A. Service Specification

Service Specification No.	
Service	**Cataract surgery**
Commissioner Lead	
Provider Lead	
Period	**October 2022 – September 2024**
Date of Review	**October 2023**

1. Population Needs

1.1 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.

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

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.

3.2.5 Training

The Provider must offer surgical training to ophthalmic doctors in training (DiT) unless they provide less than 50 cataract cases per year, to standards agreed with the RCOphth as follows, and with a process for agreeing requirements with the local Deanery:

1) The Provider must agree to take a proportionate number of trainees at different levels from the Deanery.

2) The Provider must achieve GMC recognition for training at the service centre, through the Postgraduate Dean.

3) Supervisors must be recognized, up to date, Clinical Supervisors. All trainees will already have an Educational Supervisor at their trust. As in NHS settings case selection and levels of supervision must be tailored to meet trainee needs.

4) The Provider must agree the number of trainees and cases needed with the Deanery (usually the Head of School or Training Programme Director). A phased increase from minimum 4% in the first year to 11% whole cases is expected for all providers of NHS-funded cataract surgery, unless the Deanery advises this is not required in certain units. Note this is a range and actual numbers **per provider** needed can be higher or lower dependent on local need. In order to achieve the minimum 11% and their overall training objectives, trainees will need to be involved at least in part of the case and observing cases and lists in significantly more than 11% of cases and lists. The expectation is that by the end of the 2 years the **minimum** equivalent of 11% will be achieved by all providers.

5) The Provider must ensure that the centre has appropriate equipment to provide supervision e.g. teaching arm for microscope, ability to record and review surgery

6) The Provider must provide regular feedback to the Educational Supervisor (frequency to be locally agreed with Deanery and may be trainee dependent).

7) Period of training at the centre must be agreed between the Provider and Deanery, with facilitation provided by head of school/training director and hospital site.

9) Ophthalmologists in training should be able to facilitate all the curriculum requirements for cataract surgery. If required, they should be facilitated to gain experience in pre-operative assessment of patients in units in which they operate. Likewise, where appropriate, they should be able to see some of their post-operative cases; for example, where patients not automatically discharged to community optometrists such as those with serious ocular co-morbidities and if collecting outcomes for their mandatory consecutive cataract surgery audit. They must be able to review cases with intra-operative complications). Access to pre- and post-cataract surgery visual and refractive outcomes for their performed cases must be available e.g. via NOD submission.

10) The Provider must provide training in line with relevant guidelines. The training placement should follow the guidelines developed by HEE https://www.hee.nhs.uk/our-work/doctors-training/guidance-placement-doctors-training-independent-sector, and new RCOphth guidance on how to provide cataract surgery training in high volume lists can be found here. (https://www.rcophth.ac.uk/wp-content/uploads/2021/09/Cataract-Hubs-and-High-Flow-Cataract-Lists.pdf). NHS indemnity for the trainee should already be in place and Deaneries should confirm this.

11) Simulation facilities and supervised time in simulation is to support trainees. All Providers must have access to this form of training for their trainees in their site or in collaboration with their local trusts.

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 LA 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-Fe

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.

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 commisioner

7. Individual Service User Placement

N/A

8. Applicable Personalised Care Requirements

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

Appendix 1

Ophthalmology/ Eye Care:
High Flow **All Complexity** Cataract Surgery Pathway

High Volume / Low Complexity (HVLC) Cataract Pathway

Prehospital	Hospital					Post Hospital
Referral	Patient selection & Pre-op assessment	Booking/ listing	Admission	Surgery	Post Operative	Discharge & follow-up

Referral

- Proven or suspected cataract
- Optometry First: Optometrist direct referral (inform GP, obtain medical history): discuss cataracts and option of surgery if symptomatic. Standardised shared decision making aid to be used with all patients
- +/- Cataract referral refinement: Enhanced/dilated assessment Surgical risk factor identification and general health questions Verbal +/- video information about cataract/surgery, provide copy of standard consent form and leaflet
- Provider to send agreed leaflet on shared decision making / cataract surgery if not already provided
  - (Patients on waiting list from other providers (locally agreed risk assessment / suitability agreed in advance) → Provider to send agreed leaflet)
- Provider phone call to patient to discuss surgery & ensure wish to proceed +/- phone or virtual electronic pre-op assessment
- Offer appointment in one stop pre-op assessment clinic
- Further information sent to patient about cataract surgery with copy of consent form - RNIB leaflet or equivalent to be used if not already provided

