A. Service Specifications

This is a non-mandatory model template for local population. Commissioners may retain the structure below, or may determine their own in accordance with the Contract Technical Guidance.

Service Specification No.	001
Service	Cataract surgery
Commissioner Lead	Lancashire and South Cumbria Integrated Care Board (ICB).
Provider Lead	
Period	
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

As the UK population becomes an increasingly ageing one, the incidence of eye disease is significantly increasing. According to "UK Vision Strategy 2020" sight loss is now a major health issue, affecting about two million people in the UK. The vast majority are older people, although an estimated 80,000 working age people and 25,000 children in the UK are affected by sight problems (Keil S. Key statistics. RNIB, 2008).

Mainly affecting older people, cataracts cause visual problems such as blurring, glare, and multiple images, which can affect people's ability to go about their normal lives. Cataracts causing visual problems lead to difficulty with daily tasks of reading and watching television, driving, working, managing medications, and caring for others. More severe visual reduction related to cataracts can lead to social isolation, as the person can lose confidence and dexterity when unable to see and exacerbates dementia. It can also lead to mental health problems such as depression and to falls with injuries such as fractures.

Early cataract symptoms may be possible to manage with more frequent changes in glasses. but cataract surgery is currently the only effective definitive treatment to improve or maintain vision beyond the early stage. Once cataracts start interfering with daily activities or reducing the quality of life, surgery is usually recommended. It is estimated that around 10 million cataract operations are performed around the world each year of which over 400,000 are performed in England. This makes this the most common surgical procedure undertaken in England. The operation is very cost effective with a high success rate and very low morbidity and mortality. NICE guidance demonstrates it is more cost effective to provide cataract surgery at the point of patient need than to delay.

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**	
Domain 4	**Ensuring people have a positive experience of care**	✓
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	✓

2.2 Local defined outcomes

The service will be expected to deliver the following outcomes:

- The best possible clinical outcomes for patients by providing:
  - High quality care in a safe environment.
  - Rapid assessment and initiation of treatment.
  - Services are delivered in line with current best practice.
  - Close integration with mental health, social care, low visual aids services and third sector providers to ensure full support for those who do suffer impaired vision or become blind.
  - Strong clinical leadership.

- **The best possible patient experience by providing:**
  - A convenient local service tailored to the individual needs of patients.
  - Ensuring patients are fully informed about their condition and treatment options.
  - A positive patient experience in a welcoming and friendly environment.
  - High levels of Patient satisfaction resulting in low DNA rates and increase patient compliance.

- **Excellent value for money through:**
  - Cost effective care through effective productivity and efficiency.
  - Responsive and equitable access to care.
  - Working with commissioners to adopt new technologies and treatment regimens as they emerge to streamline care.
  - Supporting achievement of the 18-week referral to treatment standards.
  - A culture of partnership between provider and commissioner to create total transparency and a joint approach to continuing quality improvement.

Clinical Outcomes

2.3. Cataract

Desired outcomes

- Restoration of vision to meet patients' needs.
- Achievement of the required refractive outcome
- Improvement of patients' quality of life
- Ensuring patient safety and satisfaction.

Visual acuity and refraction

- 90% of all patients to achieve visual acuity better than 6/12 post-operatively.
- At least 80% of patients with ocular co-morbidities to achieve visual acuity of 6/12 or better post-operatively
- 95% of patients without ocular co-morbidities to achieve visual acuity of 6/12 or better post-operatively.
- Post-operative refraction to be +/- 1 dioptre from predicted value RCOphth benchmark 85%.
- 95% of patients to report that they have benefited from cataract surgery.

Complications

- Capsule tear/rupture less than 1%
- Retinal detachment less than 1%
- Cystoid macular oedema less than 2%
- Posterior capsular opacification less than 10% after 1 year
- Raised IOP less than 2.5%
- Corneal oedema (1.4% NOD audit)
- Loss of vision following Cataract Surgery pathway <0.5%
- All other complications less than 1%

3. Scope

3.1 Aims and objectives of service

The ICB wishes to commission cataract surgery services to ensure that supply meets the demands of our ageing population, that Service Users can choose a provider that most suits their individual needs, that quality and safety are central to provision and that the service does not adversely impact the ability to deliver local comprehensive ophthalmology services.

