The ROYAL COLLEGE of OPHTHALMOLOGISTS

Commissioning Guidance

Commissioning Standards

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1. Managing demand

Ophthalmology is a high-volume specialty, accounting for over 10% of all outpatient visits and 7% of all surgical activity, with cataract surgery the most common operation performed in the UK. Demand for ophthalmic services has risen approximately 4% per year over the last 10 years and is predicted to increase by 25% over the next 10 years, mainly due to an aging and increasingly diabetic population and new therapies for common chronic eye diseases which require repeated attendance for monitoring and treatment. The ongoing severe capacity issues in ophthalmic services are resulting in delays to care and visual harm for patients.

Ophthalmology is not homogenous, nor all low risk, and includes:

- low risk minor eye conditions such as blepharitis and dry eye
- episodes of surgical care such as day case cataract surgery
- conditions that require regular assessment and treatment for many years such as glaucoma and medical retinal conditions
- rare and complex conditions which need multidisciplinary highly subspecialist care, such as paediatric uveitis

Demand needs to be managed and met in a way that considers the different clinical risk of eye disorders.

2. Delivering value safely

It is crucial that services develop and innovate to use existing resources in the most cost-effective way whilst identifying and ensuring safe care for conditions with a high risk of visual loss. Commissioners, professionals, providers, in partnership with patients, must work together to optimise delivery in primary and community settings, utilise regional networks and pathways of care within STPs, move from a primarily medical care delivery model to make full use of the multidisciplinary eye care team, and support patients to be actively engaged and self-manage where possible. There are a many publications and frameworks which describe these opportunities for value for commissioners (Appendix 2).

However, quality and safety of care must be to the same fundamental standards no matter which professional delivers it and no matter where that care is delivered. This document outlines standards for safe commissioning for ophthalmic services, and signposts to the important guidelines, quality standards and key performance indicators. This will help commissioners to assess the quality of their current service and support safe development of new models. This is particularly important where ophthalmic care is delivered in primary and community settings, in networks between providers, or by different providers within the same unit, or by a range of healthcare professionals.

3. Condition, patient group and pathway-specific standards

Commissioners should ensure that services are compliant with the key national guidance and standards (see Appendix 1 for details), and ensure providers in any setting are audited against any of these standards which are relevant to their service:

- National Institute for Health and Care Excellence (NICE)
- The Royal College of Ophthalmologists
- Clinical Counsel for Eye Health Commissioning (CCEHC) (joint with The Royal College of Ophthalmologists and the College of Optometrists)

4. Standards for any condition or patient group

These standards should be applied and measured for every individual setting and provider and across the whole pathway. There should be:

- Care and resources informed by an Eye Health Needs Assessment.

- Engagement, cooperation and collaboration between community, primary care, secondary care professionals of all relevant disciplines (ophthalmologists, GPs and non-medical health care professionals including orthoptists, optometrists, ophthalmic nurses) and commissioners, with involvement of patient representatives at all stages and from all relevant geographies eg within an STP, working with the NHS England Local Eye Health Networks or equivalent, for strategic development, improvement and managing whole system pathways for ophthalmology.
    - Decisions to restrict access to, or advise on details of, ophthalmic care provided should not be taken without consultation and involvement of ophthalmologists

- Pathways for high risk care:
    - Appropriate systems, pathways, contracting and pricing to identify and protect those with high risk conditions. Low follow up tariffs and new to follow up ratio targets adopted consistently across all ophthalmic care can compromise safety. Commissioners should consider local tariff variation[*] and appropriate new to follow up ratios of 1 in 12 to 1 in 16 for higher risk glaucoma and retinal conditions[†]. There need to be systems to measure and manage timeliness of follow up in high risk patients
    - Mutually agreed pathways for urgent advice and urgent and emergency care clearly understood and documented for patients and all professionals and providers

- Training:
    - A training and accreditation process and ongoing CPD for all non-medical health professionals involved in extended role care
    - Protected delivery of teaching and surgical experience for doctors and surgeons in training within the system

[*] Local variation rules Section 6.2 of the 2016/2017 National Tariff Payment System

[†] New to follow up (N:F) ratios in ophthalmology outpatient services, The Royal College of Ophthalmologists 2011

- Clear evidence based protocols and recorded competencies for non-medical health professionals delivering extended role care – The Royal College of Ophthalmologists has recently received funding to develop the Ophthalmology Common Clinical Competency Framework (OCCCF), enabling further development of an ophthalmology-led multidisciplinary workforce to meet the increasing demands on the hospital eye service.

