Insert name of Commissioner or Provider
Community Optometrist Cataract Care Pathway
Service Specification

Service	Community Optometrist Cataract Care Pathway
Commissioner Lead	
Provider Lead	
Period	
Date of Review	

1. Population Needs

National Context
Cataract surgery is the most frequently undertaken NHS surgical procedure with approximately 400,000 cataract operations undertaken in England in 2016-17.

35% of people over the age of 65 years have visually significant cataracts and the demand for cataract services is predicted to rise by 25% over the next 10 years and by 50% over the next 20 years.

Cataract management usually involves a multidisciplinary team that includes ophthalmologists, optometrists, nurses and technicians. Diagnosis is usually based on self-reported symptoms and a series of tests performed by a community optometrist. Traditionally referral to the HES then occurs to confirm the diagnosis and make a decision on proceeding to surgery. This results in variable conversion rates to surgery and some potentially unnecessary hospital visits.

Local Context and Evidence Base

	Number of CCG Patients
Registered CCG GP Population	*insert data*
Patients aged 65 years and over registered with CG GP practice	*insert data*
Estimated number of patients who will receive cataract surgery per year	*insert data*
Estimated number of patients who will have visually impairing cataracts in one or both eyes	*insert data*
Estimated number of patients who have already had cataract surgery	*insert data*
Estimated number of patients who will undergo cataract surgery on both eyes	*insert data*

Source: Health and Social Information Centre – December 2016

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	
Domain 2	**Enhancing quality of life for people with long-term conditions**	**x**
Domain 3	**Helping people to recover from episodes of ill-health or**	

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

2.2 Local defined outcomes

Name of commissioner expects to realise the following benefits to the overall health economy by commissioning cost-effective and high quality cataract surgery:

- Reduction in number of avoidable eye-related secondary care appointments:
  - The pathway will ensure that only patients who meet appropriate criteria **AND** who are willing to have and will benefit from surgery are referred to secondary care cataract service.
  - Only patients with complicated operations or significant co-morbidity will require postop secondary care.
- Reduction in the number of eye-related GP appointments – patients can self refer to optometrist
- Reduction in the number of hospital episodes for low risk patients.
- Reduction in the number of emergency admissions caused by cataract associated falls and/or other injury

3. Scope

3.1 Aims and objectives of service

The aims of the Community Optometrist Cataract Care Pathway (COCP) are to:

- Reduce the number of unnecessary referrals from primary into secondary care, supported by the provision of more accurate referral information and shared decision making earlier in the pathway.
- Reduce the need for GP visits for cataract related complaints.
- Reduce the number of secondary care patient episodes.
- Ensure the knowledge and skills of community optometrists are better utilised as primary care providers.
- Improve access to local care for patients and reduce the number of visits in the pathway.

The objectives of the CoCP are to:

- Assess and consider referral for patients for cataract surgery according to their visual symptoms and corrected visual acuity.
- Identify patients whose cataract meets the CGG threshold criteria
  - ***Patient has a best corrected visual acuity of 6/9 or worse in either the first or second eye***
    AND
  - ***Patient has impairment in lifestyle such as substantial effect on activities of daily living, leisure activities and risk of falls.***
- ***Other indications for surgery are where surgery is undertaken for management of ocular co-morbidities:***
  - *Glaucoma*
  - *Cataract hinders disease management or monitoring eg. diabetic retinopathy, AMD, RVO, neuro-ophthalmic disorders, diabetic retinopathy screening*
  - *Oculoplastic conditions where fellow eye requires closure as part of eyelid reconstruction*
  - *Corneal disease where early cataract removal would reduce chance of losing corneal clarity eg Fuchs dystrophy or after corneal graft*
  - *Corneal or conjunctival disease where delays might increase the risk of complications*
  - *Severe anisometropia in patients who wear glasses*
  - *Posterior subcapsular cataracts.*

Where clinicians consider the referral for cataract surgery necessary on other grounds, an IFR requires completion

