

# Supporting Guidance

## Background

1. Cataract surgery is the highest volume procedure in the NHS. The requirement for cataract surgery will continue to increase with increasing life expectancy and rising older population numbers (RCOphth The Way Forward 2017).
2. For many patients, it is a relatively simple procedure. With high post Covid backlogs and relatively low costs of market entry, the market for providing cataracts has transformed over the last three years. The share of cataract provision by provider type has changed rapidly, in 2016 over 80% NHS provided but now nearly 50% of all NHS funded cataract procedures are provided by independent sector (IS) providers.
3. This is already delivering benefits to patients by reducing waiting lists and service innovation but this rapid transformation does however mean that there are a number of issues flagged by a number of clinical, commissioning and provider stakeholders that need to be addressed to ensure that:
  - i) there is a high quality, consistent service for all patients within an ICS and that all clinical quality issues are addressed and managed,
  - ii) the service is sustainable into the future and that issues of training of the cataract workforce are addressed,
  - iii) there is greater transparency of contracts, standards and standards to ensure that providers and commissioners are working together proactively to deliver care for the population.
4. NHS England has been working with the Royal College of Ophthalmologists, NHS Providers and IS providers to agree some common principles for contracting and some wider guidance on implementing the contract. The specification and this guidance has been produced through that engagement.
5. This guidance should also be read in conjunction with the Royal College of Ophthalmologists (RCOphth) position on the provision of NHS cataract surgery<sup>1</sup>

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<sup>1</sup> [Three steps to sustainable patient care: RCOphth publishes position on the independent sector and the delivery of NHS cataract surgery | The Royal College of Ophthalmologists](#)

and training by the independent sector in 2021. The statement describes the growing role played by Independent Sector Providers (ISPs) in delivering NHS cataract surgery in England and outlines how the RCOphth will work with ISPs and others to ensure the continued delivery of a sustainable comprehensive ophthalmology service with a well-trained workforce across NHS and ISPs.

## How to use the guidance

6. This guidance should be used in conjunction with the model specification that has been developed. This can also be found [\[here\]](#).
7. The following sections give information to local commissioners and providers on completing and implementing the contract. It is likely that this will develop over time.
8. Cataract surgery services must be commissioned using the NHS Standard Contract, which is published by NHS England at <https://www.england.nhs.uk/nhs-standard-contract/>.

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## Guidance for commissioners

### Principles for cataract commissioning

9. Cataract surgery is a cost effective intervention. Cataract extraction [lowers the risk of developing dementia](#) and [significantly reduces the risk of falls in older people](#). NICE guidelines are explicit '[Do not restrict access to cataract surgery on the basis of visual acuity.](#)' The health economic assessment supporting the NICE Cataract guidelines states '[The model results suggest that for the majority of patients presenting for cataract surgery, immediate surgery may be the most cost-effective strategy even if it infers no, or only very small, immediate health-related quality of life \(HRQoL\) benefit. In the vast majority of modelled situations, delaying surgery until a visual acuity threshold is met is sub-optimal by comparison.](#)'
10. When commissioning a cataract service, there is certain good practice that you should follow including:
  - i) Patient choice is a constitutional right that commissioners are legally bound to provide for.
  - a) If the commissioner is behaving in an anti-competitive manner/ is complicit in distorting competition this could be investigated under the

Procurement Patient Choice and Competition Regulations, which are the regulations giving NHSI powers to oversee the choice rules.

- b) For providers, anti-competitive behaviour is a breach of the general licence conditions (Condition C1- The right of patients to make choices, particularly C1.4 and Condition C2 – Competition oversight, particularly C2.1(b))
  - ii) Patient choice operates at point of referral ensure you understand the process for referral to providers including the role that optometrists, GPs and any intermediaries may have on shaping referrals within your system.
  - iii) If you spend more than £200k with a particular provider through non-contract activity, you should agree a contract or become an associate on an existing one. This is set out in section 25 of the [technical guidance supporting the National Standard Contract](#).
  - iv) Where the provider operates services from a number of locations nationally, the contract must include the sites that you are commissioning services from. This is set out on section 36 of the [technical guidance supporting the National Standard Contract](#). There is significant concern that service sites are being developed in locations that were not originally envisaged under that contract by the host commissioner and that this is distorting provision across the country.
  - v) When agreeing service locations within a contract, it is good practice that the main commissioner for a particular service location should be the commissioner where the service is located or a neighbouring commissioner.
  - vi) Understand the financial arrangements and incentives upon providers when procuring services. Where there is a financial link between the provider and any referring organisation, this should be captured within the initial procurement and the service should not be commissioned. You should also ask for this information in writing as part of the tender process.
  - vii) Be mindful of perverse incentives and conflicts of interest. For example, when procuring a triage service, be clear if the organisation providing the triage is also a provider of cataracts as this may affect the choices presented to patients, whether or not they currently provide cataracts

within your area. Consider the contractual levers that you can build in to avoid conflict or developing a consortium approach to triaging as a way of protecting patient choice.

