

D12/S/a

**NHS STANDARD CONTRACT  
FOR SPECIALISED OPHTHALMOLOGY (ADULT)**

**SCHEDULE 2 – THE SERVICES – A. SERVICE SPECIFICATIONS**

<b>Service Specification No.</b>	D12/S/a
<b>Service</b>	Specialised Ophthalmology (Adult)
<b>Commissioner Lead</b>	
<b>Provider Lead</b>	
<b>Period</b>	12 months
<b>Date of Review</b>	

**1. Population Needs**

**1.1 National/local context and evidence base**

There are about 346,000 people registered as having a sight problem in Scotland, Wales and England. Registration figures may represent an underestimation of the true extent of registrable visual impairment in the population. In addition, many people with a visual impairment do not meet registration criteria but have low vision. The Royal National Institute of Blind People (RNIB) estimates that around two million people in the UK self-define as having a sight problem or seeing difficulty. About 80 per cent of people with a visual impairment are over the age of 65 years and prevalence increases dramatically with age.

In the UK, most estimates of the incidence and prevalence of eye disease have focused on registration and utilisation data rather than population based cross-sectional and cohort studies. The Royal College of Ophthalmologists (RCOphth) identifies a number of important studies that provide useful data regarding the incidence and prevalence of eye disease in the UK.

These include:

- The Royal National Institute for the Blind (RNIB) Study (1991)
- The Office of Population Census and Survey (OPCS) Causes of Blindness Study (1995)
- The Irish Glaucoma Survey (1992)
- The North London Eye Survey (NLES) (1998) and the National Cataract Surgery Survey (2000).

Using these studies and other relevant data, the Royal College of Ophthalmology generated estimates on the prevalence and incidence of key causes of blindness and visual impairment. The estimates generated indicate that in the population aged 65 years and above, around 4.3 million have impaired vision in one or both eyes.

## **2. Scope**

### **2.1 Aims and objectives of service**

- To optimise patient vision and minimise avoidable visual disability, mortality and other morbidity by providing high quality care that meets the needs of adults with ophthalmic problems.
- To provide the investigation and management of rare and/or complex visual, ocular and ocular adnexal disorders.
- To ensure that there is a sufficient, skilled and competent multi-disciplinary workforce to manage adults with ophthalmic disorders.
- To ensure that adults have their ophthalmic and general healthcare, education and social care plans coordinated.
- To ensure patients are treated in line with national guidelines and agree local pathways.

Treatment is predominately delivered in an outpatient setting and where appropriate as an inpatient (ward or day unit as required), with carefully monitored shared care arrangements in place with referring clinicians. There were 5.95 million attendances at English NHS Ophthalmology departments in 2009-10. 1.69 million of these (28%) were first attendances. Specialised services are required to keep data to ensure coding is accurate.

The service will deliver the aim to optimise vision and prevent avoidable visual disability of ophthalmic (eye and vision) disorders by:

- making timely and accurate diagnoses
- timely investigation and management
- providing high quality proactive treatment and care
- providing appropriate counselling and psychological support to patients
- support patients with poor vision
- support patients with long term conditions
- support patients to manage their condition independently
- ensuring effective communication between patients and service providers.
- providing a personal service, sensitive to the physical, psychological and emotional needs of the patient.
- provide advice, when appropriate, on Letter of Vision Impairment (LVI), Referral of Vision Impairment (RVI) and Certificate of Vision Impairment (CVI)

Clinically this service covers all ophthalmic subspecialties and is therefore by definition heterogeneous

## 2.2 Service description/care pathway

Ophthalmology services for adults encompass the investigation and management of visual, ocular and ocular adnexal disorders. Ophthalmology hospital services are provided by multidisciplinary teams (MDT) of ophthalmologists, optometrists, orthoptists, specialist nurses, and technicians. Specialised services are provided by ophthalmologists trained to fellowship standard in the appropriate subspecialty. Ophthalmic specialised services, as in most other clinical disciplines, will overlap with other specialised services. Due consideration must be given to the appropriate care of vulnerable adults.

Specialised services will be provided in a network model that will build on existing strengths and established networks and shared care practices. This will be an operational delivery network model or other network models as appropriate to the particular service. It is anticipated that the network operating model and accountability structure will be similar to that of the operational delivery networks.

