NHS
Staffordshire and
Stoke-on-Trent
Integrated Care Board

Our Ref: PW/KJJ/FOI/0625/1309

Stafford Education & Enterprise Park
Weston Road
Stafford
ST18 0BF

Telephone: 0300 123 1461

18th June 2025

Sent by email

Dear

FOI/0625/1309
Your request for information under the Freedom of Information Act 2000

Thank you for your request for information received on 10th June 2025. We can confirm that the Staffordshire and Stoke-on-Trent Integrated Care Board can provide the following information.

An anonymised copy of this response will be made publicly available on the ICB website. Please note the ICBs responses in blue.

1. Does your ICB have contracts for NHS elective care activity with either of the following private hospitals:
Nuffield Hospitals (North Staffordshire Hospital) Ramsay Hospitals (Rowley Hospitals)

Staffordshire and Stoke-on-Trent (SSOT) ICB has contracts with both of these organisations.

2. For the contracted hospitals, please can you tell me the specialties each hospital is contracted to deliver ?

Ramsay Healthcare – Rowley Hall & Beacon Park
Ophthalmology
Spinal Surgery
Pain Management
Gastroenterology
Orthopaedics
Podiatry
General Surgery
Urology

Nuffield Health – North Staffordshire
Trauma & Orthopaedics
Spinal Surgery
General Surgery

3. Please can you provide the service specifications, terms and conditions (excluding commercially sensitive information).

Current service specification are included within our response. However please note that SSOT ICB are in discussions with the Provider regarding inclusion and exclusion classifications in specific specialities and will be a contract variation added to their contracts, where relevant as there is a need for all contracts to be aligned.

4. Does the contract state 'specialties to be provide, but not limited to, are' or similar clause?

Within the contracts it states specialities to be provided.

5. Do you have contracts with any of the following:

a. Circle healthcare – Yes
b. Ramsay healthcare – Yes
c. Nuffield hospitals – Yes
d. Spire hospitals – Yes

Should you require any further information or clarification regarding this response please do not hesitate to contact us. If you are dissatisfied with the response, you are entitled to request an internal review which should be formally requested in writing and must be within two calendar months from the date this response was issued.

To request an internal review
You can request an internal review by contacting the Staffordshire and Stoke-on-Trent ICB FOI team by emailing; staffsstokeFOI@staffsstoke.icb.nhs.uk or by post to the address at the top of this letter within 40 working days of the initial response.

If you are not content with the outcome of your internal review, you may apply directly to the Information Commissioner's Office (ICO) for a decision. Generally, the ICO cannot make a decision unless you have exhausted the Staffordshire and Stoke-on-Trent Integrated Care Board's FOI complaints procedure.

The ICO can be contacted at:

Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF
www.ico.gov.uk

Yours sincerely

Paul Winter
Associate Director of Corporate Governance
Enc

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	Nuffield 01
Service	Nuffield Health North Staffordshire - NHS Funded Elective Care
Commissioner Lead	Staffordshire and Stoke on Trent ICB
Provider Lead	
Period	1 April 2024 – 31st March 2027
Date of Review	December 2024

1. Population Needs

1.1 National/local context and evidence base

NHSE Delivery Plan for Tackling the COVID-19 Backlog of Elective Care, Feb 2022.
This plan, which has been developed with expert contributions from a range of partners, both internal and external to the NHS and including patient groups, sets out a clear vision for how the NHS will recover and expand elective services over the next three years. It details ambitions, guidance, and best practice to help systems address key issues, ensuring we have a service that is fit for the future.

A central aim is to maximise NHS capacity, supporting systems to deliver around 30 per cent more elective activity by 2024-25 than before the pandemic, after accounting for the impact of an improved care offer through system transformation, and advice and guidance.

The plan requires our collective focus to:

- **Increase capacity and separate** elective and urgent care provision, while freeing clinicians' time for new patients and those with the greatest clinical need
- **Prioritise diagnosis and treatment** for those with suspected cancer or an urgent condition, and offering alternative locations with shorter waiting times for those waiting a long time
- **Transform the way we provide elective care,** including streamlined care and fewer cancellations, and more convenient access to surgical and

diagnostic procedures, using digital tools and data to drive the delivery of services

- **Better information and support to patients,** providing personalised, accessible support to patients whilst they wait, improving outcomes and reducing inequalities in health outcomes.

Crucially, the plan has a strong focus on improving patient outcomes and their experience of NHS services. Objectives include:

1. Make progressive improvements on long waits, with a goal to eliminate waits of over one year by March 2025, and waits of over two years by July 2022.

   Within this, the aim will be to eliminate waits of over 18 months by April 2023, and over 65 weeks by March 2024.

2. Reduce diagnostic waiting times, with the aim of least 95% of patients receiving tests within 6 weeks by March 2025.

3. To better monitor and improve both waiting times and patients' experience of waiting for first outpatient appointments over the next three years.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	✓
Domain 2	**Enhancing quality of life for people with long-term conditions**	✓
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	✓
Domain 4	**Ensuring people have a positive experience of care**	✓
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	✓

2.2 Local defined outcomes

The Provider shall ensure that the Service delivers the following outcomes:

Actively manage the demand for services ensuring:

- 100% of patients shall be triaged by the service
- 92% of patients referred via ERS shall be seen and treated in accordance with 18 weeks RTT National Operational Standard ((E.B.3) and 6 week diagnostic standard ((E.B.4) where applicable to relevant diagnostics)

- No patients waiting more than 65 weeks for treatment.
- Increased volume of elective and day case surgeries – restore to or exceed pre-Covid activity levels (2019/20)
- Improved waiting list performance.

- High patient and referrer satisfaction
- New to follow-up ratios to be kept to a minimum by adopting patient initiated follow up pathways

3. Scope

3.1 Aims and objectives of service

Under the Patient Choice Framework, the service enables patients to attend a hospital site of their choice for their first Consultant outpatient appointment and elective surgical procedure.

Nuffield Health North Staffordshire will provide consultant led services in the following specialties:

- Trauma and orthopaedics
- Spinal
- General surgery - Inguinal hernia – open (not Bilateral)

Nuffield will provide:

- Outpatient and follow-up consultations (this may include telephone / virtual appointments where clinically appropriate)
- Associated diagnostics
- Day case interventions
- Procedures requiring inpatient beds
- Post op physiotherapy (whilst an inpatient)

The Provider shall provide services in the most clinically appropriate setting, either in an outpatient setting or day case surgery which will be the norm, unless there are clinical indications for the procedure to be undertaken as an in-patient.