viii) The commissioner should expect any provider charging them for activity under arrangements under a contract that is held with a different commissioner to let them know the name of the host commissioner and contact details

### Guidance for providers

11. There are very few reasons that a patient should be excluded by a provider. These are:

- Under 18s.
- Patients who do not fulfil the referral criteria within the service specification
- Patients whose main reason for referral is not cataract but an associated condition requiring active management eg glaucoma or 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.
- Patients under the care of another provider for ocular co-morbidity where the managing consultant identifies the patient is clinically inappropriate for cataract surgery elsewhere
- For standalone eye units without anaesthetic or medical cover (eg some ISP sites or NHS HVLC cataract hubs), additional exclusion criteria are:
  - ASA 4.
  - Need GA
  - BMI higher than 40.

12. Shared decision making - SC10.2 of the national standard contract<sup>2</sup> provides for shared decision making. *'The Provider must comply with regulation 9 of the 2014 Regulations. In planning and reviewing the care or treatment which a Service User receives, the Provider must employ Shared Decision-Making, using supporting tools and techniques approved by the Co-ordinating Commissioner.'*

13. Commissioners must be able to assure themselves of the reasons that patients are excluded, especially where this patient is an intra-system referral to reduce

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<sup>2</sup> <https://www.england.nhs.uk/wp-content/uploads/2021/03/3-FL-SCs-2122-republished-may.pdf>

waiting lists. This should be done at regular contract meetings. They should also consider the relative exclusion rates between providers.

14. Language and lack of translators are never acceptable reasons to reject a patient.
15. For patients for local anaesthetic cataract surgery, follow [GIRFT guidance on Anaesthesia in Cataract Hubs](#) ie:
  - i) At the pre-operative assessment:
    - a) No medication needs to be altered or stopped- in particular anticoagulants should not be stopped prior to surgery. In the case of warfarin, ensure there is reasonable evidence from the yellow book that the international normalised ratio (INR) is likely to be within its therapeutic range is sufficient; no extra measurement of INR is required.
    - b) If the blood pressure is elevated but not above 180/110mmHg, the Service User should be advised to see their GP but listing for surgery should continue. If the systolic or diastolic blood pressure is higher than this, the Service User should be referred rapidly to their GP or the acute medical team if indicated, and surgery delayed until this is managed.
  - ii) On-the-day of surgery:
    - a) If the Service User has a blood pressure recorded at preassessment and/or confirmed by their GP to be at the safe level, then this does not need repeating on the day of surgery.
    - b) Blood sugar measurements (BM) do not need testing on-the-day of surgery unless a Service User with diabetes is feeling unwell. This should trigger BM measurement that would guide further management aimed at preventing cancellation wherever possible.
      - (a) If the blood sugar is less than 4mmol/l then the Service User should be offered something sweet with the aim to proceed with surgery when the BM is normal.
      - (b) A high BM on the day of surgery should not result in the cancellation of surgery unless there are concerns about hyperosmolar hyperglycaemic state (levels often over 33mmol/l) or ketoacidosis (BM greater than 13.9mmol/l with elevated ketones in blood or urine).
    - c) INR, as previously stated, does not need to be checked on the day, as long as there is evidence that the Service User's anticoagulation is likely to be within its normal therapeutic range.

### Transfer of care under a medical emergency

16. This is covered under under Schedule 2J of the Contract Particulars and is given effect by SC11.3 thus:

*'Before the transfer of a Service User to another Service under this Contract and/or before a Transfer of Care or discharge of a Service User, the Provider must liaise as appropriate with any relevant third party health or social care provider, and with the Service User and any Legal Guardian and/or Carer, to prepare and agree a Care Transfer Plan. The Provider must implement the Care Transfer Plan when delivering the further Service, or transferring and/or discharging the Service User, unless (in exceptional circumstances) to do so would not be in accordance with Good Practice.'*

17. Providers must agree a standard operating procedure with the receiving A&E. This should be renewed at appropriate intervals.

### Post-operative care

#### Post-operative outpatient appointments

18. The Royal College of Ophthalmologists and the College of Optometrists have issued [joint guidance on discharging patients post operatively](#). [NHS England have released also guidance in support of this policy](#). The majority of patients can be discharged postoperatively under the understanding that there will be a sight test in primary care optometry in the near future. At this sight test, two pieces of data should be collected and returned to the cataract provider to allow them to complete a NOD submission. This is not a post-operative follow-up but would be an additional cost.
19. Some systems have arrangements with optometry to provide post-operative checks. Prices for this vary between £15-£60 This service model ensures that post-operative data is collected and that patients get a post-operative check. However, based on national [guidance](#), this is not needed in the majority of cases. Systems should not use this as an opportunity to disinvest in eyecare services, potentially destabilising existing relationships, but should consider how optometry could be commissioned to address higher need areas of eyecare.