The objectives of networks would be to:

- Facilitate patient choice
- Ensure sufficient patient numbers to support training and experience across the range of specialties
- Provide an opportunity to train and retain clinicians in specialised areas
- Enable services to pool expertise
- Support smooth transfer of care across organisations
- Develop standards, guidelines and care pathways to facilitate assessment of care quality and promote consistency of care
- Reduce unwanted variation in clinical practice

The service needs close links with appropriate medical specialities and the national ophthalmic pathology service. Internally the multi-disciplinary team links into multiple clinical and administrative teams as a result of the broad composition of the team. Strong links are also required between the clinical and diagnostic teams involved in the service.

Staffing levels should include all those involved in the specialist care of the patient at primary, secondary and tertiary level and should include orthoptists, optometrists, Eye Clinic Liaison Officers (ECLOs), and the named nurse or social worker, whenever appropriate.

Services must always be provided in a suitable environment which meets national guidelines for the care of patients, providing access to a skilled and trained multi-disciplinary workforce to manage adults with ophthalmic problems. Care should be provided by a MDT including:

- Ophthalmologist
- Ophthalmology nurse specialist
- Orthoptists
- Optometrists
- Eye clinic liaison officers

Wherever appropriate:

- Social worker
- Genetic counsellor
- Medical photographer

All specialist services will provide education and training working closely with the Royal College of Ophthalmologists to determine educational and professional standards and with postgraduate training commissioners and providers. Clear policies should be in place to ensure that staff maintain and develop their specialist skills and knowledge. It is a requirement that medical staff can demonstrate that they are part of a revalidation cycle.

All specialised services will be actively involved with research and innovation to ensure the continued development of their service. All staff involved in specialist services will be required to be involved in education and research, be given appropriate time and funding to undertake these requirements and for medical staff to be supported to provide data for revalidation.

Some of these conditions require lifelong surveillance, and potential treatment, to limit visual loss. Discharge policies will be in place for each service.

The service is commissioned for the following conditions:

### **Orbital disorders**

Orbital disorders are uncommon, and include inflammatory conditions, of which thyroid eye disease is the most common, tumours, vascular lesions, structural abnormalities and trauma. All major orbital pathology should be dealt with in specialised networks. In addition, lid tumours spreading to the orbit and enucleation/evisceration associated with tumours should be performed by appropriately trained surgeons. Exenteration is a specialised service and requires a multidisciplinary approach. This may include an orbital surgeon, ophthalmic pathologist, neuroradiologist, oncologist, radiotherapist, neurosurgeon, plastic surgeon, oculoplastic nurse practitioner, ophthalmologist and clinical psychologist.

The management of thyroid eye disease requires a combination of medical and surgical treatment and hence good liaison between surgeons, physicians, radiologists and radiotherapists. It should be considered a specialist service in patients with severe disease.

The management of orbital cellulitis is not a specialised service. The provision of ocular prostheses is a specialised service.

### **Lacrimal disorders**

Surgery for more complex lacrimal problems or with comorbidity eg: combined with tumours, Lester Jones tubes and for any patient requiring multiple surgical revisions for the same pathology should be considered a specialist service.

### **Oculoplastic surgery**

Specialised services cover advanced ptosis surgery if no local expertise exists. Ptosis correction with autologous tissue should be managed within a specialist network as should patients who have had multiple surgical revisions for the same pathology. Complex cases of adnexal and eyelid tumours including e.g. sebaceous cell carcinoma, squamous cell carcinoma and merkel cell tumours - but excluding basal cell carcinomas are considered specialised.

An initial lid biopsy is not considered specialised, but cases with rare, more malignant pathology (recurrent basal cell, squamous cell carcinoma, all sebaceous gland carcinoma, melanoma, Merkel cell carcinomas and other rare tumours) are to be managed within a dedicated eyelid tumour clinic by a multidisciplinary team which has facilities for sentinel node biopsy.

Lid position abnormalities including, complex entropion/ectropion e.g. revision surgery for oculocutaneous pemphigoid, lamellar ichthyosis, Steven Johnson Syndrome should be considered to be a specialist service.

