**Ophthalmology: Support document for commissioners
through CCGs, STPs and regional reconfigurations**

**Appendix 2**

What are the important principles when commissioning networks of ophthalmic care across traditional boundaries – from CCG to STP?

* Involve *all* stakeholders in commissioning and establishing a network, working in partnership with a range of stakeholders, including service users and carers, community optometry services and Local Optical Committees, general practitioners, health and wellbeing boards, the hospital eye service, community pharmacy services, established local networks, social care, rehabilitation officers for the visually impaired, voluntary organisations, and adjacent clinical commissioning groups. Ideally joint ongoing and regular meetings on safety and operational issues should occur following establishment of any network
* Consideration and planning are required to ensure that key clinical stakeholders and patient representatives can be included in stakeholder meetings, including provision of dedicated resourced time for lead clinicians, and scheduling meetings so that cancellation of clinical care is required without appropriate notice
* Commissioners should be mindful of ensuring access and suitability for vulnerable or hard to reach groups, including those with special needs. Vulnerable individuals, such as people in long term care and people with learning difficulties, are at increased risk of sight loss. Care should be suitable for, and make appropriate adjustments for, the requirement of groups with special needs such as the visually impaired and those with dementia
* Organisations should use nationally recommended guidance to assess their current performance in *all* sites and care setting against evidence-based measures of best practice, and identify priorities for improvement; in particular for ophthalmology this includes Royal College of Ophthalmologists and College of Optometrists guidance and quality standards, NICE guidance for ophthalmic conditions, CQC requirements
* All providers should use evidence based guidelines, locally adapted from national guidance where available, and agreed by all parties. There should be specific protocols governing ophthalmic care which has been traditionally “medical” being delivered by appropriately trained allied health professionals
* Named clinical governance leads or contacts should be identified for all providers /settings and one overall person should be the nominated lead with overall responsibility to lead and oversee clinical governance. There should be similar expectations for clinical governance engagement and performance, adapted to be appropriate for each provider and settings
* For incidents (particularly those with moderate or severe harm), Serious Incidents and Never Events there should be across the network clear reporting structures, clear methods for joint investigation where appropriate and methods for sharing lessons learnt to network staff. The same is required for complaints and claims structures
* There should be clear methods for routinely sharing patient and clinical information to ensure all relevant documentation is available at each clinical encounter, including clinical notes and results of specialist investigations, to create seamless pathways and joined up comprehensive care; ideally this will be via secure electronic systems with role based access, but may involve paper-based systems. Paperwork shared across providers should be agreed, simple and clear
* There should be clear and agreed out of hours, urgent and emergency care for all patients and patients must be informed, including in writing, of the routes and contact numbers no matter which site or provider they are currently being cared for. Emergency care should be supported with appropriate contracts and agreements and not assumed to be provided without agreement by the larger hospital units nor should individual units withdraw unilaterally from previous emergency provision without discussion and agreement
* Arrangements for experience, training, accreditation and CPD need to be agreed so that allied health professionals can access and maintain the requisite training for providing ophthalmic care, and these should follow the recommendations of national guidance including NICE, and Royal College of Ophthalmologists, the College of Optometrists and the joint College Competency Frameworks. Staff should have documented sign off against the requirements of these documents which should be reviewed for all staff at least annually. There should be a clear performance management structure so that staff who are not performing appropriately can be proactively identified, managed and supported.
* KPIs should be realistic, meaningful and cover not only efficiency and cost effectiveness across the whole network but also patient experience and key areas of quality and safety pertinent to ophthalmology such as delays to recommended safe timings of follow up, clinical audit for key clinical outcomes, assessment to adherence for national ophthalmic guidance, false positive and false negative rates, rates of inappropriate referrals etc. Commissioners should ensure that patient focused mechanisms are in place to track appointments, which is of particular importance where integrated services straddle the hospital-community interface. Commissioners should also ensure that patients with clinical priority or at high risk are clearly identifiable and if their appointment is cancelled, missed or delayed that measures are in place to ensure that their appointment takes place within an appropriate time frame. There should be clear measures for patient experience and satisfaction for the network and all sites, and learning and actions arising from these disseminated and implemented across the network
* For all agreements and contracts, there should be appropriate and transparent arrangements, declarations and management of conflicts of interest. There should be agreed time points and systems for re-assessment and reconsideration of arrangements. Systems and arrangements which have been implemented elsewhere should be assessed and should not be implemented without change and learning where there is evidence of failure or poor performance elsewhere