*NOTE THE UKOA DOES **NOT** SUPPORT THE USE OF THRESHOLDS AGAINST NICE GUIDANCE*

- .Improve referral and diagnosis to ensure that the following are addressed before

referral
    - The cataract affects the individual's sight and quality of life
    - The patient understands the risks and wishes to proceed with surgery
- Ensure shared decision making tools are used appropriately (appendix 1).
- Ensure patients who meet the criteria are offered a choice of provider for surgery and the referral is sent electronically to the relevant provider.
- Ensure all patients suitable for surgery (and all their carers and support staff where appropriate) receive appropriate information on their condition and on cataract surgery and post-operative care.
- Ensure that referrals received are risk stratified consistently and diverted to the appropriate secondary care surgical pathway.
- Identify patients who **do not** meet the criteria for COCP and refer these patients where appropriate to an alternative secondary care pathway.

3.2 Service description/care pathway

Service description
The service provides for the assessment and direct referral of appropriate patients into secondary care for cataract surgery and for low risk routine patients to receive their postoperative care in the community.

The service will be provided by accredited local optometrists who have a range of equipment to facilitate detailed examination of the eye, as well as the specialist knowledge and skill.

The service is accessed by patients direct from the local optometrist either by:
- Self-referral to the service via local signposting ("self-referral");
- Attending a GP who recommends assessment by an optometrist ("GP referral");
- Referral from an optometrist who does not hold a contract for Community Optometrist Cataract Pathway ("optometrist referral").

The optometrist will forward the appropriate standardised pre-operative clinical information dataset (appendix 2) along with evidence of compliance with the threshold criteria, shared decision making, information provision and patient choice to secondary care.

Secondary care clinicians (usually non-medical e.g. hospital optometrist) will risk stratify patients according to agreed criteria. Patients with high risk criteria will require medically led secondary care ophthalmologist led assessment to complete the decision for surgery. Low risk patients will undergo preoperative assessment, biometry, discussion about target refraction and visual needs of patient, and consenting (this may be non-medical clinician led) and be accommodated where possible on high volume lists.

Following uncomplicated day case cataract surgery, the patient will be discharged with appropriate instructions and medication. The patient will be advised to see an accredited local optometrist for post-operative review 1-2 weeks after finishing their post-operative eye drops (usually 4-6 weeks after surgery). The operative clinical information including details of the operation will be sent to the optometrist from the hospital eye service (HES).

They will undergo a postoperative check at the accredited community optometrist practice, with return of the standardised post-operative clinical information dataset including outcomes to the HES, and can undergo refraction and update of spectacles at the same visit. Should the patient meet the threshold for second eye surgery **and** wish to proceed with the second eye, the accredited optometrist will ensure full completion of the pre-operative dataset for the second eye, repeat the shared decision making process, and will indicate the need to list for the second eye on the post-operative data return.

Care Pathway
- Patients will attend a participating community optometrist at the practice premises for a full examination to include the following:
    - **History and symptoms**

- **Previous ocular history, full medical and drug history (include complete information obtained from the GP by the patient)**
- **Visual acuities including best corrected acuity**
- **Refraction**
- **Ocular and relevant adnexal assessment**
- **Pupil responses (including RAPD) and degree of pupil dilatation**
- **Slit lamp examination of lids and anterior segment including grading and morphology of cataract, corneal status, degree of pupil dilation, lens stability and other key factors**
- **Intra-ocular pressure**
- **Dilated fundus examination**

- If the patient meets the surgical threshold criteria, the community optometrist will discuss with the patient whether they wish to proceed to surgery. This discussion will include the shared decision making tool, and the process, risks and benefits associated with surgery. The optometrist will ensure the patient understands and is willing to undergo surgery prior to referral.
- The community optometrist will provide the patient with a NCL STP patient information leaflet which will assist the patient in making an informed choice about whether they wish to proceed with surgery (appendix 3).
- The patient will indicate their choice of provider and should be informed of likely provider-specific waiting times if possible
- The patient will have a cooling off period of 1 week prior to the referral being sent. During this time, if not done already, the patient can obtain and supply to the optometrist a print out from the GP of their medical and drug history to complete the preop referral data.
- The community optometrist will complete the assessment process and will ensure an electronic referral form is electronically forwarded to the patient's chosen provider.
- Following surgery, the community optometrist will complete a cataract post-operative review and will send this to the secondary care provider.
- For second eye surgery, the optometrist will need to complete the examination again if not already performed for the first eye, ensure thresholds for cataract surgery met, discuss risks and benefits and undertake the shared decision making process again, and re-discuss refractive aims. If second eye surgery is required, this will be indicated on the postop data return.

