CLINICAL COUNCIL

FOR EYE HEALTH COMMISSIONING

Community Eye Service Framework

for the management and monitoring of less complex acute conditions and long term conditions at low risk of deterioration

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Contents

1 Purpose

This Community Eye Service Framework applies to the commissioning and provision of services in England. It was previously known as the Community Ophthalmology Framework (2015). The title change has been made for consistency and alignment with the Clinical Council for Eye Health Commissioning (CCEHC) Frameworks for Primary Eye Care Services and Low Vision Habilitation and Rehabilitation Services, and those provided by Hospital Eye Services.

The Community Eye Service Framework forms part of the Clinical Council for Eye Health Commissioning (CCEHC)'s wider ***S****ystems and* ***A****ssurance* ***F****ramework for* ***E****ye Health (SAFE)*[1] www.ccehc.org.uk.

It is published by the CCEHC and is endorsed by its members who include all the relevant professional bodies and stakeholders in eye health and care in England.

The CCEHC is recognised by NHS England/NHS Improvement for guidance for Integrated Care Systems (ICSs), Integrated Care Providers (ICPs),Clinical Commissioning Groups (CCGs), Primary Care Networks (PCNs) and Primary Care Home models, in planning, commissioning and providing eye health and care services in order to deliver the ambitions of the NHS Long term Plan (NHS LTP)[2] for eye health.

2 Context for Community Eye Services

Medicine and healthcare are changing rapidly. The drivers and challenges for these changes are especially evident for eye health and care:

- advances in technology and therapeutic interventions which mean the NHS can now prevent, identify early and treat more (eye) pathologies than ever before.[3,4,5,6,7,8]
- the development of multidisciplinary teams, including some upskilling of non-medical clinicians to perform roles that could previously only be carried out by doctors.[9,10]
- the development of new models of care for integrated service provision.
- the widening IT connectivity across the NHS – in particular for eye health between hospitals and primary optical practices enabling e-referral, image/scan transfer, and advice and guidance.
- growing needs of an ageing population and demand for health care that is exceeding capacity to provide it[11] - which is acutely evident for hospital eye services.[12]
- managing inconsistency, duplication and unwarranted variations in service provision and outcome.

The NHS Long Term Plan (NHS LTP)[2] sets out ambitions to respond to these drivers and challenges through different ways of working and harnessing new technologies and interventions to improve care and outcomes for patients and population health. Of particular relevance to eye health, the NHS LTP calls for the redesign of outpatient services and the development of Integrated Care Systems (ICSs) as the preferred model for planning, commissioning and the delivery of health and care in England.

To support these processes the CCEHC has set out priorities for implementing the NHS LTP for eye health.[13] These are:

- System improvement
- Service improvement
- Digitisation and IT connectivity
- Prevention and inequalities
- Workforce

All these are underpinned by the CCEHC's ***S**ystem and **A**ssurance **F**ramework for **E**ye-health* (SAFE)[1] which provides a systems-based approach to support transformational change at an Integrated Care System (or equivalent population) level.

A ***SAFE service system***[1] delivers a whole pathway of care providing a range and continuum of services that are based on risk stratification of a patient's condition and the competencies of the professionals providing care; the delivery of which may involve multiple providers and settings (***Figure 1. SAFE overview***). SAFE reflects the flow of patients along the length of their pathway through the service system. This whole pathway approach for the planning, commissioning and provision of services to deliver a service system addresses the fragmentation that currently exists, the need to improve patient flows through the system, and facilitates service integration and coordination.