See Appendix I for full list of surgical procedures (DoS).

Equity of access underpins the commissioning of the service and aims to contribute to the following priorities:

- Support the restoration of elective recovery in Staffordshire (post-Covid) by maximizing capacity across the system
- To adhere to national waiting list guidance and reduce waiting times for treatment
- To treat long waiters in date order based on the 18-week breach date as a system
- To treat patients in clinical priority order across the system

3.2 Service description/care pathway

The ICB's Choice and Referral Team will support the referral / transfer of patients to Nuffield Health North Staffordshire.

Patients meeting criteria for elective surgery (as listed in Appendix I), who are considered non-complex and low risk will have the option to choose Nuffield as their preferred hospital via e-RS.

Patients requiring elective T&O surgery must have been referred to and triaged by the MSK service prior to referral to Nuffield.

All patients referred for hernias must have been clinically triaged by the ICB clinician working with the Choice and Referral team.

Patients may also be identified by UHNM as long waiters and may be transferred to the Nuffield with patient consent (Choice and Referral Team will support this process and transfer relevant clinical information between the Providers). This will be mutually agreed between all parties prior to transferring any patients.

Nuffield should not accept any direct referrals from GPs, these should be returned to the referrer and advice given on local referral pathways. **All referrals should come via the ICB's Choice and Referral Team.**

Where a patient requires a secondary procedure (not indicated in the original referral) approval must be sought from the ICB.

The contract supports equity of access to elective care across the system. This service will provide this by ensuring:

- Clinical prioritisation: ensure the order in which patients are seen reflects clinical judgement on need.

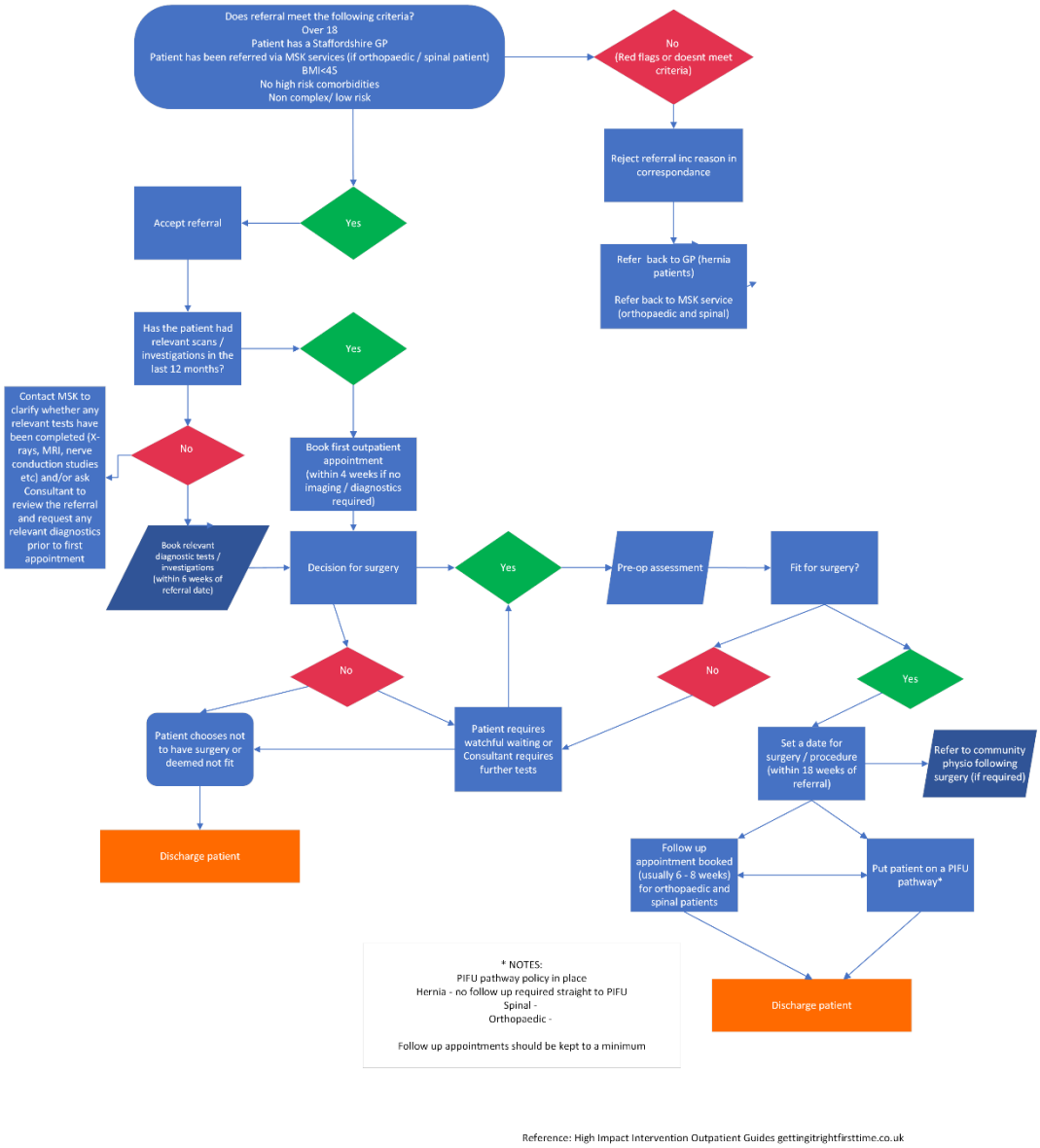
Clinical Guide to Surgical Prioritisation in the recovery from the Coronavirus Pandemic, Prioritisation - Master 28:01:22 (fssa.org.uk)

- Managing long waits: targeting support to reduce the number of people waiting a long time.

- Treatment of long waiters (P4) in date order based on the 18-week breach date.

- Referral to treatment (RTT) times will be reported as per national reporting requirements / guidance.

Nuffield North Staffordshire - Referral to Treatment Process Diagram



Reference: High Impact Intervention Outpatient Guides gettingitrightfirsttime.co.uk

Service offer

Services to include a range of elective / planned care in the following specialties:

- Trauma and Orthopaedics
- Spinal
- General surgery – Inguinal, femoral and umbilical hernias; open procedures only (not bilateral)

The service pathway will include:

- Pre-treatment e.g. referral processes; triage / clinical assessment; diagnostics (where needed and not already undertaken); consultation; pre-treatment assessment and / or work up
- Treatment e.g. outpatient / day case / inpatient treatment; joint assessments

- Recovery e.g. therapeutic environment; physiotherapy, therapy and service aids to recovery; self-care education aid to recovery
- Post op physiotherapy will also be provided on an outpatient basis for patients registered with a Stafford and Surrounds, Cannock, South East and Seisdon and East Staffordshire GP
- Discharge e.g. expected physical, self-care, psychological capabilities prior to discharge, medication, follow up appointments (where clinically required).