Population covered

The service is available to all persons registered with a GP practice located within the geographical area of NHS name commissioner.

3.3 Any acceptance and exclusion criteria and thresholds

Acceptance criteria: Cataract surgery threshold criteria

- Patient has a best corrected visual acuity of 6/9 or worse in either the first or second eye
  AND
- Patient has impairment in lifestyle such as substantial effect on activities of daily living, leisure activities and risk of falls.
- Patient is willing to have cataract surgery.

Other acceptance criteria:

- Cataract surgery can be performed for medical reasons such as glaucoma and diabetes and on patients with severe anisometropia who wear glasses (see above).

The clinical reason for the surgery should be clearly documented if not fulfilling the routine threshold criteria.

High risk criteria

- Previous refractive surgery or laser
- High myopia / High hypermetropia (+/-5.00DS), axial length <21mm, >28mm
- Shallow AC <2.5mm
- Previous retinal detachment surgery or vitrectomy
- Multiple intravitreal injections
- Other major eye surgery e.g. corneal graft, trabeculectomy, tube

- Significant corneal disease (eg keratoconus), opacity or scarring, Fuchs dystrophy or multiple guttata
- Eye lid problems eg entropion, ectropion, trichiasis, severe blepharitis, marked epiphora
- Other serious or undiagnosed ocular pathology eg uncontrolled glaucoma, marked macular degeneration, active diabetic retinopathy etc
- Dense or white cataract, no fundal view
- Posterior polar cataract
- Previous history of eye trauma (risk phacodonesis/weak zonules/very deep AC etc)
- Pseudoexfoliation
- Small pupil (<6mm dilated), posterior synechiae
- Head tremor, nystagmus
- Dementia, learning disability or other significant reduced mental capacity (inability to consent for themselves)
- Young Patient (<50years)
- Issues potentially significantly compromising positioning (eg unable to lie flat), communication (eg deafness, language difficulties) or co-operation (e.g highly anxious, psychiatric disease, dementia) with surgery
- Complications in first eye surgery
- Only seeing eye (vision irreversibly less than 6/12 in worse seeing eye)
- On tamsulosin, doxazocin or other alphablockers
- Patient requesting monovision
- Patient with astigmatism of >2.0D (may require toric lens)
- High visual needs e.g. pilot
- Other complicating factors at discretion of optometrist or surgical provider

Co-morbidity: Patients already under the care of one provider for chronic ocular disease should NOT be referred to another provider under this pathway for cataract surgery without full clinical information sharing between the two providers and consultation with the provider overseeing the chronic care and ideally should be cared for by the original provider.

3.4 Interdependence with other services/providers

Primary Care:

- GPs, Practice Nurses and non-participating Optometrists.

Acute eye-care:

- Consultant Ophthalmologists, GPs and Nurses with Special Interest in Ophthalmology.

Voluntary Sector:

Language Provider:

Language Line – Please contact NHS England for further details on how to access this service if required.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

- **NICE Cataracts in Adults: Management**
  Cataracts – (Last revised in October 2017) (https://www.nice.org.uk/guidance/ng77)

- RCOphth Quality standards for cataract services 2017

- RCOphth Commissioning standards 2018

- RCOphth Commissioning standards for cataract 2018
- RCOphth Sustainable cataract pathways 2018
- The Royal College of Ophthalmologists - The Way Forward – Cataract (https://www.rcophth.ac.uk/wp-content/uploads/2015/10/RCOphth-The-Way-Forward-Cataract-Summary-300117.pdf)
- The common clinical competency framework for non-medical ophthalmic healthcare professionals in secondary care – Cataract (November 2016) (https://www.rcophth.ac.uk/wp-content/uploads/2017/01/CCCF-Cataract.pdf)
- CCECH Safe Framework for cataract.