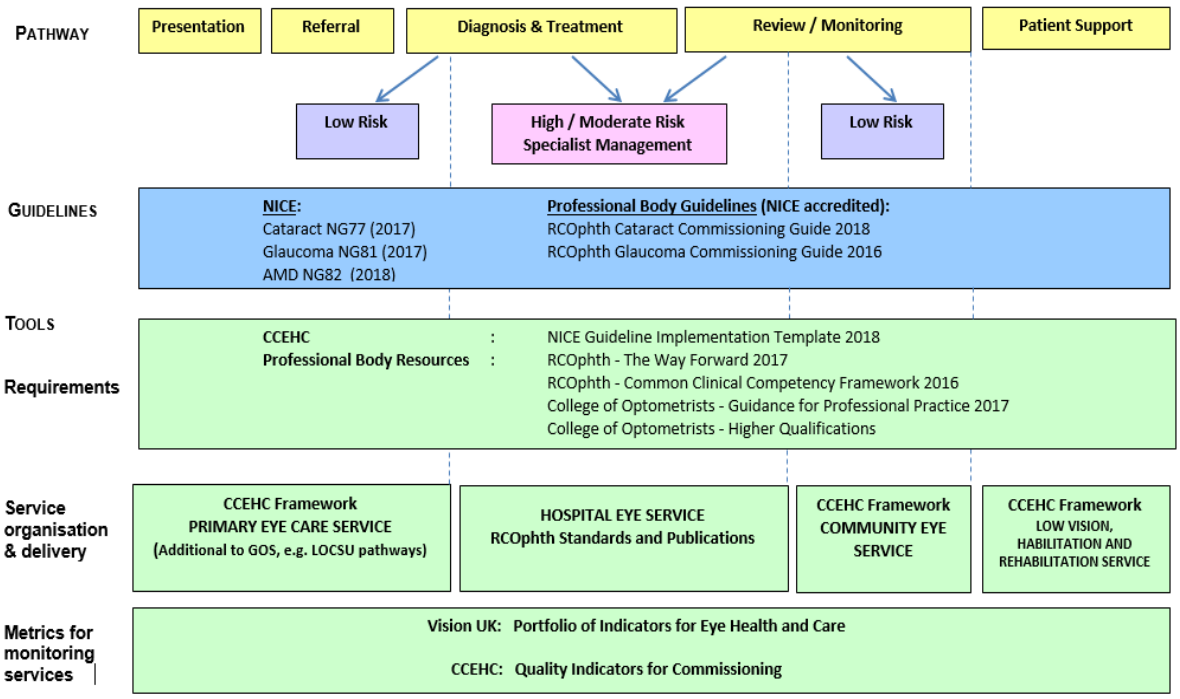

Figure 1. SAFE : System and Assurance Framework for Eye-health – Overview
www.ccehc.org.uk

As shown in ***Figure 1***, Community Eye Services are integral to a SAFE Service System. This Community Eye Service Framework is designed to operate alongside the CCEHC's Primary Eye Care Framework[14] and the CCEHC's Low Vision, Habilitation and Rehabilitation Framework[15]**.**

The distinction between "*community eye (previously ophthalmology) services*" and "*primary eye care services*" is frequently misunderstood by commissioners, providers, clinicians and the public. The terms are used loosely and interchangeably making it difficult to assess the need for and the impact of introducing these services. This Framework (together with other publications by the CCEHC [1, 14, 15]) provides the clarification needed so that there is a better understanding of the type of service being delivered and its expected benefits.

3 The Scope of a Community Eye Service

A Community Eye Service is distinct from the General Ophthalmic Service (GOS), primary and secondary eye care services. It is important not to consider a community eye service in isolation. There should be opportunities to explore whether such services should be networked and co-ordinated – or even co-located - with other community or primary care services to provide more patient-centred care for those with multi-morbidity

A Community Eye Service is a locally commissioned outpatient service for the assessment, management and monitoring of patients with less complex eye conditions or conditions at low risk of deterioration that do not require hospital intervention. The service may operate on a referral basis from primary optical practices, GPs, other community-based health professionals and secondary care. Depending on access in the local area, it might also be appropriate to accept self-referrals which exceed the criteria for a primary eye care service.

The descriptor 'community' does not imply any particular location**.** ***The key is that the service*** should be **delivered by a *community of multidisciplinary eye health professionals in the most appropriate settings**** to provide accessible, timely, high quality network of care to patients across traditional health sector boundaries.

***** *This may include optical practices, hospital-led sites, health centres, or other alternative settings*

A Community Eye Service offers:

- the ability and capacity to make definitive diagnoses and to manage and treat most cases referred into it for both adults and children
- a monitoring service for patients at low risk of their condition deteriorating (e.g. age-related macular degeneration[16]) or risk of their condition deteriorating asymptomatically (e.g. ocular hypertension[17])
- an access point for patients with recurrent symptomatic disease
- access to virtual clinics or telemedicine

Conditions typically diagnosed and managed in a Community Eye Service include:

- anterior segment conditions such as conjunctival or corneal conditions, anterior uveitis and lid conditions
- glaucoma within the context of NICE guidelines[17]
- retinal disease management (such as OCT surveillance of diabetic maculopathy)
- retinal conditions which need investigation or monitoring outside the screening service
- children with amblyopia or strabismus
- adults requiring orthoptic therapy e.g. convergence insufficiency

4 Distinction from other services provided along a system pathway

A Primary Eye Care Service is a locally commissioned service ideally at ICS level. It is additional to, and funded separately from the national NHS sight-testing and preliminary case finding services (General Ophthalmic Services). NHS primary eye care services may be accessed directly for an eye condition or vision problem, following an NHS sight test, or by self-referral following a private eye examination.