Patients will be offered video/phone consultations if preferred and where clinically appropriate to do so.

Follow up e.g. specialist support post discharge, referrals to other general or specialist services such as GP or District Nurse, self-care requirements for a period up to and including fourteen (14) days post discharge.

To give patients and their carers the flexibility to arrange their follow-up appointments as and when they need them, NHS England and NHS Improvement is supporting providers to roll out patient initiated follow-up (PIFU). A more personalised approach to outpatient follow-up appointments will ensure people who require a follow-up appointment receive one in a timely manner – protecting clinical time for the most value adding activity.

The Provider shall:

- Ensure the availability of appropriate staff who can recognise, diagnose, treat and manage patients with urgent or life-threatening conditions at all times, this should include surgical and anaesthetic back-up
- Ensure that staff are competent to undertake clinical service delivery and must have their skills updated and reviewed in line with annual appraisal for the duration of the contract
- Possess the equipment and emergency drugs to treat life threatening conditions
- Adhere to any national or local guidelines relating to clinical safety and medical emergencies

Where the Provider does not currently support critical care services, i.e. HDU and ITU, they shall have a signed contract with an appropriate NHS organisation for access to urgent expert clinical advice and emergency transfer of patients to critical care facilities by the service commencement date.

If medicines are to be prescribed or administered the provider shall seek their own professional advice to ensure compliance to legislation on safe supply, storage and administration of medicines and make appropriate provision to use Patient Group Directions, pre-packs or prescribing within a clinical governance framework. The Provider shall refer to the formularies listed in Schedule 2G - Policies.

3.3 Population covered

Patients who are registered with:

Staffordshire ICB, formerly:

- NHS North Staffordshire CCG
- NHS Stoke on Trent CCG
- NHS Stafford and Surrounds CCG
- NHS Cannock CCG
- NHS East Staffs CCG
- NHS South East and Seisdon CCG

3.4 Any acceptance and exclusion criteria and thresholds

- Patients must live with the local geography of Staffordshire

- Patients aged 18 and over

- Referrals will only be accepted in line with the Provider's directory of service and reference must be made to the Commissioner's Excluded and Restricted Procedure Policy. Details of the latest guidance for individual commissioners are specified on the Staffordshire ICB website. Procedures undertaken which are outside of these criteria will not be funded.

- Commissioners will require Providers to comply with audit processes to monitor compliance with the clinical criteria for carrying out restricted treatments set out in the Commissioning Policy for Excluded and Restricted Procedures. The details of the procedures are attached to this specification.

- Prior approval shall be sought for all procedures which fall within the Commissioner's policy through the Blueteq software. Any procedure that does not have a Blueteq approval code submitted with the monthly MDS activity data shall not be paid for by the commissioners.

- In the event that a procedure is carried out without meeting the criteria expressly stated and agreed in the Commissioning Policy for Excluded and Restricted Procedures or by fulfilling the requirements of an IFR, the respective Commissioner will not be liable for the cost incurred by the Provider.

The following exclusion criteria will apply:

- Children under the age of 18
- Procedures under general anaesthetic Airway Management Grades– where the physical status of the Referred NHS patient is not ASA1, ASA2 or Stable ASA3 and received an anaesthetic review;
- Where the NHS patient has a Body Mass Index >45 or over 200kg, will not be accepted
- Patients requiring treatment for cancer should be referred directly on to the appropriate cancer pathway
- Patients being detained by Her Majesty's Prison Service where security issues are deemed not to be appropriate
- Treatments as specified in the Commissioners policy on Excluded and Restricted Procedures eg Facet joint injections, Trigger point injections, Intradiscal therapy and Prolotherapy will not be funded for non-specific low

back pain (please note this list is not exhaustive and the Provider should refer to the most up-to-date ERP policy on the ICB website)
- Diagnostic arthroscopy will not be routinely funded (see policy for further detail)
- Patients with an unstable mental condition

Nuffield should ensure that procedures are carried out in line with recognized best practice guidance and that all other forms of non-surgical treatment have been considered / tried first. Reference should be made to the Evidence based Interventions Programme

The Evidence-based Interventions programme aims to reduce the number of inappropriate interventions carried out by clinicians in the healthcare system and to improve the quality of care patients receive.
Clinicians - aomrcebi

3.5 Interdependence with other services/providers

- General Practitioners (GPs)
- ICB Choice and Referral Team – support referral and transfer of patients / clinical information
- UHNM
- Primary and Community services – specifically community physiotherapy teams
- Social services
- NHS patient transport services
- Emergency transport / ambulance services
- Patient Advocacy and Liaison Service (PALS)
- Independent and voluntary sector as appropriate
- Clinical and other networks

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

The Service Provider must deliver services in accordance with current best practice in health care and the range of policy and clinical / operational practice guidance relating to these services, complying in all respects with the standards and recommendations. This includes but is not limited to:

NHS Policies

- NHS Long Term Plan (2019)
- NHS 2022/23 priorities and operational planning guidance
- NHS White Paper 2021
- The Francis and Keogh Reports
- NHS Constitution
- Relevant NICE Guidance NICE Trauma and Orthopaedic Guidelines (boa.ac.uk)
- NHSE Delivery Plan for tackling the Covid -19 backlog of elective care , Feb 2022

Clinical Standards and operational practice

In providing services to NHS patients Providers must at all time operate in accordance with Good Clinical Practice and Good Healthcare Practice including relevant NICE guidelines and guidelines from the Royal Colleges.

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

- Federation of Specialty Surgical Associations, Clinical Guide to Surgical Prioritisation in the recovery from the Coronavirus Pandemic, COVID-19 documents - FSSA

- Evidence Based interventions for Clinicians; Clinicians - aomrcebi

- UKHSA review into IPC guidance - Recommendations for changes to COVID-19 infection prevention and control (IPC) advice to help ease pressure on the NHS
  UKHSA review into IPC guidance - GOV.UK (www.gov.uk)

  https://cpoc.org.uk/guidelines-resources-guidelines/national-safety-standards-invasive-procedures-natssips

- Correct Site Surgery, National Patient Safety Agency & The Royal College of Surgeons (2005)

- NICE, Venous Thromboembolism: Reducing the Risk: Clinical Guideline 92: NICE 2010

- NHS England » Guide to implementing patient initiated follow-up (PIFU) in adult trauma and orthopaedic secondary care pathways

- Recommendations | Routine preoperative tests for elective surgery | Guidance | NICE

- National-Day-Surgery-Delivery-Pack_Sept2020_final.pdf (gettingitrightfirsttime.co.uk)

NB: This list is not exhaustive, and the Provider is contractually obligated to review evidence base on a continual basis to ensure compliance with Good Clinical Practice.