The Provider will:

i. Deliver high quality and value for money cataract services that reflect the best practice guidance set out by the Royal College of Ophthalmologists, Getting it Right First Time and the NHSE National Eye Care Recovery and Transformation Programme (NECRTP) and NICE.
ii. Maintain capacity to support the overall commissioned activity of the ICS, thus ensuring delivery of the national 18-week referral to treatment (RTT) cataract pathway and reduction in waiting list backlogs.
iii. Maintain access to cataract services in accessible hospital and community settings, that provides care closer to home, improves choice, delivers greater consistency and equity in access to services across the localities.

The key objectives of the service are:

iv. To ensure the provision of safe and effective cataract service provision to NHS patients
viii. To free up outpatient and primary eye care capacity for patients at higher risk of sight loss
xi. To ensure the delivery of training for the next generation of consultant ophthalmologists through equitable delivery of training to NHS trainees in all providers of NHS cataract surgery
xii. To ensure Service Users with urgent post-surgery issues and complications can be advised and managed by the Provider's own surgical ophthalmic team with any requirement and resource for other providers to support this clearly agreed.
xiii. To achieve, and drive improvements in, the NECRTP high flow cataract pathway.

Additionally, the service will:

- Ensure pro-active shared decision making (SDM) for patients and carers
- Safeguard that clinical practice/treatments are in line with the current research/evidence-based care.

- Ensure that patients have a positive experience of care resulting in improvements in patient satisfaction.

3.2 Service description/care pathway

This specification is for day case cataract surgery and associated pre and post-operative services.

The Provider must follow the recommended pathway as detailed on the NECRTP High Flow All Complexity Cataract Surgery Pathway (see Appendix 1) in respect of preoperative and pre-clinic attendance information and consent form provision, booking patients, pre-operative assessment, surgery and aftercare. The Provider must offer evening and weekend appointments to provide flexibility to service users.

The service will offer a consultant led clinical assessment, diagnostic and treatment service for patients presenting with cataract surgery requirements. This specification and contract relate to patients requiring cataract surgery and YAG laser capsulotomy following cataract surgery.

If an unrelated non-urgent condition is detected, then a re-referral must be made back to the original referrer. However, onward referrals can be made to other secondary care professionals if a non-urgent condition is detected that is related to the original referral. In cases like this if a referral to an acute hospital service is required, patients must be referred in a timely manner, be able to exercise their right to choose their provider and the information shared is of high quality and includes all pre work up information.

The Provider must offer surgery to Service Users in accordance with any risk or clinical need whilst ensuring new Service Users are not accessing surgery quickly at expense of longer waiters on NHS trust lists where these are transferred to the Provider. Service Users should be seen in chronological order unless clinical need dictates otherwise.

3.2.1 Service overview
The service will be delivered from the premises listed below:

- ***Add here***

The mobilisation of any additional premises will be in discussion with Commissioners to agree. Commissioners party to this contract will only expect services charged by at the Provider at the locations above.

The service location/s should be accessible by car and within reasonable access of public transport routes.

Premises should be DDA compliant and particularly friendly to visually impaired people.

The service location must be Patient Transport Service compliant. There must be adequate space for ambulance vehicles to park up whilst patients board and arrive.

Working with the commissioning lead, the service will be profiled for the Directory of Services on e-RS and service details will be reviewed on a quarterly basis.

Outpatient appointments and procedure and treatment slots must be offered on several days of the week with some provision in the evenings and at the weekends. The option for earlier or later appointments in line with seasonal changes (dark nights) would be advantageous for the patient demographic and transport options.