Primary eye care services are based on the same infrastructure of primary optical practices using the same staff and facilities (albeit in different configurations) to provide the service.

A Primary Eye Care Service provides first contact care which typically includes the ability to:

- manage the needs of "walk ins"; e.g. patients presenting with a red eye, foreign object in eye.
- assess and manage a range of common, low-risk eye conditions (e.g. such as conjunctivitis, blepharitis).
- enhance case-finding i.e. conduct supplementary checks to confirm abnormal test results (detected by a NHS sight test / eye examination); e.g. repeat fields and repeat pressure as outlined in NICE Glaucoma Guideline NG81[17], ocular imaging).
- provide routine 'work ups'; e.g.
    - further refine the decision to refer where risks and benefits are discussed with the patient e.g. prior to referral for cataract surgery (NICE NG77. Cataract Guideline 2017).[18]
    - post-operative cataract assessment.[18]
- in certain circumstances, provide a triage function to ensure appropriateness of referral.

A primary eye care service delivers enhanced decision-making services which support better referral decisions, and thereby provide a means for improving the quality and appropriateness of referral for specialist care.

A Secondary Eye Care Service - often known as the ***Hospital Eye Service (HES)*** – is a locally commissioned hospital-based specialist services providing care for patients with conditions which cannot be treated and managed in primary care (general medical or optical practice), or in primary eye care and community eye services. It operates on a

referral basis from primary optical practices, GPs, diabetic eye screening, and (within hospitals) from A&E and eye emergency services.

The standards and guidance for good practice, service provision, and quality for the HES are provided by the Royal College of Ophthalmologists[19].

Before commissioning a Community Eye Service, agreement should be reached between lead clinicians, provider organisations and commissioners, based on clinical risk stratification about which conditions should be managed within primary eye care and those which should be managed in the HES. It will then be clearer to define the case mix and skills requirement for the Community Eye Service.

5 Aims of a Community Eye Service

The aims of a Community Eye Service are to:

- **i.** deliver timely, accessible, high-quality clinical services, ensuring patient safety, good outcomes and a positive patient experience.
- **ii.** provide care by appropriately skilled professionals who pursue continuing professional development (CPD) to maintain their skills and who work across professional boundaries and in teams as necessary.
- **iii.** support the development of the current and future workforce.
- **iv.** make best use of available resources and skills mix.
- **v.** meet governance and quality assurance standards.
- **vi.** manage referrals and waiting times, to free up capacity for the care of higher risk patients in secondary care.
- **vii.** provide advice, guidance and feedback to GP and optometrist/optical practitioners on their referrals.
- **viii.** provide feedback summaries to patients and sign-post to support services.
- **ix.** use feedback and support from service-users to ensure continuous quality improvement.

6 How Community Eye Services should be commissioned / delivered

The commissioning and delivery of community eye services have historically been fragmented, episodic and parochial with the result that services have suffered from high transaction costs and unwarranted variations in service availability, scope and standards. This has inhibited investment in training and equipment, and commissioners and hospitals have had to cope with a myriad of models rather than a coordinated, support, referral and discharge system. This has not been in the best interests of patients or the wider NHS.

To achieve the benefits in terms of accessible, consistent, timely and efficient care, as well as reducing health service capacity pressures, Community Eye Services need to be commissioned:

- ***at scale*** and at ICS level.
- through ***a collaborative process*** including all those involved in the planning, commissioning and provision of eye health and care services, and patients.
- with a view to ***service integration*** - whilst this Framework may be free standing, it should ideally be implemented alongside Primary Eye Care Services for first contact care[14], Hospital Eye Services[19] and Low Vision, Habilitation and RehabilitationServices[15] (*Figure 1: SAFE Overview*) to achieve optimal outcomes and use of NHS resources.