4.3 Applicable local standards – optometrist practice

Equipment
To fully participate in the service, the contractor shall have adequate and appropriate equipment available to undertake this service. It is expected that the required equipment would already be available, as most of it is used for the provision of General Optical Service (GOS) e.g.

- Slit lamp
- Fundus viewing lens (e.g. Volk)
- Tonometer
- Distance test chart (Snellen/logmar)
- Near test type
- Appropriate ophthalmic drugs for pupil dilation
- Internet access

It is also expected that the contractor will have access to and use relevant technology enabling secure electronic transfer of data.

Accreditation
The community optometrist contracted in the provision of this service shall have undertaken appropriate training consisting of:

- WOPEC cataract course
- Local trust delivered training session which will cover the following areas:
  - Assessing cataract and relevant other problems - symptoms, history (including medical and previous ocular) and examination
  - Ocular comorbidities, detecting, understanding significance to outcomes of surgery and risk to surgery
  - Lid problems – distortion , blepharitis, lid squeezers
  - Conjunctival problems and infections
  - Corneal problems: opacities, Fuchs and endothelium
  - Anterior chamber depth
  - IOP and glaucoma
  - Phacodenesis and other unusual lens findings
  - Pseudoexfoliation
  - Iris and pupil – small pupil, synechiae
  - Macular e.g. AMD, other
  - Retina eg detachment
  - Optic nerve
  - Refractive errors- current, previous, high errors, astigmatism
  - Previous trauma
  - Previous refractive surgery
  - Systemic issues, detecting, significant to outcomes of surgery and risk to surgery – physical, sensory, communication, mental/psychiatric, drugs e.g. tamsulosin, mobility and lying flat
  - Mental capacity

- Understanding how the surgery is done and works
- Understanding and advising the patient on the pathway process and timings
- Understanding the on the day journey for the patient and expectations for how the surgery feels etc
- Anaesthetic types, methods/how it's done, risks, benefits, SDM
- Understanding the pathway/process for the scheme e.g. paperwork, training, referrals and timings, remuneration, audit and governance, communication
- Shared decision making and QoL assessment for cataract/vision
- Assessing vs threshold criteria
- Refractive outcome choices
- **Post op**
- Assessing the patient – what to assess/conducting routine postop checks – history, signs
- Complications – what they are, how to diagnose, significance and re-referral
- Drop allergy
- Corneal oedema
- Wound problems
- High IOP
- Anterior uveitis
- Iris trauma
- PCO and laser capsulotomy
- IOL problems
- Retinal tears and detachment, PVD
- CMO
- Refractive surprise
- Endopthalmitis
- Listing for second eye

Trusts will also, where possible, make available time for community optometrists to attend cataract pre and post op clinics and cataract surgical sessions and optometrists are encouraged to attend these by arrangement.

Optometrists should undertake regular relevant CPD for cataract care as part of routine professional updates and also attend an annual trust update session to remain accredited.

Record keeping and data collection
The community optometrist shall maintain appropriate clinical records to show:

- The results of the dilated examination and the clinical diagnosis;
- Whether or not the patient meets the referral criteria;
- Evidence of use of shared decision making tool;
- Details of any referrals made and evidence of provider choice offered;
- Evidence of providing written information on cataract surgery and the pathway;
- Details of associated ocular co-morbidities or other reasons for referral;
- Details of any post-operative review and/or follow-up required
- Evidence of returning the postop data to secondary care.

4.4 Applicable local standards – surgical provider

Equipment, staffing, surgical and care processes
Surgical care providers should be compliant with:

- NICE guidelines for cataracts in adults
- RCOphth Quality Standards for cataract services
- RCOphth Ophthalmic Service Guidance Theatre Processes

Post operative issues and emergencies
The surgical provider must have the facility to deal with any queries from patients or a clear agreed pathway to deal with post operative complications including endophthalmitis, retained lens matter, acute vitreoretinal problems and raised intraocular pressure.
Patients must receive written information with a clear contact number for in hours and out of hours for concerns or urgent problems.
If the patient experiences a potential emergency such as a red or painful eye or sudden loss of vision in the weeks following the operation, the patient will be instructed to seek help

immediately from the surgical provider which must have 24/7 arrangements.