- Named clinical governance leads for all parties.

- Robust system-wide clinical governance:
    - Facilities for incident reporting and complaints, for investigating these and for sharing the learning, across the whole primary and secondary care network/pathway and between providers
    - Clinical audit of care against recognised and agreed standards and processes for joint clinical audit of care across the whole primary and secondary care network/pathway and between providers, including return of outcome data from community optometrists for the national cataract audit where they have been commissioned to provide post-operative care
    - Facilities for joint clinical governance, case review and educational meetings where pathways or services involve multiple sites/providers
    - A performance management structure including a process for dealing with underperforming or potentially unsafe professionals
    - Identified medicolegal responsibilities for all care provided

- Communication and transfer:
    - Clear criteria for referrals in and out of each setting or between each provider
    - Avoidance of referral for one eye disorder, particularly cataract surgery, without appropriate consideration of other ocular co-morbidities and without full information sharing between, and involvement of, providers caring for the co-morbidities
    - A discharge summary or letter to GPs, community optometrists, other relevant professionals (eg diabetic retinopathy services) and patients after all attendances
    - Clear communication channels, including use where possible of information technology solutions, for sharing clinical and clinical governance information between different providers, sites and settings

- Patient centred:
    - Suitable patient information leaflets about their condition, and symptoms of concern to look out for, given to the majority of attendees
    - Patient satisfaction measured regularly in all settings and for all providers

- Assessment:

- Clear, meaningful and realistic KPIs including any false positive and false negatives referrals to secondary care, unplanned return rate, outcomes of care, adherence to process
- Evidenced adherence to NICE, RCOphth, College of Optometrists, CCECH and other important national guidance and standards (Appendix) and assessment of the Portfolio of Indicators for Eye Health and Care
- Regular formal assessments of cost effectiveness for areas provided by individual parties and across the whole network or pathway
- Time points for re-evaluation of any new network, pathway or scheme

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Appendix 1: standards and guidance for ophthalmic care

National Institute for Health and Care Excellence (NICE)

- Cataracts in adults: management NG77
- Macular degeneration NG82
- Diabetic macular oedema (DMO) TA346 and TA349
- Retinal vein occlusion (RVO) TA229 and TA283
- Glaucoma diagnosis and management NG81
- Glaucoma in adults QS7

Clinical Council for Eye Health Commissioning (CCEHC), The Royal College of Ophthalmologists, College of Optometrists

- Commissioning guidelines for cataract
- Commissioning guidelines for glaucoma
- Commissioning framework for community ophthalmology
- Commissioning framework for primary care ophthalmology
- Commissioning framework for low vision, habilitation and rehabilitation

The Royal College of Ophthalmologists ophthalmic service guidance

- Eye care services for adult with learning disabilities
- Emergency eye care in hospital eye units and secondary care
- Ophthalmic theatre facilities, ophthalmic theatre processes
- Standards for virtual clinics in glaucoma care
- Standards for intravitreal injections

The Royal College of Ophthalmologists service quality standards

- Quality Standard for adnexal services
- Quality standards for urgent and emergency eye care
- Quality Standard for cataract services
- Quality Standards for cornea services
- Quality Standard for glaucoma services
- Quality Standard for medical retina disease services
- Quality Standard for neuro-ophthalmology services
- Quality Standard for vitreoretinal services
- Quality Standards for diabetic retinopathy services
- Quality Standards for services to patients with learning disabilities
- Quality Standards for ophthalmic care and services for children and young people
- Quality standard for people with sight loss and dementia in an ophthalmology department

The Royal College of Ophthalmologists clinical guidelines

- Retinal vein occlusion
- Diabetic retinopathy guidelines

Appendix 2: Publications on cost effective models of care

- Commissioning framework for community ophthalmology
- Commissioning framework for primary care ophthalmology
- Commissioning framework for low vision, habilitation and rehabilitation
- CCEHC, Systems and assurance framework for eye health (SAFE) framework (Publication TBA)
    - SAFE cataract
    - SAFE glaucoma
    - SAFE AMD
- The Royal College of Ophthalmology 'The Way Forward'
    - The Way Forward Cataract
    - The Way Forward AMD
    - The Way Forward Glaucoma
    - The way Forward Emergency Eye care
- Standards for virtual clinics in glaucoma care
- Commissioning guidelines for cataract
- Commissioning guidelines for glaucoma
- LOCSU website

