions in a locally commissioned monitoring service will need agreement with the optometrist and ophthalmic pathway clinical leads as well as the lead consultants from the local macular /diabetic eye services. It would be desirable but not essential for optometrists who are autonomous decision-makers to have completed the requirements for a grader in DESP. Where there is a locally commissioned service for non-high-risk maculopathy but the images are reviewed in the hospital eye service, image capture does not require the skills of an optometrist and can be performed by a technician. The image capture protocol does however need to be agreed with the clinical lead from the hospital eye service supported by regular audit to ensure image quality.

Advice and Guidance (A&G)

A&G is a process that allows one clinician to seek advice from another and should be facilitated across all care pathways within the integrated eye care model. Advice and guidance (A&G) may be provided by ophthalmologists, other clinicians within the hospital eye service or optometrists with higher qualifications working within primary care, depending on the clinical pathway and expertise required.

The advice may be to:

- help inform ongoing management
- request clarification regarding information received from providers
- support appropriate referral decision-making.

In some circumstances, seeking ophthalmology A&G may negate the need for a referral or further appointment. This supports the service objectives of reducing the number of patients who need to be managed within a secondary care setting. The advice (and the outcome following the advice) should be documented within the patient care record and fully auditable.

Patient support and health prevention

All eye care pathways, especially those involving conditions which can lead to visual loss (e.g. glaucoma and retina conditions), should proactively offer timely access, through clear referral pathways, to services for low vision habilitation and rehabilitation, sight loss support including Eye Clinical Liaison Officers (ECLO) & counsellors and low vision aids, integrated into the eye care system in line with CCEHC SAFE Low Vision, Habilitation and Rehabilitation Services framework and the RNIB ECLO framework and support guidance. All professionals providing

assessments and care have a role to play as part of the wider team providing patient support including low vision support, and need to have the appropriate knowledge and skills in how to be involved in this process and how to ensure patients who need support e.g. from an ECLO can be provided with that. Provision of care outside the traditional F2F hospital setting not limit this access which should be built in throughout the pathways, including support beyond discharge as required.

Health prevention and general health care services which are relevant should be integrated into the pathways including smoking cessation, and prevention and better management of conditions such as diabetes and high blood pressure.

3.2.3 Days and hours of operation

The service will be available across the week from across a network of optical practices and / or diagnostic hubs. It is expected the majority of local primary care and community appointments will be between the hours of 9am and 5pm, Monday to Friday.

For urgent eye care, same day appointments will be available which will include evening and weekend provision to meet patient needs following telephone triage - subject to current COVID-19 restrictions, changes in workforce and/or government strategy.

The service care pathways and supporting documents are listed in the table below:

	Care Pathway	**Clinical protocol / service delivery protocol and supporting implementation resources**	**Relevant SAFE and NICE documents**
CUES: Patient pathway	CUES pathway	COVID-19 urgent Eye Care Service (CUES) in England	SAFE Emergency and urgent care
Glaucoma – New patient pathway	COVID-19 Glaucoma new patient pathway	RCOphth/UKEGS GLAUC STRAT FAST risk tool UKOA /Glaucoma UK glaucoma information checklist LOCSU guidelines: • Referral refinement • Enhanced case finding • Repeat measures	NG81 SAFE glaucoma
Glaucoma – Long Term Care pathway	COVID-19 Glaucoma long term care pathway	RCOphth/UKEGS risk tool UKOA /Glaucoma UK glaucoma information checklist	NG81 SAFE glaucoma

Cataract	COVID-19 Cataract pathway	RCOphth/GIRFT Restarting and Redesigning of Cataract Pathways in response to the COVID 19 pandemic RCOphth/UKOA Cataract consent form for COVID-19 Sample COVID-19 cataract protocol for primary care optometrists LOCSU clinical management guideline: integrated cataract pathway	NG77 SAFE cataract
Medical Retina: Wet Maculopathy	COVID-19 Wet maculopathy pathway	Sample COVID-19 wet maculopathy protocol LOCSU pathway guideline: Maculopathy referral filtering and monitoring	NG82 SAFE AMD
Medical Retina: Diabetic macular oedema (DMO)	COVID-19 DMO pathway	Sample COVID-19 DMO protocol LOCSU pathway guideline: Maculopathy referral filtering and monitoring	NG17, NG28 PHE/ DESP

3.2.4 Records and patient information and involvement and support

Record Keeping

Complete and accurate records will be held for each patient including clinical information by the provider in either paper or electronic format and stored securely. Information within records should be processed in compliance with the Data Protection Act 2018.

Records will clearly state where a remote consultation (telephone or video consultation) has occurred and any significant limitations which arose due to use of this modality.