Enucleations/eviscerations are not specialist procedures unless done for intraocular malignancies.

Mohs micrographic surgery is used as an excision technique for lid tumours. It is a specialised service and is used in particular for the management for high risk or recurrent periocular basal cell carcinomas. Referral to a specialist centre for Mohs micrographic excision should be considered for all recurrent basal cell carcinomas (BCC).

Lid Reconstruction- subsequent reconstruction can be performed locally if expertise exists.

All non-BCC eyelid carcinomas require multidisciplinary management through a Head and Neck Cancer Team and is considered specialist. However any diagnostic biopsy is not a specialist procedure.

Primary eyelid basal cell carcinoma is common and its management is not considered specialist IF local expertise exists.

### **Corneal disorders**

Treatment for some corneal conditions including severe anterior segment inflammation refractory to topical therapy (mucous membrane pemphigoid, Stevens-Johnson syndrome and acanthamoeba sclerokeratitis).

High risk keratoplasty - grafts needed in those with one previous failed graft, and/or deep vascularisation 1 quadrant, and/or superficial vascularisation 2 quadrants, and/or autologous plasma/serum services, and/or specific aetiologies (viral, autoimmune), and/or any graft needing long term systemic immunosuppression (greater than 3 months).

Ocular surface reconstruction- keratolimbal allografts, ex vivo stem cell

allografts, cultured oral mucosal epithelial transplant, conjunctival limbal autograft (living related also).

Endothelial keratoplasty will be delivered within the network (Descemet stripping endothelial keratoplasty (DSEK) / Descemet stripping automated endothelial keratoplasty (DSAEK) / Descemet membrane endothelial keratoplasty (DMEK) / automated lamellar therapeutic keratoplasty (ALTK), deep anterior lamellar keratoplasty, corneal inlays corneal implants- Intacs, Kerarings.

Kerato-prosthesis.

Collagen cross linking.

Excimer lasers are used in a small number of ophthalmic departments to treat corneal pathology (phototherapeutic keratoplasty (PTK)).

The primary repair of a penetrating injury is not a specialised service. The repair of a globe perforation due to an underlying condition will be managed within the network.

There are a small number of conditions which require specialist contact lens services e.g. scleral contact fitting.

### **Eye Banking**

- Tissue processing-i.e. for DSAEK- producing pre-cut tissue
- Plasma / serum production
- Cell culture production- ocular surface stem cells, retinal stem cells
- Amniotic membrane production.

### **Vitreoretinal Surgery**

This is not a specialised service for elective or emergency services.

### **Medical Retina**

Specialist diagnostic services are needed for 'second opinions' and management of uncommon retinal conditions. These services must offer the full range of retinal imaging and electrodiagnostic investigations. Recognised national and international standards must be adhered to for electrophysiological tests. Some forms of laser therapy, such as photodynamic therapy, are best provided in specialist centres. Primary adult retinal tumours, such as melanoma, should be managed in specialist centres, as they are now.

### **Uveitis**

Intraocular inflammation carries a significant burden of blindness. This complex group of disorders has a wide range of causes and is often associated with systemic disease. A coordinated multi-specialist approach to care is necessary for severe ocular disease, particularly in the context of the use of systemic treatments for

ocular disease, when it would be deemed a specialised service.

### **Cataract**

This is not considered a specialised service.

### **Glaucoma**

Surgical treatment for complex glaucoma is specialised. This will include all treatment modalities for complex glaucoma (e.g. multiple previous failed drainage surgery, patients at high risk of surgical failure, very shallow anterior chambers, nanophthalmos and buphthalmos).

### **Neuro-ophthalmology**

Neuro-ophthalmology includes the evaluation and multidisciplinary care of patients with a range of serious neurological conditions which may all first present with visual problems. Adverse patient outcomes are associated with late or delayed diagnosis. Hospital Eye Service Neuro-Ophthalmology clinics reduce the risk to patients and providers of adverse events and serious incidents. Specialist neuro-ophthalmology services are provided within two contexts:-

- Specialist neuro-ophthalmology clinics within the hospital eye service

Patients who present to the hospital eye service and require specialist evaluation within the ophthalmic realm in order to achieve a sufficiently precise diagnostic formulation. These include visual failure due to optic neuropathies, suspected raised intracranial pressure and double vision. Working as cognitive rather than procedure based specialists, patients can be rapidly and accurately evaluated in detail to deliver accurate diagnosis of a range of sight threatening and sometimes life threatening conditions including brain tumours, idiopathic intracranial hypertension, myasthenia gravis and multiple sclerosis. Specialists are supported by rapid access to brain imaging, electrodiagnostics, clinical neurophysiology, ultrasound and retinal imaging.