Journal publications

General

1. The developing role of optometrists as part of the NHS primary care team. Parkins DJ, Curran R, Pooley JE, Ryan B. Optometry in Practice 2014; 15: 177-84
2. Multistakeholder perspectives of locally commissioners enhanced optometric services. Baker H, Harper RA, Edgar DF, Lawrenson JG. BMJ Open. 2016 Oct 25;6:e011934.
3. Effectiveness of UK optometric enhanced eye care services: a realist review of the literature. Baker H, Ratnarajan G, Harper RA, Edgar DF, Lawrenson JG. Ophthalmic Physiol Opt. 2016 Sep;36:545-57.
4. A qualitative study of stakeholder views regarding participation in locally commissioned enhanced optometric services. Konstantakopoulou E, Harper RA, Edgar DF, Lawrenson JG. BMJ Open. 2014 May 29;4:e004781.
5. Models for joint ophthalmology-optometry patient management. Kim JJ, Kim CM. Curr Opin Ophthalmol. 2011 Jul;22:256-60.
6. Improving patient access to prevent sight loss: ophthalmic electronic referrals and communication (Scotland). Khan AA, Mustafa MZ, Sanders R. Public Health. 2015 Feb;129:117-23.
7. Teleophthalmology with optical coherence tomography imaging in community optometry. Evaluation of a quality improvement for macular patients. Kelly SP, Wallwork I, Haider D, Qureshi K. Clin Ophthalmol. 2011;5:1673-8.

Primary care and minor eye

8. Evaluation of a minor eye conditions scheme delivered by community optometrists.

   Konstantakopoulou E, Edgar DF, Harper RA, Baker H, Sutton M, Janikoun S, Larkin G, Lawrenson JG.BMJ Open. 2016 Aug 10;6(8):e011832.
9. Demographics, referral patterns and management of patients accessing the Welsh Eye Care Service. McAlinden C, Corson H, Sheen N, Garwood P. Eye Vis . 2016 18;3:14.
10. Novel optometrist-led all Wales primary eye-care services: evaluation of a prospective case series. Sheen NJ, Fone D, Phillips CJ, Sparrow JM, Pointer JS, Wild JM. Br J Ophthalmol. 2009;93:435-8.

Cataract

11. Hughes EH, Forrest F, Diamond JP. 'One-stop' cataract surgery: the Bristol Eye Hospital experience 1997-1999. Eye 2001;15(Pt 3): 306-8.
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14. Changing trends in postoperative cataract care: impact of electronic patient records in optometrist-delivered shared care. Mongan AM, Kerins F, McKenna B, Quinn SM, Mullaney P. Ir J Med Sci. 2017 Oct 23.

Glaucoma

15. Shared care of patients with ocular hypertension in the Communit and Hosptial Allied Network Glaucoma Evaluation Scheme (CHANGES). Manalos A, Bourne R, French K, Newsom W, Chang L. Eye 2012;26:564-7.
16. Can a community optometrist-based referral refinement scheme reduce false positive glaucoma hospital referrals without compromising quality of care? The community and hospital allied network glaucoma evaluation scheme (CHANGES). Bourne RR, French KA, Chang L, Borman AD, Hingorani M, Newsom WD.Eye 2010;24:881-7.
17. Share Cared for Stable Glaucoma Patients: Economic Benefits and Patient-centered Outcomes of a Feasibility Trial. Goh D, de Korne DF, Ho H, Mathur R, Chakraborty B, Van Hai N, Perera S, Tin A, Wong TY, Lamoureux EL. J Glaucoma. 2017 Dec 21. doi: 10.1097/IJG.0000000000000852. [Epub ahead of print]
18. A Mixed-Methods Evaluation of a Community-Based Glaucoma Check Service in Hackney, London, UK. Holdsworth E, Datta J, Marks D, Kuper H, Lee H, Leamon S, Lindfield R, Wormald R, Clarke J, Elkarmouty A, Macdowall W. Ophthalmic Epidemiol. 2017 Aug;24(4):248-256.
19. A technician-delivered 'virtual clinic' for triaging low-risk glaucoma referrals.Kotecha A, Brookes J, Foster PJ. Eye 2017 Jun;31:899-905.
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