7 Key Steps for Implementation

Collaborative working to implement a Community Eye Service will involve the following:

i. *Scoping the service need and review of current services, pathways and available workforce*

- mapping and reviewing how care is currently delivered, where and by whom?
- mapping and review of current care pathways
- assessment of the level of activity/demand that needs to be delivered. This should also include an assessment of delays to follow up outpatient appointments in the hospital eye service.[19]
- identification of less complex eye conditions and those at low risk of progression, within the hospital eye service (which will be included in the Community Eye Service specification)
- assurance of ongoing risk stratification within the hospital eye service?[19,20]
- confirmation that there are health professionals ready and willing to take on a wider role, and develop further skills where necessary, to deliver the service
- confirmation that the supporting infra-structure (equipment, IT, estate) is available for service delivery
- consultation with current primary and secondary care providers
- consultation with patients and the public

ii. *Specifying the service*

Based on a review of service need, and taking account of the service scope (as defined above), the Community Eye Service specification should specify what the service covers with indicative volume and cost envelopes, and the metrics for quality assurance and performance of the service. This is so that both commissioners and providers know what they are paying/being paid for, and what they are meant to be delivering, to whom, when, and to what standard.

iii. ***Being clear about roles and collective responsibilities of all those involved in the planning, commissioning and provision of the service,*** which are based on evidence-based guidelines and protocols (ideally applied consistently across the ICS (or equivalent level); for example:

- NICE Guideline NG81: Glaucoma Diagnosis and Management. 2017[17]
- NICE Guideline NG82: Age Related Macular Degeneration. 2018[16]
- SAFE Glaucoma 2018[21]
- SAFE Age-related Macular Degeneration 2018[22]
- SAFE Emergency and Urgent Care 2018[23]

iv. ***Engaging a Multi-disciplinary Team*** which may include:

- Ophthalmologists
- Optometrists
- Orthoptists
- Ophthalmic nurses
- Dispensing / contact lens opticians
- General Practitioners (GPs) with an interest in ophthalmology
- Technicians / healthcare assistants
- Eye clinic liaison officers (ELCOs)
- Pharmacists

Service management and administrative support are also required. The composition of the multi-disciplinary team will depend on the availability of health professionals with relevant skills to work within the service during the period of the contract. The roles of individual health professionals will depend on their professional registration, scope of practice, demonstrated competencies, and the model of service. It is essential to provide support for health professionals to work under supervision while they develop further skills.

v. ***Specifying the professional clinical competencies required for service provision***

All healthcare professionals working in community eye services must hold relevant qualifications, or have relevant training or certification for the roles they are to fulfil as, or equivalent to, those specified by the professional bodies. In line with their professional registration, they must also demonstrate maintenance and development of competence through appropriate continuing professional development (CPD).

A list of resources providing information on professional qualifications and competency standards is provided in ***Appendix 1***.

vi. Clinical Leadership and Governance

Clinical Leadership - the service specification should require a Lead Clinician(s) who will take overall responsibility for the quality of patient care and has the competence to make the necessary clinical decisions. This should be a consultant ophthalmologist or clinician with a higher-level qualification e.g. a certificate of completion of training. The lead clinician should ensure appropriate supervision of other staff developing enhanced skills or training for higher qualifications.

Governance - the responsibility for governance and accountability lies with all those involved in commissioning, providing and managing the service. Governance arrangements for the service should span clinical, information, financial and corporate governance. Processes for regular reporting and review across these domains at ICS level should ideally be embedded in the developing infrastructure but can be effected immediately through existing processes e.g. Trust / CCG contract monitoring groups, clinical quality review groups.

vii. Technology

A community eye service should support patient accessibility and make best use of new and emerging technologies such as telemedicine and virtual clinics, where diagnostic tests / assessments are conducted with a view to obtaining a non-face to face senior clinical opinion at a later time.