- Clinical Neurosciences Centres

Neuro-Ophthalmologists working in a secondary and tertiary ophthalmic environment need access to multidisciplinary care networks to expedite patient pathways and optimise outcomes. These are located in Clinical Neuroscience Centres where subspecialist neurology, neurosurgery and neuro-imaging expertise need to be made available quickly to selected patients presenting to ophthalmology.

Participation in multi-disciplinary care facilitates enhanced outcomes for patients with brain tumours and pituitary tumours, hydrocephalus and idiopathic intracranial hypertension. Highly specialist surgical procedures may be undertaken in this context including optic nerve sheath decompression. Recently established brain cancer/ tumour networks

including neuroscience and radiotherapy/ oncology centres are one example of how such networks support care quality and enhance outcomes. In addition, sub-specialist multi-disciplinary neurology clinics with expertise for the management of neuro-genetic, neuro-inflammatory and neuro-degenerative disease. Neuro-Ophthalmologists are also directly involved in Neuro-Rehabilitation, undertaking surgery for patients with double vision and facilitating access to appropriate levels of support and therapy for visual problems following neurological illness, again enhancing quality and shortening hospital stays.

### **Strabismus/ Motility**

Adult strabismus is a common condition managed in most ophthalmic units across the country. It does not generally require specialist or expensive equipment. Surgery is normally already undertaken by consultants with appropriate sub-specialty training and experience. At present adult strabismus would therefore not be considered a specialised service requiring central commissioning. There are a few units, however, who offer eye movement recording as an adjunctive investigation for certain patients e.g. some nystagmus patients. Eye movement recording facilities may be considered a specialised service.

### **Ocular Genetic Disorders**

Ocular genetic disorders are best managed by specialist centres which provide multidisciplinary services including access to electrodiagnostic testing, genetic counselling, molecular genetic testing, specialist imaging, research facilities, and specialist ophthalmologists. This provides patients and families with timely accurate diagnosis, increased knowledge of the nature of the condition, information on prognosis, and access to increasing clinical trials.

Whilst emergency ophthalmic care will normally be commissioned at Clinical Commissioning Group (CCG) level there will be occasions when it needs to be specially commissioned.

The over-arching generic referral criterion covering specialised ophthalmology services is as follows:

The condition is covered by the list in 2.2 of this specification.

Referrals will mainly be from ophthalmology departments in secondary care, but will also include referrals from general practitioners, hospital consultants for medical or surgical assessment and management of specialised ophthalmology diseases/ conditions. Once referred the patient will be assessed by a specialist multidisciplinary team.

### **2.3 Population covered**

The service outlined in this specification is for patients with conditions included in section 2.2, ordinarily resident in England; or otherwise the commissioning responsibility of the NHS in England (as defined in 'Who Pays?: Establishing the

Responsible Commissioner', and other Department of Health guidance relating to patients entitled to NHS care or exempt from charges).

Note: for the purposes of commissioning health services, this EXCLUDES patients who, whilst resident in England, are registered with a General Practitioner (GP) practice in Wales, but INCLUDES patients resident in Wales who are registered with a GP practice in England.

## **2.4 Any acceptance and exclusion criteria**

The service is accessible to all patients regardless of sex, race, or gender. Providers require staff to attend mandatory training on equality and diversity and the facilities provided offer appropriate disabled access for patients, family and carers. When required the providers will use translators and printed information available in multiple languages.

Specialised commissioners and CCGs must work with operational provider networks to ensure that medically necessary transport for patients is commissioned and funded to ensure equity of access for patients.

The provider has a duty to co-operate with the commissioner in undertaking Equality Impact Assessments as a requirement of race, gender, sexual orientation, religion and disability equality legislation.

Criteria will differ for each condition.