The provider shall ensure that it has adequate support mechanisms for patients their guardians or carers, who have a disability or do not speak sufficient English to effectively, communicate and understand information given in appointments. This includes people whose first language is not English, people who are hearing impaired and people who cannot read English. The provider shall ensure that such arrangements are in place to support patients accessing services and accessing associated support and information. These measures should naturally be outstanding for those who are visually impaired.

Days/Hours of operation

The provider must offer days and hours of service not limited to the 'standard' Monday to Friday 9.00 am – 5.00 pm. The provider shall ensure the service has sufficient clinics and theatre slots to meet waiting times. Arrangements must be flexed to meet demand and to support patient choice.

Staffing

Staff will have attended an approved training session run by Department of Ophthalmology, or equivalent, and maintain standards through continuous professional development in the area of ophthalmology. Evidence of training will be required.

The provider shall ensure that all practitioners who provide the service demonstrate competence, to include:

- Ensuring all clinical staff hold current professional registration, are members of their respective professional body and have current DBS clearance.
- Certificate or a sign-off letter from the supervising consultant(s) for any clinical working within an extended scope of practice, e.g., optometrist or specialist nurse.
- Evidence of on-going and continued competence including individual clinical performance through a comprehensive audit programme.
- Evidence of completion of statutory and mandatory training
- Safeguarding adults at risk; there will need to be an identified safeguarding lead.
- All staff (clinical and non-clinical) should have an annual appraisal and an agreed personal development plan.
- Appropriate supervision arrangements for all levels of staff will be in place, including induction and clinical supervision.
- Competent practitioners will assess referrals and patients in accordance with agreed protocols and pathways which are based on national clinical guidelines and evidenced good practice.
- There will need to be a named clinical governance lead.
- Professional accountability must be formulated with an agreed governance structure.
- Staff will have a commitment to continuing professional development.
- Engage in undergraduate and postgraduate education assisting in the teaching and learning activities of the deanery and universities.
- Engage in research and the work of the Academic Health Science Network.
- Staff will ensure that patients are always treated with dignity and respect.

Training and development of the workforce is a key element in the sustainability of the service to ensure business continuity in the event of staff absence, e.g. holiday/sick leave.

Quality and Governance

The provider must have robust clinical governance processes in place with strong clinical leadership and clear lines of accountability which operates across organisational and/or professional boundaries.

The provider must have effective systems and processes in operation, which ensure that high standards of clinical care are maintained, and the quality of services provided are continually improved.

Referral

The provider will only accept referrals from optometrists and GP's in line with each of the local ICB referral pathways as outlined in the table below. The provider must follow any process as and when they change in the future within 1 full calendar month of notification of the change.

Referrals must not be accepted outside of the ICB referral pathway.

CCG Referral Pathway	
East Lancashire CCG	Via e-RS GP or via Opera
BwD CCG	Via e-Rs GP or via Opera
Blackpool CCG	Single point of access via e-RS or GP or via Opera

Fylde & Wyre CCG	Single point of access via e-RS or GP or via Opera
Chorley & South Ribble CCG	Via e-Rs (RMC) choice or GP or Opera
Greater Preston CCG	Via e-Rs (RMC) choice or GP or Opera
West Lancashire CCG	Via e-RS following local triage and choice or GP
Morecambe Bay CCG	Direct referral via e-RS for GP and NHS net for Optometrist referral
North Cumbria CCG	Direct referral via e-RS for GP and NHS net for Optometrist referral

Referrals must not be accepted outside of the CCG referral pathway unless the referral is urgent and the patient has been seen by the service for the same condition previously.

Any referral that has not been received through an ICB commissioned referral process as outlined above will not be funded, this includes correct allocation for UBRN numbers as outlined within local ICB pathway.

Providers must contact the patient within 3 working days offering them an appointment if they have not been given one already.