4.3 Applicable local standards

- PIFU Policy

- Echocardiogram Policy
- MRSA Policy

5. Applicable quality requirements and CQUIN goals

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

5.2 Applicable CQUIN goals (See Schedule 3E)

6. Location of Provider Premises

6.1 The Provider's Premises are located at:

Nuffield Health North Staffordshire Hospital
Clayton Road, Newcastle-under-Lyme
Staffordshire ST5 4DB

Nuffield Health Cannock Fitness & Wellbeing Gym
East Cannock Road
Cannock WS12 1LU

Nuffield Health Stoke Fitness & Wellbeing Gym
George Eastham Avenue
Stoke on Trent ST4 4TU

7. Individual Service User Placement

Not applicable

8. Applicable Personalised Care Requirements

8.1 Applicable requirements, by reference to Schedule 2M where appropriate

Service Specification No.	Nuffield 02
Service	Cataract Surgery
Commissioner Lead	
Provider Lead	
Period	Last signature date to 31 March 2026
Date of Review	December 2024

1. Population Needs

1.2 National/local context and evidence base

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

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

Early cataract symptoms may be possible to manage with more frequent changes in glasses. but cataract surgery is currently the only effective definitive treatment to improve or maintain vision beyond the early stage. Once cataracts start interfering with daily activities or reducing the quality of life, surgery is usually recommended. It is estimated that around 10 million cataract operations are performed around the world each year of which over 400,000 are performed in England. Locally last year there were c8,000 procedures performed. This makes this the most common surgical procedure undertaken in England. The operation is very cost effective with a high success rate and very low morbidity and mortality. NICE guidance demonstrates it is more cost effective to provide cataract surgery at the point of patient need than to delay.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

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

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

2.2 Local defined outcomes

The following outcomes will be monitored through the contract:

- Actively manage the demand for services ensuring:
  - 100% of patients shall be triaged by the service
  - 92% of patients shall be seen and treated In accordance with 18 weeks RTT National Operational Standard ((E.B.3)and 6 week diagnostic standard ((E.B.4)where applicable to relevant diagnostics).
- To ensure patients report positive outcomes and would recommend a family member or friend to the provider.
- Patients to report an improvement of the following clinical outcomes, post-surgery:
  - high contrast acuity (e.g.Snellen),
  - contrast sensitivity,
  - glare disability,
  - visual field
  - colour vision
- To ensure pathways with community optometrists are seamless and integrated
- To provide regular clinical feedback and training to referring clinicians
- To offer high quality advice and guidance to patients and referring clinicians
- To increase productivity through theatres from a baseline of on average 5 cataract procedures per 4 hour session to on average 7.

3. Scope

3.1 Aims and objectives of service

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

The Provider will:

i. Deliver high quality and value for money cataract services that reflect the best practice guidance set out by the Royal College of Ophthalmologists, Getting it Right First Time and the NHSE National Eye Care Recovery and Transformation Programme (NECRTP) and NICE.

ii. Maintain capacity to support the overall commissioned activity of the ICS, thus ensuring delivery of the national 18-week referral to treatment (RTT) cataract pathway and reduction in waiting list backlogs.

iii. Maintain access to cataract services in accessible hospital and community settings, that provides care closer to home, improves choice, delivers greater consistency and equity in access to services across the localities.

The key objectives of the service are:

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

3.2 Service description/care pathway

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

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

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

HRG List of agreed procedures:

BZ33Z - Minor, Cataract or Lens Procedures
BZ34C - Phacoemulsification Cataract Extraction and Lens Implant, with CC Score 0-1
BZ34B - Phacoemulsification Cataract Extraction and Lens Implant, with CC Score 2-3ac
BZ34A - Phacoemulsification Cataract Extraction and Lens Implant, with CC Score 4+
BZ32A - Intermediate, Cataract or Lens Procedures, with CC Score 2+
BZ32B - Intermediate, Cataract or Lens Procedures, with CC Score 0-1
BZ30B - Complex, Cataract or Lens Procedures, with CC Score 0-1
BZ30A - Complex, Cataract or Lens Procedures, with CC Score 2+
BZ31B - Very Major, Cataract or Lens Procedures, with CC Score 0-1
BZ31A - Very Major, Cataract or Lens Procedures, with CC Score 2+

3.2.1 Preoperative provider assessment

The provider must only accept referrals that have been through the Community Cataract Refinement Service, any direct referral from any source that has not been through this service must be rejected back to the source of the referral with an explanation stating the appropriate pathway.
The Provider must offer a one-stop assessment where possible, and Service Users wishing to proceed with cataract surgery should not have to attend multiple pre-operative face to face assessments, where sedation or a general anaesthetic (GA) is not required. This should incorporate essential elements including the eye examination, biometry and intra-ocular lens (IOL) selection, consent for one or both eyes, and any pre-op anaesthetic or medical health assessment that has not already been completed remotely e.g. blood pressure check. Procedure specific consent form and standardised pre- & post-operative information should be used, but needs to be supplemented with details for the Service User's specific situation. This is particularly the case for those with higher complexity e.g. glaucoma, narrow angle, tamsulosin-use and pseudoexfoliation. Service Users should be informed about the possibility that surgical training may take place.

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

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

3.2.2 Fitness for surgery

Management of comorbidities is as follows:

Ocular co-morbidities:

1. Where the patient has a clinically stable ocular condition under management (e.g. glaucoma, treated diabetic retinopathy) the Provider must contact the managing ophthalmologist for that condition that
    - the condition is stable,
    - surgery can go ahead without compromising the service user clinical outcome,
    - they can exclude any requirements for extra procedures which might mean surgery is only suitable for the managing ophthalmologist for that condition to undertake,
    - or to arrange follow up for their co-morbid eye condition.
2. Where the patient has uncontrolled or clinically unstable ocular conditions, the Provider must exclude the patient from surgery until the patient's managing NHS or IS ophthalmologist has treated, stabilised and confirmed that surgery is safe to proceed.