### **Orbital disorders:**

Enucleation of blind, painful eyes is carried out in every ophthalmic department and is not a specialised service. The management of orbital cellulitis is not a specialised service.

### **Lacrimal disorders:**

Surgery for blocked nasolacrimal ducts i.e. dacryocystorhinostomy (DCR) is widely available and is not a specialised service.

### **Oculoplastic surgery:**

The majority of oculoplastic/adnexal surgery is provided in most ophthalmic departments and is not a specialised service. Basal cell carcinomas are usually managed in local hospitals and are not specialised services.

### **Uveitis:**

Common forms of uveitis, e.g. anterior uveitis, are managed in every ophthalmic department and treatment is not a specialised service.

### **Glaucoma:**

Trabeculectomy for non-complex glaucoma is available in a large number of ophthalmic departments and is not a specialised service.

### **Strabismus surgery:**

The majority of strabismus surgery is provided in most ophthalmic departments and is not a specialised service.

### **Vitreoretinal Surgery:**

This is not a specialised service for elective or emergency services.

## **2.5 Interdependencies with other services**

Referrals will mainly be from ophthalmology departments in secondary care but will also include referrals from community and hospital consultants, established community services, trauma units, medical genetic departments and other disparate groups. Patients are referred from general practitioners, hospital consultant for medical or surgical assessment and management of specialised ophthalmology diseases/ conditions. Once referred the patient will be assessed by a specialist MDT.

Whilst emergency ophthalmic care will normally be commissioned at CCG level, there will be occasions when it needs to be specially commissioned.

The following areas of this specialised service need particular attention to important interdependencies:

- Oculoplastics: For eyelid tumours, a dedicated clinic is needed with an appropriate MDT. Links are needed with the national ophthalmic pathology service.
- Orbital disorders: the management of dysthyroid eye disease requires a combination of medical and surgical treatment and hence good liaison between surgeons and physicians.
- Posterior uveitis: There needs to be close liaison with other medical specialities in the investigation and treatment.
- Neuro-ophthalmology: There needs to be close liaison with neuroscience centres for both investigation and treatment.
- Medical Genetic Services: diagnostic confirmation/carrier detection is required for certain ophthalmic conditions for the purposes of genetic counselling.
- Neuroimaging and specialist neuroradiology
- Ocular Oncology Services
- Ophthalmic Pathology
- Osteo-donto-keratoprosthesis

In addition, there may be interdependencies with the following specialised services:

- Radiotherapy
- Specialised Cancer

- Blood & Marrow Transplantation Haemophilia and other bleeding disorders  
Human immunodeficiency virus (HIV)
- Infectious Diseases
- Haemoglobinopathies
- Specialised Immunology and Allergy Services
- Adult Neurosurgery
- Neurology
- Neurosciences
- Medical Genetics
- Metabolic Disorders

## 2.6 Services which should be co-located

### Oculoplastics

For periocular non melanoma skin cancer management there requirements include:

- Mohs surgeon ideally on site or in close by regional centre
- Histo pathology service with rapid paraffin turnover or with frozen section capability. Dermatopathologists or MOHs as above required to interpret histology
- MDT to discuss high risk or complex cases including oncology to offer radiotherapy, dermatology to offer topical treatment or PDT laser of superficial cancer.
- Cases with large areas of cancer may require expertise of Plastic surgeons if other facial areas involved.

Melanoma skin cancers should have available MDT expertise.

Other oculoplastics conditions require an experienced surgeon trained to perform complex procedures.

### Orbital Service:

- MDT of ophthalmologist, histopathologist and oncologist available to interpret scans, histology and to offer chemo or radiotherapy.
- cranio facial team including Ear Nose and Throat (ENT) if extensive orbital condition which involves sinuses or cranium.

### Lacrimal service:

- may need diagnostic radiology service for scintillagrophy and dacryocystogram.

### Thyroid Eye Disease Requires MDT services:

- Medical management jointly by ophthalmologist, endocrinologist/immunologist, orthoptic and radiology services. Oncologist required for orbital radiotherapy

- Surgical management includes sight saving orbital decompression for optic neuropathy or severe corneal exposure. This should be done by a specialist orbital surgeon and/or ENT and maxillofacial surgeon.
- Squint surgery for diplopia is performed by ophthalmologists in particular strabismologists.
- Rehabilitative surgery includes decompression for proptosis and corneal exposure (as above) and includes corrective eyelid surgery by oculoplastic/orbital surgeons.
- Thyroidectomy for thyrotoxicosis may be required and this is performed by general surgeons or head and neck surgeons eg ENT.