Training
Secondary care provision of surgery must not disadvantage the training requirements of ophthalmologists in training allocated to the region.

Governance
Surgical secondary care providers should each have a named cataract pathway clinical governance lead.

At least one named quality / clinical governance lead for accredited community optometrists will be appointed.

All the secondary care / surgical provider clinical governance leads and optometry clinical governance leads will regularly liaise and jointly manage aspects of pathway performance, any incidents or complaints, clinical audit performance and results / action planning. They will agree on the clinical governance content of any provider accreditation update sessions and any requirement to communicate adverse events or learning across the pathway. The optometry clinical governance lead will be responsible for managing any community optometrist performance issues, need to re-training or decision to remove accreditation

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements

Quality in Optometry

- The Contractor must complete Level One and Level Two of Quality in Optometry within one year of the service commencement date.

Significant incident reporting

- The contractor shall comply with the requirements of the name of commisioner's policy for the Reporting and Handling of Serious Incidents
- A record of all significant incidents (SI), near misses and potential incidents must be maintained by optometrists and providers. SI must be reported to the designated quality lead within 24 hours. All serious incidents or serious complaints will be shared between the optometry quality lead and the provider cataract clinical governance leads for shared management and root cause analysis for those involved and for mutual learning across the pathway. Learning from Sis and complaints should also be included in the annual accreditation training.
- Fitness to practice concerns shall be reported by the contractor to name of commissioner Professional Lead for Optometry

Clinical audit

- The contractor shall participate in any clinical audit activity as reasonably required by Name of commissioner, and maintain appropriate records to evidence and support such activity.
- All providers will submit to the RCOphth NOD national cataract audit.
- The optometry quality lead and the secondary care clinical governance leads for cataract will jointly agree what clinical audit activities will be undertaken.

Patient experience

- The contractor will participate in an annual patient survey by engaging patients in the completion of a patient questionnaire.

Service Review

- The contractor shall co-operate with name of commissioner as reasonably required in respect of the monitoring and assessment of the services including:-
    - Answering any questions reasonably put to the contractor by name of commissioner
    - Providing any information reasonably required by name of commissioner

including clinical audits, distribution of patient satisfaction surveys as developed by name of commissioner and release of non-identifiable patient information for the purposes of quality improvement initiatives to be undertaken by name of commissioner relating to this specific patient group

- Attending any meeting or ensuring that an appropriate representative of the contractor attends any meeting (if held at a reasonably accessible place at a reasonable hour, and due notice has been given), if the contractor's presence at the meeting is reasonably required by name of commissioner.

5.2 Applicable CQUIN goals)

N/A

6. Location of Provider Premises

The Provider's Premises are located at:
The service shall be provided in locations across name of region where ophthalmic practitioners have successfully undertaken accreditation and will provide the community optometrist cataract pathway for patients presenting at the practice premises.

The contractor shall ensure that any additional ophthalmic practitioners who are able to provide the community optometrist cataract pathway for patients presenting at the practice premises, have successfully undertaken accreditation, have read and understood this service specification.

Appendix 1

Name of Commissioner

Shared Decision Making Tool Cataract Surgery

A stepped decision making process

What is a cataract?

A cataract is a clouding, or opacity, of the lens inside the eye. Cataracts usually form slowly over a period of years, causing a gradual blurring of vision which eventually may not be correctable with glasses. In some people the vision can deteriorate quickly.

Developing cataracts can also cause glare, difficulty with night time driving and multiple images in one eye, which can affect the quality of your vision.

There are two main options for managing cataracts

1. Using aids and adaptations to help you manage your vision
2. An operation to remove the cataract

Vision aids and adaptations

Vision aids are things you can use to help you see better for specific tasks such as glasses and magnifiers.

Adaptations are changes you can make to reduce the problems you have such as adjusting computer print size to make text appear bigger or changing your room lighting or using large print books.

These aids and adaptations do not treat the cataract but can help your sight

Your GP or optometrist can refer you to a low vision service who would be able to give you advice about aids and adaptations.

Cataract surgery

Cataract surgery is an operation to remove the cataract. The operation involves removing the cloudy lens and replacing it with a clear artificial lens.