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

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

Resuscitation, Transfer Policy in Case of Medical or Clinical Emergency

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

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

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

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

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

The provider shall ensure patients who have had uncomplicated surgery are referred for a post operative assessment to an accredited Optometry practice as part of the commissioned Integrated cataract service in Staffordshire and Stoke on Trent ICB footprint.

Providers will discharge patients in line with the Commissioners agreed post-operative cataract pathways for a post operative cataract assessment with primary care optometrist with return of data. Follow ups should be minimal (expect less than 15% of people will have a follow up appointment, as per GIRFT Recommendations).

3.2.3 Postoperative Complications

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

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

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

3.3 Population covered

1. The age range for the service is for adults only age 18+ and patients must be registered with a GP within Staffordshire and Stoke on Trent ICB.

3.4 Any acceptance and exclusion criteria and thresholds

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

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

3.4.1 Exclusion criteria

1. Under 18s.
2. Service users who are not registered with a GP within Staffordshire and Stoke on Trent ICB.
3. Service Users who do not fulfil the above referral criteria
4. Service Users whose main reason for referral is not cataract but an associated condition requiring active management e.g. glaucoma or age-

related *macular degeneration* (AMD). If urgent wet AMD is identified this should be referred to an appropriate provider following the local fast track direct referral route following NICE and RCOphth guidance.

5. Service Users under the care of another provider for ocular co-morbidity where the managing consultant identifies clinically inappropriate for cataract surgery elsewhere
6. For standalone eye units without anaesthetic or medical cover (e.g. some ISP sites or NHS HVLC Cataract hubs), additional exclusion criteria are:
    I. ASA 4.
    II. Need GA
    III. BMI higher than 40.

Early dementia or mild mental capacity issues where cooperation for local anesthetic is possible with support should not be exclusions. Implantable cardiac defibrillators, unless surgical procedure uses diathermy (which cataract surgery does not), should not be exclusions: Revised-guideline-CIED-and-surgery-Feb-19.pdf

3.4.2 Referral sources

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

i. **Routine referral from the primary care optometrist that provides the Cataract Refinement Service only.**

All patients that are suspected to require a cataract operation will undergo a pre cataract assessment by a primary care accredited Optometrist as part of the commissioned Integrated Cataract Service. Based on the outcome of the assessment, the Optometrist may undertake a shared decision making process with the patient and the above referral criteria to assist the patient to agree their pathway provider of choice. It is envisaged that the majority of patients will enter the pathway this way.

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

Although the GP can choose to refer directly into the pathway, the provider should not accept referrals unless they have had pre cataract assessment by accredited Optometrists as part of the commissioned Integrated Cataract Service.

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

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

For the avoidance of doubt all referrals will be sent via the Choice and Referral Centre only.

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

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

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

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

3.5 Interdependence with other services/providers

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

1. Professionals and organisations which are the source of referrals, including GPs and optometrists and local optical committees, ensuring clear understanding of commissioned service provision, can offer informed choice and that the service is pro active to meet their needs.
2. NHS and IS providers of cataract surgery, ophthalmology and urgent eye care pathways, to ensure joined up navigable pathways for patients, appropriate transfer of patients or clinical information where required, seamless management of ophthalmic emergencies and two way exchange of data on complications and incidents identified by other providers relevant to the service from the Provider.
3. Acute urgent medical services and A&Es, to ensure seamless management of medical emergencies

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

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

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

The Royal College of Ophthalmologists

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

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

HEE [link to the HEE training guide needed]

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

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

4.3 Applicable local standards **4.4 Applicable recruitment a standards**
5. Applicable quality requirements and CQUIN goals
N/A
6. Location of Provider Premises
6.1 To be agreed with the commissioner
7. Individual Service User Placement
N/A
8. Applicable Personalised Care Requirements
8.1 Applicable requirements, by reference to Schedule 2M where appropriate

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	Ramsay Health Care 01
Service	Ramsay (Rowley Hall and Beacon Park) - NHS funded Outpatient, Daycase and Elective Care
Commissioner Lead	Staffordshire and Stoke on Trent ICB
Provider Lead	Hospital Director
Period	1 April 2024 – 31st March 2027
Date of Review	December 2024

1. Population Needs
1.1 National/local context and evidence base **NHSE Delivery Plan for Tackling the COVID-19 Backlog of Elective Care, Feb 2022.** This plan, which has been developed with expert contributions from a range of partners, both internal and external to the NHS and including patient groups, sets out a clear vision for how the NHS will recover and expand elective services over the next three years. It details ambitions, guidance, and best practice to help systems address key issues, ensuring we have a service that is fit for the future. A central aim is to maximise NHS capacity, supporting systems to deliver around 30 per cent more elective activity by 2024-25 than before the pandemic, after accounting for the impact of an improved care offer through system transformation, and advice and guidance. The plan requires our collective focus to: • **Increase capacity and separate** elective and urgent care provision, while freeing clinicians' time for new patients and those with the greatest clinical need • **Prioritise diagnosis and treatment** for those with suspected cancer or an urgent condition, and offering alternative locations with shorter waiting times for those waiting a long time • **Transform the way we provide elective care,** including streamlined care and fewer cancellations, and more convenient access to surgical and diagnostic procedures, using digital tools and data to drive the delivery of services

- **Better information and support to patients,** providing personalised, accessible support to patients whilst they wait, improving outcomes and reducing inequalities in health outcomes.

Crucially, the plan has a strong focus on improving patient outcomes and their experience of NHS services. Objectives include

1. Make progressive improvements on long waits, with a goal to eliminate waits of over one year by March 2025.

2. Reduce diagnostic waiting times, with the aim of least 95% of patients receiving tests within 6 weeks by March 2025.

3. To better monitor and improve both waiting times and patients' experience of waiting for first outpatient appointments over the next three years.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	✓
Domain 2	**Enhancing quality of life for people with long-term conditions**	✓
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	✓
Domain 4	**Ensuring people have a positive experience of care**	✓
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	✓

2.2 Local defined outcomes

The Provider shall ensure that the Service delivers the following outcomes:

Actively manage the demand for services ensuring:

1. 100% of patients shall be triaged by the service and clinically prioritised and seen in date order
2. Increased volume of elective and day case surgeries – restore to or exceed pre-Covid activity levels (2019/20)
3. Improved waiting list performance.
4. Referral to treatment (RTT) times will be reported as per national reporting requirements / guidance
5. No patients waiting more than 65 weeks for treatment by end of Sep 2024 and no patients waiting more than 52 weeks by end of March 2025New to follow-up ratios to be kept to a minimum by adopting patient initiated follow up pathways

6. High patient and referrer satisfaction

3. Scope

3.1 Aims and objectives of service

The Provider shall provide services in the most clinically appropriate setting, either in an outpatient setting or day case surgery which will be the norm, unless there are clinical indications for the procedure to be undertaken in a theatre / inpatient setting.