Records will include details of advice and guidance sought and given and the outcome and advice given following virtual review. Where patients are moved from the HES into a primary or community monitoring pathway, the community or primary care health care professionals must be provided with access to full records or sufficient clinical information and images to allow comparison to detect change for autonomous decision makers and, where required by the pathway, with a clear management plan with criteria for action, seeking HES support or review, and discharge criteria or timing.

Communication between professionals

Where a referral is made, all relevant professionals should be informed (primary care optometrist, GP, DESP if relevant). For referrals made by primary care optometrists, there must be feedback on every referral to the primary care optometrist as well as to the GP. For optometric or hub assessments, a copy of the consultation report will be forwarded to the

patient's GP within 48 hours and offered to the patient. Where applicable, information will be sent to the original referrer (primary care optometrist and GP) and ophthalmology / surgical provider. Where possible, communications should be via electronic channels, which must comply with information governance requirements.

Patient Information and Communication

At the end of the consultation, the practitioner will summarise and discuss their findings, options for management and any recommendations with the patient. Information, relevant to their condition, will be provided in order to promote their active participation in care and self-management. Information provision and support for patient self-care should be provided in line with the appropriate NICE guidance for the pathway. Patients should also be advised of their level of risk as appropriate e.g. for cataract surgery or glaucoma care. Shared decision-making should underpin all decisions for care throughout the pathways.

The patient will be provided with both oral and written information and offered a copy of any letters between healthcare professionals regarding their care (ideally by email, alternatively by post) in a timely manner.

Patient information and support materials should be from recognised professional, NHS or eye charity sources e.g.

College of Optometrists: **https://lookafteryoureyes.org/eye-conditions/**

Royal College of Ophthalmologists: https://www.rcophth.ac.uk/patients/

NHS England: https://www.nhs.uk/

RNIB https://www.rnib.org.uk/supportingyou

The Macular Society https://www.macularsociety.org

Glaucoma UK https://glaucoma.uk/

Surveys, feedback and patient experience

The service will use the Friends and Family Test (FFT) in accordance with FFT requirements. Other surveys should be developed locally to include pathway specific service user experience and workforce and carer surveys (where appropriate), and other modalities such as focus groups or patient involvement groups are extremely helpful. Feedback and patient views should be used to quality assure and to develop and improve services.

Patient awareness and understanding of service. It is crucial to ensure patients and users, the public, and all relevant professionals, providers and health advice services are aware of and informed about the new pathways and services. Pathways and access to care, and how they integrate, needs to be clear and easily navigated by users. Significant changes to the way care is delivered needs to be appropriately consulted and then communicated and patients need to be assured that they will be offered care that is safe and effective with staff who have the right knowledge and skills and sites with suitable equipment and that this is overseen by (where appropriate) and integrated with all parts of the eye care system including the consultant-led hospital eye service.

3.2.5 Clinical governance

The service should have effective clinical leadership in line with the Joint College's Vision, with principles of multidisciplinary and organisational collaboration, training, clinical governance, risk management and clinical audit central to this.

- There should be a joint lead primary care optometrist and lead ophthalmologist for the service for each pathway, with co-development and agreement from clinical lead ophthalmologists of local trusts and other regional leads with appropriate subspecialty expertise as required.
- There should be agreed local protocols and guidelines for integrated care between primary care optometrists and HES based on guidance from the Colleges and other national guidance especially NICE. Learning and feedback should be used to improve these protocols.
- All primary care optometry and secondary care clinical/governance leads should jointly manage pathway performance, outcomes, incidents, complaints, clinical audit, clinical governance and local accreditation or update sessions and learning from adverse events across the pathway.
- The locally-based clinical lead primary care optometrist(s) will oversee the implementation and performance management of the service delivered in optical practices.

3.2.5.2 Workforce, competencies, training and qualifications

Each system should assess their workforce and have workforce development plans to support restoration and transformation of eye care services in line with the Joint College's Vision.

- Local systems will recognise capability in optometric core competency, better utilise optometrists with appropriate IP and other higher qualifications and, led by the joint optometrist and ophthalmologist leads, agree with all key stakeholders and clinical leaders any additional training or upskilling for specific pathways.
- There should be shared learning and updates available for all local practitioners who are delivering enhanced care.
- Training of trainee ophthalmologists, optometrists undertaking IP and other higher qualifications, and other clinicians must be protected and promoted.

The optical provider will make training available to enable the optometrist / practitioner to revisit core learning and demonstrate that their core skills are up to date. All optometrists / practitioners will be expected to:

- Recognise their own learning needs and identify appropriate resources to meet these needs. All DOCET / WOPEC distance learning is still available.
- Work within their own competency and experience.
- If required, on a case-by-case basis, make use of the mentorship and guidance available within the network of local primary care optical practice and through advice and guidance processes delivered by optometrists with higher qualifications as well as the HES ophthalmologists.