For example: Virtual clinics are being used to manage glaucoma conditions (low-risk glaucoma, ocular hypertension and glaucoma suspects) and medical retinal conditions (e.g. stable age related macular degeneration (wet), diabetic maculopathy and stable treated proliferative diabetic retinopathy). Virtual clinics may be operated by appropriately trained non-medical practitioners. The delivery of virtual clinics and their setting will be dependent on the availability of the necessary IT infrastructure and staff, the training and support of front-line staff in using the technology, and sharing clinical information and images for direct patient care.

viii. Processes (including reporting, review and feedback) for regular clinical audit, quality assurance and evaluation of the service

Ideally, and for the longer term, these processes should be embedded in the developing infrastructure at ICS level, but can be effected immediately through existing processes for clinical audit, contract monitoring and clinical quality reviews. Service specification should include regular reporting and review of the following:

- Metrics for community eye services (detailed in section 8)
- Agreed measures for :-
    - clinical outcomes
    - patient safety
    - competence of the workforce
    - patient reported outcome and experience
    - patient satisfaction e.g. friends and family test
    - appropriate infra-structure (equipment, premises etc.) for the service.

ix. ***Communications*** – this is an often overlooked element of new services and poor communications can often inhibit service uptake and value for money. As a minimum the launch of the service should be accompanied by pre- and post-launch communication to all relevant hospital staff, GPs, primary optical practices, PALs, PCNs, local representative committees, local patient groups and sight loss charities about the "what, why, who and how" to access the service and what, if any, services the new service replaces.

8 Achieving service integration

This **Community Eye Service Framework** can be used to re-align existing services and to commission and provide consistent, quality-assured care across the ICS (or equivalent level). In doing so, it should clarify the relationship between primary, community and secondary eye care services across the whole system pathway to facilitate integration and avoid duplication.

For example: The package of care provided by a commissioned Community Eye Service will support implementation and delivery of SAFE Service Systems for Glaucoma[21], Age Related Macular Degeneration[22], and Emergency and Urgent Eye Care.[23] These are directly aligned to the NHS LTP[2] priority for re-design of outpatient services and the optimal use of the multidisciplinary team (MDT) across boundaries recommended by NHS England's Elective Care Transformation Programme.[20]

There is potential for existing local providers of primary and secondary care to collaborate to develop and deliver a Community Eye Service. If existing providers are unable to do so, commissioners should consider whether and how external providers might be invited into the local health system to deliver it. However, the starting point should always be the existing NHS providers (HES providers, optical practices etc.) which may provide greater benefits and scope for developing a sustainable workforce and fully integrated pathways within eye service systems over time.

There are various contracting models and a number of options for locations from which Community Eye Services could be delivered depending on local circumstances. The model should be flexible in its use of available premises, providers and workforce, and should avoid becoming a carbon copy of the hospital eye service in another setting as this will not achieve the transformational changes required.

Competitive behaviour and silo-working between providers within the system pathway can lead to clinical risk, delay, inconvenience, confusion and cost. Commissioners should be clear about this and ensure that there is demonstrable, appropriate multidisciplinary working across the existing services, and collaboratively along the length of the wider system pathway.

9 Metrics for Community Eye Services

It should be possible to monitor the effectiveness and assure the quality of the service by applying defined, measurable outcomes and key indicators (KIs). Some evidence-based metrics meeting these criteria are listed below.

(a) for Commissioning

SAFE Quality Indicators for Commissioning[24] - these are a series of statements focusing on the quality of the commissioning process for ensuring that structures and process are in place for safe and effective service provision.

(b) for Service Provision

i. SAFE: Portfolio of Indicators for Eye Health and Care - *Eye-specific indicators*[25]

- ***Indicator 13:*** Has a Monitoring Pathway been commissioned for low risk ocular hypertension (OHT) and suspect chronic open angle glaucoma (COAG)? [17,21,25]
- ***Indicator 14:*** Has a Monitoring Pathway been commissioned for early AMD, late dry AMD, and patients discharged from hospital (secondary care)? [16,22,25]

ii. NICE Quality Standard (QS180) – 2019[26]

- ***Quality Statement 5*:** Reassessment-chronic open angle glaucoma or related conditions.

iii. Additional suggestions

- % of false positive referrals***** from community eye service to the Hospital Eye Service - for urgent eye care, suspect wet AMD, glaucoma.
- % of false positive referrals* from OCT surveillance of diabetic maculopathy to Hospital Eye Service.

***** The denominator is the total number of patients referred from the community eye service for a condition e.g. suspect wet AMD. The numerator will be the number of referrals for that condition that were found not to have it after further diagnostic tests performed in the HES.