Equity of access underpins the commissioning of the service and aims to contribute to the following priorities:

- Support the restoration of elective recovery in Staffordshire (post-Covid) by maximizing capacity across the system
- To adhere to national waiting list guidance and reduce waiting times for treatment
- To treat long waiters in date order based on the 18-week breach date as a system
- To treat patients in clinical priority order across the system

NHS England and NHS Improvement is supporting providers both NHS and independent sector to roll out patient-initiated follow-up (PIFU). PIFU gives patients and their carers the flexibility to arrange their follow up consultations as and when they need them.

PIFU is to be used with patients in all specialities. This approach is designed to empower patients to manage their own condition and level of care, which in turn will enable shared decision making and support self-management in line with the NHS personalised care agenda 2019 NHS England » Patient initiated follow-up

3.2 Service description/care pathway

Under the Patient Choice Framework, patients will be able to attend a hospital site of their choice for their first Consultant outpatient appointment and elective surgical procedure.

Ramsay Healthcare will provide consultant led services in the following specialties:

- Orthopaedics
- Spinal
- General surgery
- Gynaecology
- Gastroenterology
- Urology
- Cataract surgery

For Staffordshire and Stoke-on-Trent ICB, The Staffordshire ICB Choice and Referral Team will support the referral / transfer of orthopaedic and spinal patients to Ramsay Healthcare as per the agreed pathway with local MSK services (MICATS/ IPOPS and NIMS).

Patients requiring elective T&O surgery must have been referred to and triaged by the MSK service prior to referral to Ramsay Healthcare.

Patients meeting criteria for elective surgery, who are considered non-complex and low risk will have the option to choose Ramsay Healthcare as their preferred hospital via e-RS.

For Staffordshire and Stoke-on-Trent ICB, The Staffordshire ICB Choice and Referral Team will support the referral of cataract patients to Ramsay Healthcare as per the agreed pathway. Referrals should not be received directly from Community Optometrists.

Patients may also be identified by local acute trusts as long waiters and may be transferred to Ramsay Healthcare with patient consent, any inter provider transfers however must be mutually agreed between all parties (including the ICB) prior to transferring any patients

Where a patient requires a secondary procedure (not indicated in the original referral) approval must be sought from the ICB

The contract supports equity of access to elective care across the system. This service will provide this by ensuring:

1. Clinical prioritisation: ensure the order in which patients are seen reflects clinical judgement on need.
    - Clinical Guide to Surgical Prioritisation in the recovery from the Coronavirus Pandemic, Prioritisation – Master 28:01:22 (fssa.org.uk)

2. Managing long waits: targeting support to reduce the number of people waiting a long time.
    - Treatment of long waiters (P4) in date order based on the 18-week breach date.

Pathways

The Provider should adhere to best practice pathways and make reference to GIRFT Workstreams - Getting It Right First Time - GIRFT

Service offer

The Provider shall provide Services to inpatients over 7 days a week, 24 hours a day over a 52 week year including bank holidays. .

Outpatient appointments will be provided at the following times throughout the year (recognising that this may vary slightly in line with consultant availability):

Monday to Friday 08:00 to 18:00 and Saturday 08:00 to 16:00

However, the opening hours, function and processes of the unit should be sufficiently flexible to accommodate future changes in service volume and specialty groupings which may occur due to changes in case mix and/or potential increase in numbers, as per the standard contract terms.

The service pathway will include:

1. Outpatient and follow-up consultations (this may include telephone / virtual appointments if preferred by the patient and where clinically appropriate)
2. Associated diagnostics (where needed and not already undertaken)
3. Day case interventions
4. Surgical procedures requiring inpatient beds
5. Physiotherapy (and any aids / equipment) to support admission and post-op pathways
6. Occupational therapy to support admission and post-op pathways
7. Aftercare e.g. expected physical, self-care, psychological capabilities prior to discharge, medication, follow up appointments (where clinically required).

The Provider shall:

Ensure the availability of appropriate staff who are able to diagnose, treat and manage patients with urgent or life-threatening conditions at all times, this should include surgical and anaesthetic back-up

Ensure that staff are competent to undertake clinical service delivery and must have their skills updated and reviewed in line with annual appraisal for the duration of the contract

Possess the equipment and emergency drugs to treat life threatening conditions

Adhere to any national or local guidelines relating to clinical safety and medical emergencies

Where the Provider does not currently support critical care services, i.e. HDU and ITU, they shall have a signed contract with an appropriate NHS organisation for access to urgent expert clinical advice and emergency transfer of patients to critical care facilities by the service commencement date.

The Provider will be responsible for the taking and processing of blood samples and will have access to pathology or an arrangement in place with local pathology services.

If medicines are to be prescribed or administered the provider shall seek their own professional advice to ensure compliance to legislation on safe supply, storage and administration of medicines and make appropriate provision to use Patient Group Directions, pre-packs or prescribing within a clinical governance framework. The Provider shall refer to the. Staffordshire and Stoke-on-Trent ICS Formulary

The Provider shall ensure patients have appropriate follow up arrangements e.g. specialist support post discharge, referrals to other general or specialist services such as GP or District Nurse, clear instructions on self-care requirements (inc medication) for a period up to and including fourteen (14) days post discharge.

Follow up appointments will be kept to a minimum and will be offered where clinically appropriate and in line with national and specialty specific guidance. The Provider is expected to implement Patient Initiated Follow Up (PIFU) processes. If no follow ups are requested by the patient after an agreed period, the patient will be discharged from the PIFU pathway.

Post discharge physiotherapy will be delivered in line with NICE guidance and patients, where possible, will be given self-directed therapy.
https://www.nice.org.uk/guidance/ng157/chapter/Recommendations

Recommendations | Joint replacement (primary): hip, knee and shoulder | Guidance | NICE (Section 1.10)

3.5 Population covered

Patients who are registered with:

Staffordshire ICB, formerly:

- NHS North Staffordshire CCG
- NHS Stoke on Trent CCG
- NHS Stafford and Surrounds CCG
- NHS Cannock
- NHS East Staffs
- NHS South East and Seisdon

3.6 Any acceptance and exclusion criteria and thresholds

- Patients must live within the local geography of Staffordshire **AND** and Stoke on Trent ICB

- Patients must be over the age of 18

- Referrals will only be accepted in line with the Provider's directory of service and reference must be made to the Commissioner's Excluded and Restricted Procedure Policy. Details of the latest guidance for individual commissioners are specified on the Staffordshire ICB website. Procedures undertaken, which are outside of these criteria, will not be funded.