Optometrist practitioners will:

- Be registered with the General Optical Council (GOC)
- Be registered on the NHS England Performers List (optometrists only)
- Have an enhanced DBS check (or application in progress)
- Have completed Safeguarding Level 2 (Adults), and Safeguarding Level 2 (Children)
- Have appropriate levels of Indemnity (including medical negligence insurance)
- Have completed GOC continuing education and training requirements to demonstrate up to date competency.

3.2.5.3 Risk

This should be in line with the NHSE&I Eye Care Restoration and Transformation Risk Toolkit and the Colleges' Joint Vision.

- There should be agreed risk stratification process across the system based on national guidance (e.g. RCOphth) applied to all patients at each interaction, as risks change over time. Risk levels should be recorded and used to make decisions on care modality and prioritisation. Risk levels should be discussed with patients.
- There should be clear mechanisms for joint reporting and managing of incidents/complaints/serious incidents, clinical audit and shared learning across the integrated eye care pathway.
- Clinical audit and performance measures should be agreed between optometric and ophthalmic leads and any other regional leads with assessment equitably across the system.
- Performance management of professionals should be delivered in an integrated and collaborative manner.
- Where pathways are reliant on imaging (e.g. for virtual assessments) it is crucial that there is clear agreement on quality requirements for images and regular quality assurance audits of images. Where there is autonomous decision-making by primary care optometrists, there should be regular audits of the quality and accuracy of decision making.
- Failsafe processes and officers should be in place across the pathway for glaucoma and MR conditions.

3.2.5.4 Premises

All participating optical practices need to be providers of General Ophthalmic Services. As such, they are required to complete the "Quality in Optometry" toolkit https://www.qualityinoptometry.co.uk/ which includes:

- Taking steps to improve accessibility for people with disabilities and compliance with the Equality Act.
- Providing a safe, secure, clean & warm environment which protects patients, staff, visitors and their property; and the physical assets of the organisation.

- Ensuring patient privacy and confidentiality, protecting patient details (written and on the computer) are not accessible to members of the public.
- Conducting patient consultations in private and ensuring any diagnostic tests, performed outside of the consultation room are not undertaken within the view of other patients.
- Ensuring that cleanliness levels in clinical and non-clinical areas meet NHS standards for clean premises; and that staff are aware of correct handwashing procedures.
- Meeting requirements for safety of equipment and disinfection.

This 'Quality in Optometry' clinical governance toolkit will be the benchmark used for the service. Each participating practitioner must adhere to the core standards as set out in the toolkit and be able to provide evidence of this to the CCG if requested to do so.

Alternate ophthalmology providers (community diagnostic hubs, that are not also optical practices) and the prime provider for optical practices will be required to complete the Data Security and Protection (DSP) Toolkit https://www.dsptoolkit.nhs.uk/

All locations delivering the service are subject to approval by the commissioners in advance of service commencement and should include the following:

- Enclosed reception and/or waiting facilities (provision of seating with adequate social distancing as a minimum).
- Suitable private room for assessment and treatment.
- Ability to provide suitable COVID-19 protection.

3.2.5.5 Equipment

Providers delivering the service will be expected to have appropriate equipment available for the safe and effective delivery of the service. This should be used, maintained, calibrated and cleaned in line with industry standards and up to date infection control requirements that will continue to be updated throughout the COVID-19 pandemic.

In addition to equipment already available for the delivery of GOS services, this should include:

- Access to the internet (for data reporting and referral system)
- Access to NHS.net
- Access to telephone/video consultation functionality
- Slit lamp including facility (lenses, indirect) for fundoscopy
- Slit lamp breath shields
- Tonometer (applanation type [Goldmann or Perkins], ORA or I-care)
- Appropriate diagnostic ophthalmic drugs:
    - Mydriatic
    - Anaesthetic
    - Staining agent

- Suitable Personal Protective equipment (PPE)

Pathway specific equipment requirements will need to be locally agreed and may include:

- SD - OCT – (maculopathy, DMO, glaucoma monitoring, CUES -although *optional for CUES but needed within some optical practices participating in the service)*
- Equipment for foreign body removal (CUES)
- Goldmann-type applanation tonometer or ORA ((Glaucoma)
- Fundus imaging

3.2.5.6 Infection control

Service delivery must use robust infection control procedures, regularly updated to include control for COVID-19, including:

• Using a breath guard on slit lamps.