- % of all new referrals from these services that were discharged following their first attendance in HES

Rationale for inclusion:

- Evidence-based recommendations (NICE) for AMD[16] and Glaucoma[17] pathways, and the NHS Diabetic Eye Screening Programme[27,28]
- Indicators of quality and effectiveness of community eye service, to identify themes for service improvement; e.g.
    - patient safety
    - feedback to referrers
    - advice and guidance for clinical uncertainties,
    - review and update of protocols for clinical management and referral

10 Equality Impact

Services must comply with the requirements of the Equality Act 2010.

The law requires providers to make reasonable adjustments to accommodate people with disability.

NHS information must be provided in an accessible format**.**

In order to ensure equitable access to and uptake of a community eye service, the following must be taken into account:

- Disability access
- Assisted transport
- Interpreter services
- Personal budgets

Framework Development Group

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Royal College of Nursing	Nicola Dunlop
Royal College of Ophthalmologists / NHS England LEHN	Wojciech Karwatowski
Royal National Institute for Blind People	Helen Lee
College of Optometrists (Secretariat)	Olivier Denève

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References

1. SAFE. CCEHC 2018. www.ccehc.org.uk
2. NHS Long Term Plan 2019. https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/
3. NICE TA 155 2008 https://www.nice.org.uk/Guidance/TA155
4. NICE TA 294 2013 https://www.nice.org.uk/guidance/ta294
5. NICE TA 346 2015 https://www.nice.org.uk/guidance/ta346
6. NICE TA 409 2016 https://www.nice.org.uk/guidance/ta409
7. NICE TA 305 2015 https://www.nice.org.uk/Guidance/TA305
8. NICE TA 486 2017 https://www.nice.org.uk/guidance/ta486
9. Royal College of Ophthalmologists. Ophthalmic Common Clinical Competency Framework 2016. https://www.rcophth.ac.uk/professional-resources/new-common-clinical-competency-framework-to-standardise-competences-for-ophthalmic-non-medical-healthcare-professionals/
10. College of Optometrists Accredited Higher Qualifications. https://www.college-optometrists.org/cpd-and-cet/training-and-qualifications/higher-qualifications.html
11. Telegraph. 26 April 2019. Alarm raised over tripling in cancelled NHS appointments. https://www.telegraph.co.uk/news/2019/04/26/alarm-raised-tripling-cancelled-nhs-appointments/
12. NHS Digital Hospital Episode Statistics. Out-patient attendances by Main Specialty. https://digital.nhs.uk/data-and-information/publications/statistical/hospital-outpatient-activity/hospital-outpatient-activity-2013-14

    https://digital.nhs.uk/data-and-information/publications/statistical/hospital-outpatient-activity/2017-18
13. Priorities for Delivering the NHS Long Term Plan for Eye Health – June 2019. www.ccehc.org.uk

    https://www.college-optometrists.org/the-college/ccehc/planning-commissioning.html
14. CCEHC: Primary Eye Care Services Framework – first contact care 2016 revised 2018. https://www.college-optometrists.org/uploads/assets/8a93d228-ac28-4e6e-98af94c62c0f8442/Primary-Eye-Care-Framework-for-first-contact-care.pdf
15. CCEHC: Low vision, habilitation and rehabilitations services framework 2017 revised 2018. https://www.college-optometrists.org/uploads/assets/2642d67c-96f9-4e12-ab4c402b2df4e15c/Low-vision-habilitation-and-rehabilitation-framework-for-adults-and-children.pdf

16. NICE Guideline NG82: Age Related Macular Degeneration 2018. https://www.nice.org.uk/guidance/ng82

17. NICE Guideline NG81: Glaucoma Diagnosis and Management 2017. https://www.nice.org.uk/guidance/ng81

18. NICE Guideline NG77: Cataracts in adults 2017. https://www.nice.org.uk/guidance/ng77

19. Royal College of Ophthalmologists. Ophthalmic Services Guidance. https://www.rcophth.ac.uk/standards-publications-research/ophthalmic-services-guidance-2/

20. NHS England's Elective Care Transformation Programme: Specialty Transformation for Ophthalmology (2019). https://www.england.nhs.uk/wp-content/uploads/2019/01/ophthalmology-elective-care-handbook-v1.1.pdf

21. SAFE Glaucoma. CCEHC 2018. https://www.college-optometrists.org/uploads/assets/3f3cdfcc-98f7-47a3-bf339c57e88741d5/SAFE-Glaucoma.pdf