3.2.2 Preoperative provider assessment

The Provider must offer a one-stop assessment, and Service Users wishing to proceed with cataract surgery should not have to attend multiple pre-operative face to face assessments, where sedation or a general anaesthetic (GA) is not required. This should incorporate essential elements including the eye examination, biometry and intra-ocular lens (IOL) selection, consent for one or both eyes, and any pre-op anaesthetic or medical health assessment that has not already been completed remotely e.g. blood pressure check. Procedure specific consent form *[RCOphth example consent forms can be found here]* and standardised pre- & post-operative information should be used, but needs to be supplemented with details for the Service User's specific situation. This is particularly the case for those with higher complexity e.g. glaucoma, narrow angle, tamsulosin-use and pseudoexfoliation. Service Users should be informed about the possibility that surgical training may take place.

The Provider must risk assess Service Users. Enough information must be recorded and shared pre-operatively to ensure admin staff and theatre staff are able to ensure Service Users are directed to the right surgical list relative to their complexity, and to support any transfer of patients to other providers where there are long waits. If possible, this should use the RCOphth or similar risk rating methodology agreed locally to allow benchmarking of outcomes and productivity measures.

The Provider must check in with the Service User a few days before surgery to ensure any COVID testing is completed, confirm transport arrangements and ensure the Service User is still able to attend. This is encouraged to reduce failures to attend or on the day of surgery issues.

3.2.2 Fitness for surgery

Management of comorbidities is as follows:

Ocular co-morbidities:

1. Where the patient has a clinically stable ocular condition under management (e.g. glaucoma, treated diabetic retinopathy) the Provider must contact the managing ophthalmologist for that condition that
    - the condition is stable,
    - surgery can go ahead without compromising the service user clinical outcome,
    - they can exclude any requirements for extra procedures which might mean surgery is only suitable for the managing ophthalmologist for that condition to undertake,

- or to arrange follow up for their co-morbid eye condition.

2. Where the patient has uncontrolled or clinically unstable ocular conditions, the Provider must exclude the patient from surgery until the patient's managing NHS or IS ophthalmologist has treated, stabilised and confirmed that surgery is safe to proceed.

Systemic co-morbidities
For patients for local anaesthetic cataract surgery, follow GIRFT guidance on Anaesthesia in Cataract Hubs

Service Users unfit for surgery should be handled as per the 18-week National RTT guidelines.

Resuscitation, Transfer Policy in Case of Medical or Clinical Emergency

Anaesthesia and Perioperative Care
While most cataract surgery is carried out under local anaesthesia, has no requirement for an anaesthetist present, and has a very low mortality and systemic morbidity, the provider must ensure appropriate patient monitoring during surgery, that resuscitation facilities are readily available, and that an appropriately qualified person is readily available to undertake resuscitation should the need arise.

Where there is no anaesthetist, there must be a member of the theatre team who takes primary responsibility for observing / monitoring the patient during surgery. There should be a member of staff with Immediate Life Support (ILS) training if in a theatre complex with anaesthetic support close by, or, with Advanced Life Support (ALS) training if operating at a remote site. Where there is not a full resuscitation team available on site, there must be a written Standard Operating Procedure (SOP) to transfer an unwell Service User to the most appropriate hospital for ongoing care. This would usually be the nearest hospital with an A&E department via a 999 call to emergency services. *All transfer of and discharge of care for all patients must be in line with Service Condition 11*

For ocular intraoperative complications:
The provider must manage ocular intraoperative complications prior to resolution by the Provider. Most intraoperative complications will be addressed during surgery and any requirement for postoperative management, review or further urgent surgery including vitreoretinal intervention (e.g. dropped nucleus) should be provided by the Provider at the same or alternative nearby site, and arranged with the patient on the day of surgery. If this cannot be provided by the Provider, there must be specific clinical threshold criteria for transfer of patients in an ocular emergency from the provider to secondary care with emergency arrangements and any resource allocation to be agreed with an SLA [include agreement of full post-operative care pathway] with any applicable local NHS trusts.

Any Service User requiring an early postoperative review (e.g. surgical complication, need for postoperative pressure check) should be performed by the Provider and the appointment given to the Service User before they leave on the day of surgery.