## 2.7 Discharge criteria

Criteria for discharge from inpatient care:

- No further investigation required
- No adverse outcomes anticipated
- Patient is safe post surgery
- Clinically appropriate shared arrangements for local care and specialist ophthalmology service follow-up have been discussed and agreed by all relevant parties including the need to continue with regular sight test to identify eye health problems
- Parents / carers have demonstrated competence in any care they will be required to provide in relation to treatment
- Parents / carers understand and have the necessary information to contact their specialist ophthalmology service provider.

All discharge planning will be managed by the ophthalmologists in charge of the case with local health and social care providers being fully informed of the patient's condition and any responsibilities they will have to assume. This will be formalised in written communication to the patient's GP and all other relevant parties. Some of these conditions require lifelong surveillance, and treatment when necessary, to limit visual loss and which will necessitate a planned transition to adult services.

## 2.8 Relevant networks and screening programmes

Common referral networks will be between national screening programmes, general practitioners, optometrists, ophthalmologists in secondary care and those in the specialised unit.

The provider will link with patients' local healthcare providers to ensure provision of high quality, integrated care, in addition to liaison with employers etc. as necessary to provide support and advice.

Voluntary sector, low vision services and rehabilitation services.

## 2.9 Location of service delivery

Network models of care will mean that some travelling may be required for specialist care. However, this should be minimised wherever possible. This should be offset by implementing shared care arrangements.

## 2.10 Days / hours of operation

Urgent care: 24 hours / seven days a week for new referral of patients and acute referrals. This may include inpatient facilities where appropriate.

Day case: as a minimum 5 days a week, Monday to Friday.

Outpatient Clinics: as a minimum 5 days a week, Monday to Friday.

## 3. Applicable Service Standards

### 3.1 Applicable national standards e.g. NICE, Royal College

The Royal College of Ophthalmologists is the guardian of excellence in ophthalmology. It aims to set standards in all aspects of the delivery of ophthalmic care in the interests of patients and the public. Guidance is provided under various topics (see below) and is reviewed regularly. The guidance is intended to inform both ophthalmologists and those managing eye services.

Standards of practice are clearly identified. The maintenance of these standards may only be achieved through adequate staffing levels, proper facilities and appropriate managerial support. Ophthalmic care for patients must continuously improve through regular robust audit, professional development, innovation, and training. Guidance, including clinical management guidance is available from The Royal College of Ophthalmologists website [www.rcophth.ac.uk](http://www.rcophth.ac.uk)

- Vision 2020
- The National Framework for action to promote eye health and prevent avoidable blindness and vision loss, 2009
- Standards for the retrieval of human ocular tissue used in transplantation
- Research and Training, The Royal College of Ophthalmologists, October 2008
- National Institute for Clinical Excellence (NICE),  
• <http://www.nice.org.uk/media/2A7/C8/GlaucomaQualityStandard.pdf>
- Preventing delay to follow-up for patients with glaucoma. National Patient Safety Agency(NPSA), Rapid Response Report:  
<http://www.nrls.npsa.nhs.uk/alerts/?entryid45=61908>
- Electro physiology Eye Service Standards:  
• <http://www.iscev.org/standards/proceduresguide.html>
- Mental Capacity Act,  
[http://www.legislation.gov.uk/ukpga/2005/9/pdfs/ukpga\\_20050009\\_en.pdf](http://www.legislation.gov.uk/ukpga/2005/9/pdfs/ukpga_20050009_en.pdf)
- [www.commissioningforeyecare.org.uk](http://www.commissioningforeyecare.org.uk)

### **3.2 Revalidation**

All medical staff providing specialised services are required to be part of a robust appraisal process. The General Medical Council (GMC) recommends that doctors in specialist practice should consult the supporting information guidance provided by their College or Faculty. This guidance amplifies the headings provided by the GMC, by providing additional detail about the GMC requirements and what each College or Faculty expects relating to this, based on their specialty expertise. These expectations are laid out by the GMC.