- Prior approval shall be sought for all procedures which fall within the Commissioner's policy through the Blueteq software. Any procedure that does not have a Blueteq approval code submitted with the monthly MDS activity data shall not be paid for by the commissioners.

- In the event that a procedure is carried out without meeting the criteria expressly stated and agreed in the Commissioning Policy for Excluded and Restricted Procedures or by fulfilling the requirements of an IFR, the respective Commissioner will not be liable for the cost incurred by the Provider.

The following exclusion criteria will apply:

- Children and young people under the age of 19
- Procedures under general anaesthetic Airway Management Grades– where the physical status of the Referred NHS patient is not ASA1, ASA2 or Stable ASA3 and received an anaesthetic review;
- Where the NHS patient has a Body Mass Index >45 or over 200kg, may not be accepted. Ramsay will adhere to their Medical Admissions Exclusions Criteria (Appendix IV).
- Patients requiring treatment for cancer should be referred directly on to the appropriate cancer pathway
- Treatments as specified in the Commissioners policy on Excluded and Restricted Procedures e.g. Facet joint injections, Trigger point injections, Intradiscal therapy and Prolotherapy will not be funded for non-specific low back pain (please note this list is not exhaustive and the Provider should refer to the most up-to-date ERP policy on the ICB website)
- Diagnostic arthroscopy will not be routinely funded (see ICB ERP policy for further detail)
- Routine lumbar spine x-ray or MRI will not be funded for non-specific low back pain
- Patients with an unstable mental condition
- Patients being detained by Her Majesty's Prison Service where security issues are deemed not to be appropriate

Ramsay Healthcare should ensure that procedures are carried out in line with recognised best practice guidance and that all other forms of non-surgical treatment have been considered / tried first.

Local clinical policies should make reference to the Academy of Medical Royal Colleges Evidence based Interventions Programme.

The Evidence-based Interventions programme aims to reduce the number of inappropriate interventions carried out by clinicians in the healthcare system and to improve the quality of care patients receive.

Evidence Based Interventions A-Z

3.7 Interdependence with other services/providers

- General Practitioners (GPs)

- ICB Choice and Referral Team – support referral and transfer of orthopaedic / spinal patients clinical information
- Acute Trusts
- Primary and Community services –community physiotherapy, district nursing, OTs
- Social services
- NHS patient transport services
- Emergency transport / ambulance services
- Patient Advocacy and Liaison Service (PALS)
- Independent and voluntary sector as appropriate
- Clinical and other networks

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

The Service Provider must deliver services in accordance with current best practice in health care and the range of policy and clinical / operational practice guidance relating to these services, complying in all respects with the standards and recommendations. This includes but is not limited to:

NHS Policies

- NHS Long Term Plan (2019)
- NHS 2022/23 priorities and operational planning guidance
- NHS White Paper 2021
- The Francis and Keogh Reports
- NHS Constitution
- Relevant NICE Guidance
- NHSE Delivery Plan for tackling the Covid -19 backlog of elective care , Feb 2022

Clinical Standards and operational practice

In providing services to NHS patients Providers must at all time operate in accordance with Good Clinical Practice and Good Healthcare Practice including relevant NICE guidelines and guidelines from the Royal Colleges.

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

- Federation of Specialty Surgical Associations, Clinical Guide to Surgical Prioritisation in the recovery from the Coronavirus Pandemic, COVID-19 documents - FSSA

- Evidence Based interventions for Clinicians; Clinicians - aomrcebi

- UKHSA review into IPC guidance - Recommendations for changes to COVID-19 infection prevention and control (IPC) advice to help ease pressure on the NHS
  UKHSA review into IPC guidance - GOV.UK (www.gov.uk)

  https://cpoc.org.uk/guidelines-resources-guidelines/national-safety-standards-invasive-procedures-natssips

- Correct Site Surgery, National Patient Safety Agency & The Royal College of Surgeons (2005)

- NICE, Venous Thromboembolism: Reducing the Risk: Clinical Guideline 92: NICE 2010

- NHS England » Guide to implementing patient initiated follow-up (PIFU) in adult trauma and orthopaedic secondary care pathways

- Recommendations | Routine preoperative tests for elective surgery | Guidance | NICE

- National-Day-Surgery-Delivery-Pack_Sept2020_final.pdf (gettingitrightfirsttime.co.uk)

NB: This list is not exhaustive and the Provider is contractually obligated to review evidence base on a continual basis to ensure compliance with Good Clinical Practice.

4.3 Applicable local standards

- Ramsay Healthcare clinical policies – see schedule 2G for further detail

5. Applicable quality requirements and CQUIN goals

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

5.2 Applicable CQUIN goals (See Schedule 3E)

6. Location of Provider Premises

6.1 The Provider's Premises are located at:

Rowley Hall Hospital
Rowley Park

Stafford
ST17 9AQ

and

Beacon Park Hospital
Brereton Way
Stafford
ST18 0XF

7. Individual Service User Placement

Not applicable

8. Applicable Personalised Care Requirements

8.1 Applicable requirements, by reference to Schedule 2M where appropriate

Service Specification No.	Ramsay Healthcare 02
Service	Cataract Surgery
Commissioner Lead	
Provider Lead	Hospital Director
Period	Last signature date to 31 March 2027
Date of Review	December 2024

1. Population Needs

1.2 National/local context and evidence base

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

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

Early cataract symptoms may be possible to manage with more frequent changes in glasses. but cataract surgery is currently the only effective definitive treatment to improve or maintain vision beyond the early stage. Once cataracts start interfering with daily activities or reducing the quality of life, surgery is usually recommended. It

is estimated that around 10 million cataract operations are performed around the world each year of which over 400,000 are performed in England. Locally last year there were c8,000 procedures performed. This makes this the most common surgical procedure undertaken in England. The operation is very cost effective with a high success rate and very low morbidity and mortality.