In most cases surgery is highly successful and most people who have a cataract operation can see better afterwards.

As with any operation there are small risks. About 10% of people have some complication during cataract surgery and around 0.1% of people have worse vision afterwards.

How is your cataract affecting you?

Put a cross next to all items that apply to you	X
Because of your eyesight, have you had a problem with your ability to work?	
Because of your eyesight, have you had a problem with driving?	
Because of your eyesight, have you had a problem with your ability to undertake leisure activities such as reading, watching television or recognising faces?	
Because of your eyesight have you had a problem with your mobility or do you feel that you are at risk of falls?	
Because of your eyesight, are there other problems you are experiencing?	

Please add details below:

……..

Are you willing to wait and see what happens to your vision?	
Are you willing to explore using aids and adaptations to see better?	
Are you willing to have surgery that may make your vision worse?	

Appendix 2

Preoperative dataset

- **Date of examination**
- **Patient details** – name, address, dob, telephone number, NHS number
- **GP details** – name, address, telephone number
- **Optometrist details** – name, address, telephone number
- **History**:
    - Visual symptoms: Glare, blurred vision, decreased night vision multiple images etc
    - Previous ophthalmic history, amblyopia, surgery or trauma: no or yes give details
    - Medical history details:
    - Any mobility or positioning problems eg problems lying flat, wheelchair user no / yes give details
    - Any mental capacity issues: no / yes give details
    - Any co-operation or communication issues: no / yes give details
    - Systemic medications:
    - Eyedrop medications
    - Allergies:
    - Relevant social history: work, driver, HGV driver, lives alone, dependents, etc
- **Examination provide for both eyes:**
    - Visual acuity unaided
    - VA pinhole
    - VA best corrected
    - Current refraction
    - Indicate if index myopia
    - Lids: blepharitis yes / no
    - Cornea including endothelium normal yes / no give details
    - AC : van herick OR shallow yes / no
    - IOP NCT / Goldmann; level:
    - RAPD yes / no
    - Pupil dilates well yes / no give details
    - Pseudoexfollation: yes / no
    - Cataract: nuclear / cortical / psco / IOL / other (give details)
    - Cataract: mild / moderate / severe/ total white / dense brown / hypermature
    - Cataract: no fundal view yes / no
    - Macular / Retina normal yes / no: details
    - Disc normal yes/no details
    - Other ocular abnormalities found no / yes: details

- **Suitability for cataract surgery:**
    - Meets threshold criteria:
        - VA ≤6/9
        - Affecting lifestyle
        - Wants surgery

        - Other criteria: glaucoma anisometropia, diabetic retinopathy, other please identify:
    - Process, risks and benefits discussed: yes / no
    - Shared decision making tool used: yes / no
    - Written information leaflet given: yes / no
    - Choice of provider given: yes / no
- Other information for provider:
    - Interpreter required: yes / no / detail language
    - Transport required: yes / no
    - Surgery for: First eye / second eye
    - Eye for surgery: right eye / left eye
    - Refractive aim discussed yes / no
    - Refractive aim is emmetropia / very low myopia / other (detail)
    - Wants / needs: LA, LA and sedation / GA

Postop data set

- **Date of examination**
- **Patient details** – name, address, dob, telephone number, NHS number
- **GP details** – name, address, telephone number
- **Optometrist details** – name, address, telephone number
- **History**:
    - Vision better than preop / happy with vision yes / no (details:
    - Any pain/discomfort: no / yes: details
    - Other problems yes /no (details)
- **Examination**
    - Visual acuity unaided
    - Refraction
    - VA best corrected distance and near
    - Cornea: clear / abnormal (details):
    - Wound: satisfactory. concerns (details):
    - AC deep and quiet / problems (details)
    - Pupil and iris normal / issues (details)
    - IOL and capsule satisfactory / problems (details)
    - IOP (NCT / AT), level
    - Dilated / not dilated
    - Fundus satisfactory / fundus abnormal (details)
- **Next steps:**
    - List for second eye (ensure preop dataset all completed including refractive aims) yes / no
    - Hospital to send appointment for post op problems: no / yes routinely / yes urgently