Postoperative Care
The provider must discharge the patient with information in an appropriate format (such as a leaflet) advising on postoperative self-care, instructions on use of the drops, what to expect in terms of normal postoperative symptoms and timescale for recovery, to visit their optometrist in 1-2 months, red flag symptoms and a contact telephone number for both in hours and out of hours. This will be manned 24/7 and provide access to clinical advice as required.

The Provider must arrange routine postoperative care following cataract surgery where required. The majority of Service Users, (i.e. those with routine surgery with no serious intraoperative complications and no unstable ocular co-morbidity specifically requiring a postoperative visit) should not receive a postoperative appointment in the provider clinic, in line with the joint Colleges' statement.

Providers may discharge patients in line with the Commissioners agreed post-operative pathways, to a sight test by a primary care optometrist with return of the postoperative data (best corrected visual acuity and refractive error in operated eye) from the primary care optometrist (preferred option) or by the patient; otherwise, or for selected suitable patients, the postoperative cataract assessment occurs by the primary care optometrist with return of data.

The CCG is committed to developing integrated pathways and therefore the provider is expected to develop arrangements with community optometrists to provide the post-operative cataract surgery follow-up where clinically appropriate. The provider will be expected, to discharge all stable post-

operative cataract surgery patients to community optometrists as part of an integrated pathway. It is expected that this will equate to approximately 90% of all non-complex cataract surgery patients.

The provider must ensure that where the patient is already being seen at another ophthalmology provider for a long-term condition, the provider will liaise with the treating Consultant prior to surgery to ensure that there are no reasons they should not proceed with surgery.

Patients who were referred with bilateral cataracts where both eyes are eligible for cataract surgery may be listed for surgery for both eyes (no less than 2 weeks between surgery).

All patients who are clinically suitable must be referred to the cataract follow up service after second eye surgery.

The provider must refer eligible patients back to the referring optometrist or GP, unless the patient specifically requests an alternative optometrist.

Providers must undertake and document Best Corrected Visual Acuity (BCVA) both pre and post operatively.

The provider will audit its compliance against this safety process to report to commissioners.

Post-Operative Referral Pathway by CCG	
East Lancashire CCG	Via the providers subcontract arrangement with our local Optometrist
BwD CCG	Via the providers subcontract arrangement with our local Optometrist
Blackpool CCG	Via the providers subcontract arrangement with our local Optometrist
Fylde & Wyre CCG	Via the providers subcontract arrangement with our local Optometrist
Chorley & South Ribble CCG	Refer back to referring Optometrist via local pathway
Greater Preston CCG	Refer back to referring Optometrist via local pathway
West Lancashire CCG	Via the providers subcontract arrangement with our local Optometrist
Morecambe Bay CCG	Refer back to referring Optometrist
North Cumbria CCG	Refer back to referring Optometrist

3.2.3 Postoperative Complications

The Provider must resolve Ocular early postoperative complications. The Provider must have an urgent phone helpline with direct access to a trained clinician who can provide advice on patient concerns and is able to identify and triage symptoms of concern or which may indicate a complication or a need for an urgent review. This clinician should have direct access to a consultant surgeon. This needs to be available 24/7.

Service Users with urgent issues who can safely be triaged should be offered an early review by the Provider at the clinically appropriate time e.g. the next day or next working day. Where there is an emergency requiring immediate review, the Provider should arrange to see and manage the Service User at one of the Provider's sites with reasonable access for the Service User, with a consultant or senior surgeon available as necessary to treat events such as endophthalmitis or very high intraocular pressure.

Where the Provider has an agreement with another provider for the management of post-operative complications, this must be documented as a formal service level agreement (SLA) with clear provision for an in and out of hours service. The SLA must be shared with the commissioners of the service.