Patient selection & Pre-op assessment

- One stop pre-op assessment clinic
- Attendance at hospital for biometry, pre-op assessment; low risk patients may be non-medically led; all high risk patients see ophthalmologist. Prepare both eyes if patient will need bilateral surgery
- Record risk stratification of patient's / cataract complexity. Offer immediate bilateral sequential cataract surgery (ISBCS) if appropriate
- Advise follow-up plan eg with primary care optometrist if routine. Subspecialist clinic (eg for co-existent glaucoma) adjust follow up date as needed. Standard consent form +/- supplemental information tailored to any complexities given & signed/take away to sign. IOL chosen & recorded
- All systemic issues sorted out before day of op, local protocol in line with GIRFT guidance
- Give dates for Covid-19 swab (if required) and surgery. Date both eyes if bilateral sequential surgery unless ocular complexity requires F2F post op visit prior to 2nd surgery listing
- Give drops to patient with agreed instructions on instilling drops at least 1 hour before procedure. Identify patients who cannot self/carer dilate to arrive earlier on the day. Select likely post-operative drop regime (standard, high risk maculopathy, high risk uveitis) and consider generating prescription

Booking/ listing

- List patient for surgery
- Default to daycase LA & training. Identify patients requiring list with extra support
  - ≥8 LA routine cataracts per 4hr list if trainee performing whole cases, less if GA/complex cases (1)
  - ≥10 LA routine cataracts per 4hr list, modular training or experienced trainee whole cases
- Covid-19 screening results obtained if required
- Phone reminder to patient of pre-op drop regime / confirm attendance 2-3 days prior to surgery

Admission

- Day of surgery
- LA patient attends hospital ≤ 30 minutes prior to surgery with staggered arrival times (linked to pre-dilation requirements); 45-60 minutes if needs hospital dilating drops/pellet
- Consider patient wait away from unit (e.g. in car) and be paged to attend when needed to arrive in surgical hub
- Lateral flow test if not PCR swabbed
- +/- Single member of staff "primary nurse" to meet, admit, and follow patient through whole surgery journey
- Trained nurse confirms consent
- Operation site marked by trained nurse
- Patient to meet member of surgical team prior to surgery without disruption to theatre flow

Surgery

- Surgery
- 5 Steps to Safer Surgery Team Brief prior to starting list Patient sent for
- Patient taken to theatre-adjacent area or anaesthetic room by day care staff and positioned WHO Sign-in: 2 members of staff Anaesthetic drops and iodine instilled
- WHO Time Out Scrub / theatre team trained to prep, drape, insert speculum
- Patient has cataract surgery (20 minutes – 'surgical time') Nurse able to pre-complete op-note (2)
- WHO Sign Out Patient taken back to discharge area by daycase staff
- Team Debrief at end of list

Post Operative

- Post Operation
- Criteria led discharge with pre-prepared agreed drop and advice pack
- Agreed pathway and patient instructions in the event that patient has concerns
- LA patient in hub for 60 minutes on average

Discharge & follow-up

- Discharge
- Routine patients: Discharge to sight test with optometry data return; urgent or CUES pathway return if required. +/- 1-2 day hospital visit eg minor complications or IOP check
- Complex patients or serious unstable ocular co-morbidity: Optometrist in primary care commissioned follow-up OR HCP led hospital appointment OR consultant led hospital appointment
- If fellow eye needs surgery, patient offered surgical date without further clinic review unless already has date or requires F2F in addition to primary care optometrist, as guided by ocular complexity
- Process to ensure NOD outcome data returned to provider from optometry
- Agreement with local units to feedback any post-op complications if seen elsewhere

Notes:

1. All lists can be training lists. Highest flow lists - full cases performed by trainee surgeons able to complete a standard case in < 20 minutes, otherwise modular training to focus on specific skills. Reduced flow if trainee surgeons doing whole cases but not yet able to complete standard case in <20mins. It is the expectation that all providers of NHS commissioned cataract surgery will train.
2. In a case of 'in surgery' posterior capsular rupture avoid delaying flow of list / causing cancellations. Consider closing with suture after limited anterior vitrectomy and to refer to VR with availability to operate within 24hrs (agreed pathway).

January 2022 v2.1