For those support staff involved in specialist eye care, revalidation is also necessary. Orthoptists and other allied health professionals including Operating Department Practitioners must be registered with the Health Professions Council (HPC), optometrists registered with the General Optical Council (GOC) and nurses with the Nursing and Midwifery Council (NMC). These processes require revalidation and proof of competency. For those staff who do not require registration to practice, appropriate legislation (such as occupational health checks), as well as a robust Knowledge and Skills Framework (KSF) appraisal, will be required.

### **3.3 Service user / carer information**

Every patient must have the opportunity to discuss their diagnosis, prognosis and treatment and receive information about their condition in an accessible format clearly understood by patients and free from jargon.

The information must cover:

- A description of the disease
- the life-long implications of the disease
- the prognosis for retention of sight
- management of the disease within the scope of the commissioned service as described in the specification, clinical pathways and service standards
- details of appointments including expected duration, requirement for pupil dilatation etc
- details of who to contact in between appointments if the condition changes
- diagnostic procedures and methods of investigations during assessment
- any requirements for on-going monitoring
- drugs and other treatments commissioned in the clinical pathway including any available compliance aids, drop instillation technique, drug storage etc
- treatment options including mode of action, frequency and severity of side effects, and benefits of treatment so that people are able to be active in the decision making process
- a realistic assessment of predicted outcome
- the importance of self-management and care
- dietary and nutrition information
- the availability of genetic counselling for inherited ocular conditions
- information about support organization and internet resources

- advice, when appropriate, on Letter of Vision Impairment (LVI), Referral of Vision Impairment (RVI) and Certificate of Vision Impairment (CVI)
- details of who the patient's lead clinician is
- contact details of the patient's allocated named nurse

The service must also provide education to patients and carers on:

- symptoms of disease
- contact in case of concern

### 3.4 Patient Groups

Services should work with patient groups to ensure patient input into the development and provision of the services provided.

## 4. Key Service Outcomes

### 4.1 Governance

Quality standards for Ophthalmology Services have been established by the Royal College of Ophthalmologists:

<http://www.rcophth.ac.uk/news.asp?section=24&itemid=515&search>

- Providers will support clinical teams to routinely collect outcome data to demonstrate quality standards
- Providers will ensure that clinical teams will have inbuilt time and resources for continuous professional development, education, revalidation and service developments
- All patients will have a lead clinician responsible for management of their care within the operational provider network
- The facilities and environment are required to be safe and appropriately staffed to deliver and care for these complex cases
- Incidents recorded and investigated.
- Annual report of morbidity and mortality
- Annual report of complaints and outcomes of recommendations

### 4.2 Service Specific Outcomes

To be agreed condition, national and international standards but generic Quality Standards have been set out by the Royal College of Ophthalmologists:

<http://rcophth.ac.uk/news.asp?section=24&itemid=515&search>

There will be a continual audit cycle across the service. This will include feedback from patients, for example, through regular questionnaire surveys or routine use of patient reported experience measures.

There is a need to develop routine data collection systems to allow standardised outcomes assessment and audit in services.

Service improvement will be continually ensured through areas such as:

- the appropriate investigation and management of complaints
- monitoring information on the effectiveness of interventions
- regular feedback to commissioners regarding patient outcomes
- learning good practice from other specialist services
- service user feedback/patient and public involvement through regular surveys
- continued research within the service and publication of the results of research
- the development of appropriate policies and guidance on best practice modifying the service, such as additional outreach clinics in new locations as needed

Service improvement may be stimulated through other areas such as:

- monitoring information
- provider feedback
- learning from other services
- needs assessments
- other communication with stakeholders
- external peer review research

This must be an on-going and dynamic process, providers and commissioners have a commitment to working together to continually improve the service and react to innovative and dynamic ideas. They have a responsibility to continually review and redesign services and consider and act upon requests of the other party.

## Appendices

- D12/S(HSS)/a Ocular oncology service specification
- D12/S(HSS)/b Ophthalmic pathology service specification
- D12/S(HSS)/c D12 Specialised Ophthalmology Services Osteo-odonto keratoprosthesis service for corneal blindness service specification