3.2.5 Training

The Provider must offer surgical training to ophthalmic doctors in training (DiT) unless they provide less than 50 cataract cases per year, to standards agreed with the RCOphth as follows, and with a process for agreeing requirements with the local Deanery:

1) The Provider must agree to take a proportionate number of trainees at different levels from the Deanery.

2) The Provider must achieve GMC recognition for training at the service centre, through the Postgraduate Dean.

3) Supervisors must be recognized, up to date, Clinical Supervisors. All trainees will already have an Educational Supervisor at their trust. As in NHS settings case selection and levels of supervision must be tailored to meet trainee needs.

4) The Provider must agree the number of trainees and cases needed with the Deanery (usually the Head of School or Training Programme Director). A phased increase from minimum 4% in the first year to 11% whole cases is expected for all providers of NHS-funded cataract surgery, unless the Deanery advises this is not required in certain units. Note this is a range and actual numbers **per provider** needed can be higher or lower dependent on local need. In order to achieve the minimum 11% and their overall training objectives, trainees will need to be involved at least in part of the case and observing cases and lists in significantly more than 11% of cases and lists. The expectation is that by the end of the 2 years the **minimum** equivalent of 11% will be achieved by all providers.

5) The Provider must ensure that the centre has appropriate equipment to provide supervision e.g. teaching arm for microscope, ability to record and review surgery

6) The Provider must provide regular feedback to the Educational Supervisor (frequency to be locally agreed with Deanery and may be trainee dependent).

7) Period of training at the centre must be agreed between the Provider and Deanery, with facilitation provided by head of school/training director and hospital site.

9) Ophthalmologists in training should be able to facilitate all the curriculum requirements for cataract surgery. If required, they should be facilitated to gain experience in pre-operative assessment of patients in units in which they operate. Likewise, where appropriate, they should be able to see some of their post-operative cases; for example, where patients not automatically discharged to community optometrists such as those with serious ocular co-morbidities and if collecting outcomes for their mandatory consecutive cataract surgery audit. They must be able to review cases with intra-operative complications). Access to pre- and post-cataract surgery visual and refractive outcomes for their performed cases must be available e.g. via NOD submission.

10) The Provider must provide training in line with relevant guidelines. The training placement should follow the guidelines developed by HEE https://www.hee.nhs.uk/our-work/doctors-training/guidance-placement-doctors-training-independent-sector, and new RCOphth guidance on how to provide cataract surgery training in high volume lists can be found here. (https://www.rcophth.ac.uk/wp-content/uploads/2021/09/Cataract-Hubs-and-High-Flow-Cataract-Lists.pdf). NHS indemnity for the trainee should already be in place and Deaneries should confirm this.

11) Simulation facilities and supervised time in simulation is to support trainees. All Providers must have access to this form of training for their trainees in their site or in collaboration with their local trusts.

3.3 Population covered

1. The age range for the service is for adults only age 18+.

3.4 Any acceptance and exclusion criteria and thresholds

Referrals for cataract should only be made when the following criteria are fulfilled:

1. The Service User has significant degree of cataract with reduced visual function interfering with daily activities which is not relieved by refractive correction (glasses) checked during a sight test
2. The Service User understands the process, and risks and benefits of surgery

3.4.1 Exclusion criteria

1. Under 18s.
2. Service Users who do not fulfil the above referral criteria
3. Service Users whose main reason for referral is not cataract but an associated condition requiring active management e.g. glaucoma or age-related *macular degeneration* (AMD). If urgent wet AMD is identified this should be referred to an appropriate provider following the local fast track direct referral route following NICE and RCOphth guidance.
4. Service Users under the care of another provider for ocular co-morbidity where the managing consultant identifies clinically inappropriate for cataract surgery elsewhere
5. For standalone eye units without anaesthetic or medical cover (e.g. some ISP sites or NHS HVLC Cataract hubs), additional exclusion criteria are:
    I. ASA 4.
    II. Need GA
    III. BMI higher than 40.

Early dementia or mild mental capacity issues where cooperation for LA is possible with support should not be exclusions. Implantable cardiac defibrillators, unless surgical procedure uses diathermy (which cataract surgery does not), should not be exclusions.