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20. Regardless of how an ICS chooses to set up its post-operative pathway, they should ensure that arrangements are consistent between providers and that where the cataract provider is responsible for making the payment, that the payments are equal and transparent in order to avoid accusations of paying for referrals.
21. Where providers sub-contract activity this must be included within Schedule 5b of the contract.

#### Post-operative complications

22. The provider that treats the patient should manage post-operative complications or ensure that arrangements are in place to manage them and not simply rely on the patient accessing local NHS services to pick up IS provider complications without agreement. This should be included within the contract and commissioners must assure themselves that the care of patients is being adequately managed. Providers should be able to provide details of any patients that have post-operative complications and how these were managed. This should be reviewed as part of regular contract meetings. Contractual levers should be considered where these arrangements are not in place or not being followed.
23. Where patients are accessing other services to address post-operative complications, for example through A&E, this needs to be escalated to the commissioner who should either address this with the provider or the host commissioner (where another commissioner is the host).

#### Training

24. There are 600 trainee ophthalmologists who need to have done an average of 550 whole or near whole cataract operations by CCT which equates to trainees performing 47,143 cases per year. This is about 11% of all NHS commissioned cataract operations performed per year in all settings. Modular training or simulation training, at the beginning of the training programme to build up to whole cases is extra to this. 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

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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.

25. As the volume of cataracts performed by the IS is increasing as a share of the total, without sharing the training load, there is a risk to the ophthalmology workforce. This means that all cataract providers should take an equal role in the delivery of training.
26. Each ICS will be different, have different numbers of trainees, trainees at different stages and have a range of different providers. Some provider sites may provide too few cataracts to meaningfully provide training (less than 50). This means that there may be a need to approach training requirements in a slightly different way but the principle remains that the ICS, and the providers providing cataracts to it, must take responsibility for delivering the right level of training to sustain the service into the future.
27. Local providers (IS and NHS) must work with the deanery to agree Trainee training plans, this should be in line with Trainee rotation from the deanery.

#### Reducing the backlog and equalising waiting lists

28. Organisations may wish to refer cataract patients from themselves to another provider for example, where they will have a long wait or where they wish to create capacity to see patients who require different eye surgery or are at higher risk of sight loss.
29. Where there are long backlogs (greater than 18 weeks) with one provider but the ability to reduce long waits for patients by giving patients a choice of alternative provider, then this should be encouraged.
30. The ability to do this relies on:
  - i) The patient choosing to move to another provider. Patient choice must be respected. Patients are much less likely to move where they have had a pre-operative assessment already.
  - ii) The ability of the referring organisation to overcome their internal systems and, sometimes the reluctance of their staff, to transfer patients.

iii) The capacity and communication skills of the staff needed to support the transfer.

31. The patient should be given choice over their new provider (including choosing to remain on the list). To facilitate this, receiving providers should consider providing administrative resource or support. Local arrangements should be developed supported by the ICS.

### Collection of data

32. Providers of NHS services are expected to make routine data submissions, Detail on these submissions can be found schedule 6 of the standard contract.

33. It is important for the quality and sustainability that audit data and data on training, is collected, monitored and reported. Training data should be in line with the requirements of your appropriate deanery. For every patient that appears on SUS then there should be data to the National Ophthalmic Database. This allows ongoing monitoring and improvement of care for patients.

	Reporting Period Format of Report	Timing and Method for delivery of	Report Application	Service category
<a href="#">National ophthalmic database Audit</a>	<a href="#">As set out in NODA guidance</a> <a href="#">Submission must capture 100% of data recorded on SUS</a>	<a href="#">As set out in NODA guidance</a>	<a href="#">As set out in NODA guidance</a>	<a href="#">Ophthalmology services</a>
<a href="#">Medical Training</a>	<a href="#">[Agree locally]</a>	<a href="#">[Agree locally]</a>	<a href="#">[Agree Locally]</a>	<a href="#">Ophthalmology services</a>

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#### Additional reference material

34. As well as the [Eyecare Hub on NHS Futures](#) there are a number of sites and documents that you should consider including:

- i) [NICE Managing Cataracts in Adults NG77](#)
- ii) [Cataract Commissioning Guidance | The Royal College of Ophthalmologists \(rcophth.ac.uk\)](#)
- iii) [Getting it Right First Time](#)

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