NICE guidance demonstrates it is more cost effective to provide cataract surgery at the point of patient need than to delay.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	
Domain 2	**Enhancing quality of life for people with long-term conditions**	✓
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	
Domain 4	**Ensuring people have a positive experience of care**	✓
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	✓

2.2 Local defined outcomes

The following outcomes will be monitored through the Local Quality Requirements Schedule of the contract:

- Actively manage the demand for services ensuring:
  - 100% of patients shall be triaged by the service
  - 92% of patients shall be seen and treated In accordance with 18 weeks RTT National Operational Standard ((E.B.3) and 6 week diagnostic standard ((E.B.4)where applicable to relevant diagnostics).
- To ensure patients report positive outcomes and would recommend a family member or friend to the provider.
- Patients to report an improvement of the following clinical outcomes, post-surgery:
  - high contrast acuity (e.g.Snellen),
  - contrast sensitivity,
  - glare disability,
  - visual field
  - colour vision
- To ensure pathways with community optometrists are seamless and integrated
- To provide regular clinical feedback and training to referring clinicians
- To offer high quality advice and guidance to patients and referring clinicians
- To increase productivity through theatres from a baseline of on average 5 cataract procedures per 4 hour session to on average 7.

3. Scope

3.1 Aims and objectives of service

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

The Provider will:

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

The key objectives of the service are:

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

3.2 Service description/care pathway

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

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

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

HRG List of agreed procedures:

BZ33Z - Minor, Cataract or Lens Procedures
BZ34C - Phacoemulsification Cataract Extraction and Lens Implant, with CC Score 0-1
BZ34B - Phacoemulsification Cataract Extraction and Lens Implant, with CC Score 2-3ac
BZ34A - Phacoemulsification Cataract Extraction and Lens Implant, with CC Score 4+
BZ32A - Intermediate, Cataract or Lens Procedures, with CC Score 2+
BZ32B - Intermediate, Cataract or Lens Procedures, with CC Score 0-1
BZ30B - Complex, Cataract or Lens Procedures, with CC Score 0-1
BZ30A - Complex, Cataract or Lens Procedures, with CC Score 2+
BZ31B - Very Major, Cataract or Lens Procedures, with CC Score 0-1
BZ31A - Very Major, Cataract or Lens Procedures, with CC Score 2+

3.2.1 Preoperative provider assessment

The provider must only accept referrals that have been through the Community Cataract Refinement Service, any direct referral from any source that has not been through this service must be rejected back to the source of the referral with an explanation stating the appropriate pathway.
The Provider must offer a one-stop assessment where possible, and Service Users wishing to proceed with cataract surgery should not have to attend multiple pre-operative face to face assessments, where sedation or a general anaesthetic (GA) is not required. This should incorporate essential elements including the eye examination, biometry and intra-ocular lens (IOL) selection, consent for one or both eyes, and any pre-op anaesthetic or medical health assessment that has not already been completed remotely e.g. blood pressure check. Procedure specific consent form and standardised pre- & post-operative information should be used, but needs to be supplemented with details for the Service User's specific situation. This is particularly the case for those with higher complexity e.g. glaucoma, narrow angle, tamsulosin-use and pseudoexfoliation. Service Users should be informed about the possibility that surgical training may take place.

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

3.2.2 Fitness for surgery

Management of comorbidities is as follows:

Ocular co-morbidities:

1. Where the patient has a clinically stable ocular condition under management (e.g. glaucoma, treated diabetic retinopathy) the Provider must contact the managing ophthalmologist for that condition that
    - the condition is stable,
    - surgery can go ahead without compromising the service user clinical outcome,
    - they can exclude any requirements for extra procedures which might mean surgery is only suitable for the managing ophthalmologist for that condition to undertake,
    - or to arrange follow up for their co-morbid eye condition.
2. Where the patient has uncontrolled or clinically unstable ocular conditions, the Provider must exclude the patient from surgery until the patient's managing NHS or IS ophthalmologist has treated, stabilised and confirmed that surgery is safe to proceed.

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

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

Resuscitation, Transfer Policy in Case of Medical or Clinical Emergency

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

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

For ocular intraoperative complications:
The provider must manage ocular intraoperative complications prior to resolution by the Provider. Most intraoperative complications will be addressed during surgery and any requirement for postoperative management, review or further urgent surgery including vitreoretinal intervention (e.g. dropped nucleus) should be provided by the Provider at the same or alternative nearby site, and arranged with the patient on the day of surgery. If this cannot be provided by the Provider, there must be specific clinical threshold criteria for transfer of patients in an ocular emergency from the provider to secondary care with

emergency arrangements and any resource allocation to be agreed with an SLA with any applicable local NHS trusts.

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

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

The provider shall ensure patients who have had uncomplicated surgery are referred for a post operative assessment to an accredited Optometry practice as part of the commissioned Integrated cataract service in Staffordshire and Stoke on Trent ICB footprint.

Providers will discharge patients in line with the Commissioners agreed post-operative cataract pathways for a post operative cataract assessment with primary care optometrist with return of data. Follow ups should be minimal (expect less than 15% of people will have a follow up appointment, as per GIRFT Recommendations).

3.2.3 Postoperative Complications

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

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

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

3.3 Population covered

1. The age range for the service is for adults only age 18+ and patients must be registered with a GP within Staffordshire and Stoke on Trent ICB.

3.4 Any acceptance and exclusion criteria and thresholds

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

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

3.4.1 Exclusion criteria

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

Early dementia or mild mental capacity issues where cooperation for local anaesthetic is possible with support should not be exclusions. Implantable cardiac defibrillators, unless surgical procedure uses diathermy (which cataract surgery does not), should not be exclusions: Revised-guideline-CIED-and-surgery-Feb-19.pdf

3.4.2 Referral sources

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

i. **Routine referral from the primary care optometrist that provides the Cataract Refinement Service only.**

All patients that are suspected to require a cataract operation will undergo a pre cataract assessment by a primary care accredited Optometrist as part of the commissioned Integrated Cataract Service. Based on the outcome of the assessment, the Optometrist may undertake a shared decision making process with the patient and the above referral criteria to assist the patient to agree their pathway provider of choice. It is envisaged that the majority of patients will enter the pathway this way.

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

Although the GP can choose to refer directly into the pathway, the provider should not accept referrals unless they have had pre cataract assessment by accredited Optometrists as part of the commissioned Integrated Cataract Service.

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

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

For the avoidance of doubt all referrals will be sent via the Choice and Referral Centre only.

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

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

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

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

3.5 Interdependence with other services/providers

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

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

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

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

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

The Royal College of Ophthalmologists

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

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

HEE [link to the HEE training guide needed]

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

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

4.3 Applicable local standards

4.4 Applicable recruitment a standards

5. Applicable quality requirements and CQUIN goals

N/A

6. Location of Provider Premises

6.1 To be agreed with the commissioner

7. Individual Service User Placement

N/A

8. Applicable Personalised Care Requirements

8.1 Applicable requirements, by reference to Schedule 2M where appropriate