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3.4.2 Referral sources

The patient will enter the care pathway in one of three ways:

i. **Routine referral from the primary care optometrist**

The primary care optometrist will conduct a sight test, undertake an informed discussion using shared decision-making principles and the above referral criteria to help the patient to agree their pathway of choice, location of choice discussion varies across the ICB (either within optomery or within a referral management centre). It is envisaged that most patients will enter the pathway this way.

ii. **Routine referral from the general practitioner**

Although the GP can choose this pathway, most patients are referred via the primary care optometrist and no patient should be referred without having undergone a sight test and a shared decision-making discussion. The Provider should not accept patients that have been referred without this.

iii. **Referral from the hospital consultant / between providers for patients on the NHS waiting list.**

These transfers are only by agreement with the ICS. The referring Provider and the receiving Provider should develop a local agreement to develop a joint administrative function to tackle waiting lists, identify suitable patients, and transfer Service Users (ensuring fully informed choice is supported) to sites with shorter waits, as well as ensuring any required patient records transfer securely. Joint provider conversations with the patient are encouraged, to ensure full information provision and a well-supported and transparent process.

[Insert any relevant information on the ICS referral pathway]

Joint processes should be developed with clinical teams to seamlessly transfer patients in line with the inclusion criteria with clear justification where patients are not suitable.

The Provider must provide all referrers with feedback or outcome letter.

For patients with bilateral cataracts, the referrer and provider should discuss the benefits of bilateral simultaneous vs sequential bilateral cataract surgery and at the first visit both eyes should be prepared for surgery to reduce the requirement for a pre-op outpatient visit for second eye surgery.

Information: The Provider must agree standardised patient information and consent materials with the commissioner and the route of dissemination. This may include the primary care optometrist, posted, electronic or by the provider upon receipt of the referral.

3.5 Interdependence with other services/providers

In order to provide the most appropriate treatment and care for patients, and to fulfil training requirements, the service provider will be required to develop excellent working relationships and knowledge with a range of providers and service areas, for example:

1. Professionals and organisations which are the source of referrals, including GPs and optometrists and local optical committees, ensuring they have a clear understanding of the service provision, can offer informed choice and that the service proactively meets their needs – but local pathways regarding choice should be followed
2. NHS and IS providers of cataract surgery, ophthalmology and urgent eye care pathways, to ensure joined up navigable pathways for patients, appropriate transfer of patients or clinical information where required, seamless management of ophthalmic emergencies and two way exchange of data on complications and incidents identified by other providers relevant to the service from the Provider.
3. Acute urgent medical services and A&Es, to ensure seamless management of medical emergencies
4. Deanery ophthalmic training leads and training leads and trainees in NHS providers, to ensure optimal local surgical training for doctors in training.

,4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

NICE Guidance for cataracts and
Eye care, https://www.nice.org.uk/guidance/ng77

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

The Royal College of Ophthalmologists

1. RCOphth Cataract hubs and high flow cataract lists
2. RCOphth Restarting cataract surgery
3. RCOphth quality standards - cataract
4. RCOphth training guidance in high volume settings

Getting It Right First Time (GIRFT)/ RCOphth High Volume Low Complexity Guidance [Link to follow when published]

HEE [link to the HEE training guide needed]

Clinical Council for Eye Health Commissioning (CCECH): SAFE cataract LOCSU

National ophthalmology database NOD - National Ophthalmology Database Audit (nodaudit.org.uk)