22. SAFE Age-Related Macular Degeneration. CCEHC 2018. https://www.college-optometrists.org/uploads/assets/8f341242-0f18-4572-bbb3c6f5b4112df4/SAFE-Age-related-macular-degeneration-AMD.pdf

23. SAFE Emergency and Urgent Care. CCEHC 2018. https://www.college-optometrists.org/uploads/assets/e827d379-9165-4656-9458c83b0e33da79/SAFE-Emergency-and-Urgent-Care.pdf

24. SAFE: Quality Indicators for Commissioning. CCEHC 2018. https://www.college-optometrists.org/uploads/assets/29af6c37-788f-490b-9a371d64146b84e1/SAFE-Quality-Indicators-for-Commissioning.pdf

25. SAFE: Portfolio of Indicators for Eye Health and Care. CCEHC 2018. https://www.college-optometrists.org/the-college/ccehc/safe-systems-assurance-framework-for-eye-health.html

26. NICE Quality Standards: Serious Eye Disorders (QS180). 2019. Quality Statement 5. https://www.nice.org.uk/guidance/qs180/chapter/Quality-statement-5-Reassessment-chronic-open-angle-glaucoma-or-related-conditions

27. NHS public health functions agreement 2019-20. Service specification no.22 NHS Diabetic Eye Screening Programme. July 2019. Publication number – 000019 https://www.england.nhs.uk/wp-content/uploads/2017/04/Service-Specification-No.22-NHS_Diabetic_eye_screening.pdf

28. Public Health England publications. Gateway Number: GW-626. Closer monitoring and treatment of diabetic retinopathy. Update August 2019. https://www.gov.uk/government/publications/diabetic-retinopathy-monitoring-and-treatment/closer-monitoring-and-treatment-of-diabetic-retinopathy

APPENDIX 1

Professional Qualifications and Competency Standards

A. Royal College of Ophthalmologists

Information, guidance and standard to support the science and practice of high-quality ophthalmology

i. **Education and Training (including CPD)**: https://www.rcophth.ac.uk/training/

ii. **Standards and Publications**: https://www.rcophth.ac.uk/standards-publications-research/

iii. **Professional Resources:** https://www.rcophth.ac.uk/professional-resources/

B. College of Optometrists

Professional skills, competencies and standards for high quality optometric practice

i. **Training and Qualifications:** https://www.college-optometrists.org/cpd-and-cet/training-and-qualifications.html

ii. **CPD**: https://www.college-optometrists.org/cpd-and-cet.html

iii. **College accredited higher qualifications:** https://www.college-optometrists.org/cpd-and-cet/training-and-qualifications/higher-qualifications.html

C. Ophthalmic Common Clinical Competency Framework (OCCCF)

This provides standards and guidance for the development of knowledge, skills and competencies for non-medical eye healthcare professionals providing patient care within multi-disciplinary teams in hospital settings. It does not apply to non-medical healthcare professionals with competencies already within their scope of practice or higher qualifications that allow them to manage patients within their extended scope of practice [Biii].

https://www.rcophth.ac.uk/professional-resources/new-common-clinical-competency-framework-to-standardise-competences-for-ophthalmic-non-medical-healthcare-professionals/

The Clinical Council for Eye Health Commissioning (CCEHC)

The Clinical Council for Eye Health Commissioning (CCEHC) is an independent advisory body providing evidence-based national clinical leadership, advice and guidance to policy makers in health, social care and public health, and those commissioning and providing eye health services in England. It is recognised as such through a Memorandum of Understanding with NHS England. The CCEHC's recommendations are provided in the best interest of patients, on the best evidence available and independent of any professional or commercial interests.

As reflected by its membership, the CCEHC represents the major clinical professions, social care, charity and voluntary organisations within the eye health and care sector -

- Association of British Dispensing Opticians
- Association of Directors of Adult Social Services
- British and Irish Orthoptic Society
- College of Optometrists
- Faculty of Public Health
- International Glaucoma Association
- Macular Society
- Optical Confederation (including Local Optical Committee Support Unit)
- Royal College of General Practitioners
- Royal College of Nursing (Ophthalmic Section)
- Royal College of Ophthalmologists
- Royal National Institute of Blind People
- Vision UK