• Wiping clinical equipment and door handles after every patient, as well as other surfaces that may have been contaminated with body fluids using a suitable disinfectant such as an alcohol wipe. All surfaces must be clean before they are disinfected.

• Sanitising frames before patients try them on. If a focimeter needs to be used on patients' spectacles, the patient should be asked to take them off and should be provided with a wipe to sanitise their frames before these are touched by the professional.

• Supporting good tissue practice (catch it, kill it, bin it) for patients and staff by having tissues and covered bins readily available.

• Ensuring that thorough hand washing techniques are adhered to.

Personal Protective Equipment (PPE) – follow national PPE guidance: https://www.gov.uk/coronavirus:

3.2.5.7 Disposal of waste

This is the responsibility of the provider and should meet legal requirements.

3.2.5.6 Patient complaints and compliments

Practices will be expected to display information on complaints procedures and make them available to patients and to manage patient complaints in accordance with NHS complaints procedures. www.dh.gov.uk/health/contact-dh/complaints

Patient compliments and feedback will be encouraged. To minimise contact collection of feedback should be facilitated remotely. The clinical governance leads and the service should use all complaints, compliments and feedback to share learning across the pathway/system and to drive improvements.

3.2.5.7 Service Evaluation and Audit **–** provider organisation requirements

The service is underpinned by collaborative clinical leadership with named optometric and ophthalmic governance leads for all pathways. The clinical leads will support the service evaluation and audit, using the learning from this to lead and inform continued service development.

Provider organisations will work collaboratively to deliver the service and support system level service evaluation and audit. A secure IT web-based platform will be used to provide the data required to demonstrate performance against the service key performance indicators (KPIs) and to facilitate regular audit.

Providers will ensure that all contract performance management requirements are met and will attend virtual performance monitoring meetings with the commissioner / contract manager as necessary. Providers will work collaboratively to undertake regular internal clinical audit and review and to take action to implement any learning acquired during this process.

Where it is identified that the service is not delivering the anticipated activity levels and/or the service outcomes, then providers will work with the CCG to identify, and address, the root cause.

3.3 Population covered

The Service will be accessible to all adult and child patients, meeting the service and individual care pathway eligibility / acceptance criteria and registered with a GP within the relevant ICS.

The Service will accommodate those who are not registered with any GP but are resident and eligible for NHS care e.g. members of travelling communities, homeless people.

3.4 Acceptance and exclusion criteria and thresholds

Acceptance:
See individual care pathways

Exclusion:

- People with a minor eye condition who are able to fully self-manage their condition or people with a complex condition who require specialist intervention and / or care within the hospital eye service.
- People with an eye care need that is best met within GOS
- 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.

3.5 Interdependence with other services/providers

- Ophthalmology hospital and surgical providers
- Local Optical Committees
- Local Medical Committees
- CCG
- ICS
- GPs and their practice staff
- Pharmacy practice staff
- Primary optical practice staff
- Local Eye Health Network.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

The Provider will ensure all aspects of the service are delivered where applicable within:

- NICE Guidelines, particularly NG77, NG81, NG82, NG28, NG17
- National Screening Committee for diabetes and diabetic eye care (DESP)

https://www.gov.uk/government/publications/diabetic-eye-screening-programme-standards/diabetic-eye-screening-standards-valid-for-data-collected-from-1-april-2019

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

- RCOphth Quality standards (cataract, medical retina, diabetic retinopathy, glaucoma)
- RCOphth Commissioning guidance (cataract, sustainable cataract, glaucoma, emergency, standards)
- The Royal College of Ophthalmologists - The Way Forward (cataract, AMD, glaucoma, emergency)
- RCOphth Ophthalmic service guidance
- RCOphth The common clinical competency framework for non-medical ophthalmic healthcare professionals in secondary care
- The College of Optometrists Guidance for Professional Practice https://guidance.college-optometrists.org/home/
- The College of Optometrists Clinical Management Guidelines. https://www.college-optometrists.org/guidance/clinical-management-guidelines.html
- CCECH Safe Frameworks
- CCECH portfolio of eye health indicators
- GIRFT Ophthalmology report
- NHSE Eyes Wise
- NHSE High Impact Intervention Ophthalmology Handbook and Specification
- UKOA patient standards

4.3 Applicable local standards

- Local guidelines and clinical protocols between optical practice and ophthalmology will be developed ahead of service implementation and based on the generic clinical service protocols offered within this service specification

  (NB guidelines should be agreed for the service/ ICS and not for each and every local trust).

4.4 NHSE&I Eye Care Restoration Road Map

- Remote consultation toolkit
- Virtual diagnostic toolkit
- Risk stratification toolkit
- A&G support.