4.3 Applicable local standards

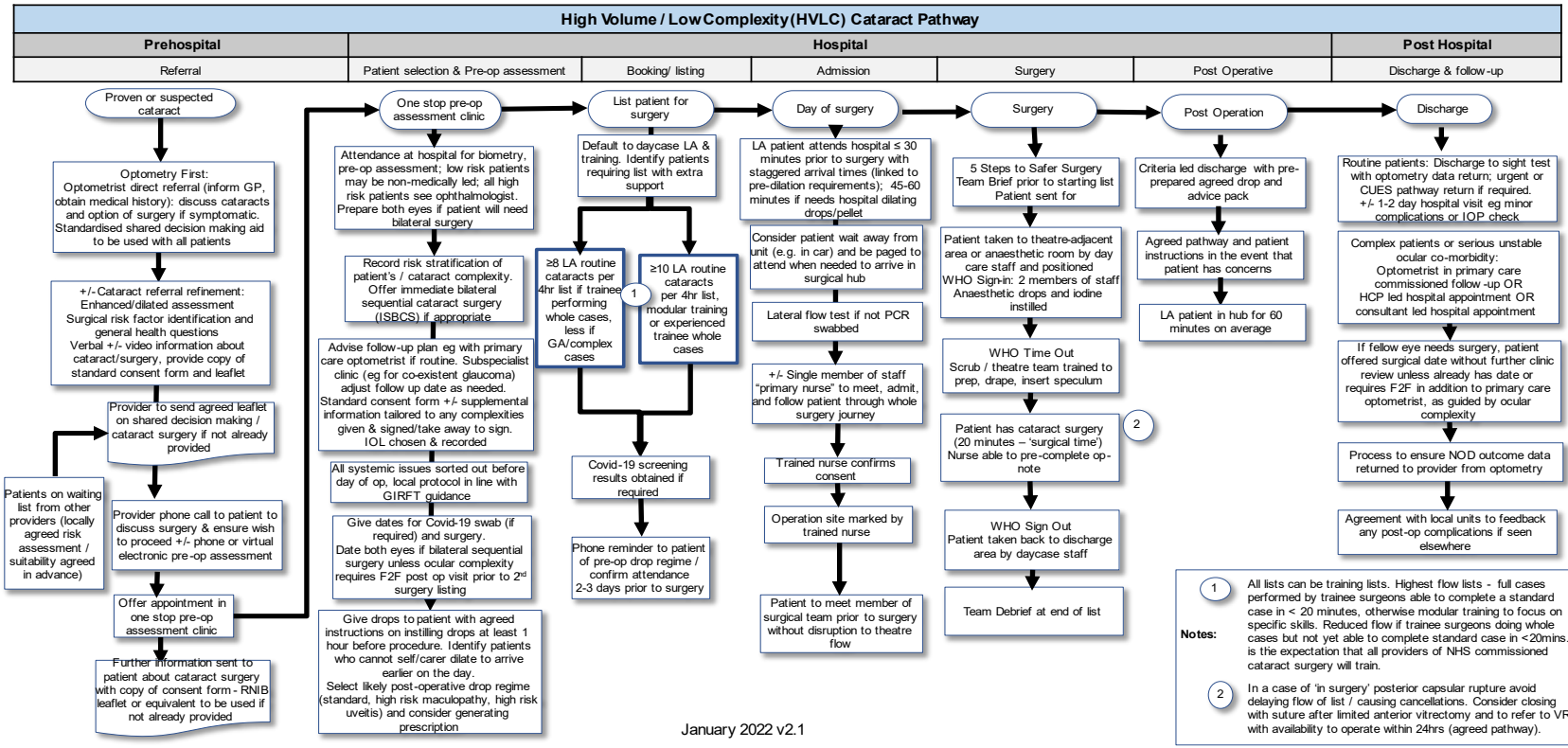
4.4 Applicable recruitment a standards

5. Applicable quality requirements and CQUIN goals

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

5.2 Applicable CQUIN goals (See Schedule 3E)
6. Location of Provider Premises
6.1 The Provider's Premises are located at: [this must list the cataract surgical sites for this pathway between this commissioner and provider]
7. Individual Service User Placement
8. Applicable Personalised Care Requirements
8.1 Applicable requirements, by reference to Schedule 2M where appropriate

Ophthalmology/ Eye Care:
High Flow All Complexity Cataract Surgery Pathway



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