NHS
Rotherham
Clinical Commissioning Group

Procurement template

To be used when commissioning services from GP practices, including provider consortia or organisations in which GPs have a financial interest.

Service: Ocular Hypertension Enhanced Service	
Question	Comment/Evidence
How does the proposal deliver good or improved outcomes and value for money – what are the estimated costs and the estimated benefits? How does it reflect the CCG's proposed commissioning priorities? How does it reflect the CCG's commissioning obligations?	Chronic open angle glaucoma (COAG) is a common and potentially blinding condition. It is usually asymptomatic until advanced and many people will be unaware there is a problem with their eyes until severe visual damage has occurred. Ocular hypertension (OHT) is a major risk factor for developing COAG, although COAG can occur with or without raised eye pressure. Approximately 10% of UK blindness registrations are attributed to glaucoma. Around 2% of people older than 40 years have COAG, rising to almost 10% in people older than 75 years in white Europeans. The prevalence may be higher in people of black African or black Caribbean descent or who have a family history of glaucoma. With changes in population demographics the number of individuals affected is expected to rise. Based on these estimates 480,000 people are currently affected by COAG in England and there are over a million glaucoma-related outpatient visits in the hospital eye service annually. (NICE Clinical guidelines 85, Apr 2009). The most common method of IOP checking in optometric practice is by non-contact Tonometer, which is known to give false positive readings in some patients. The number of patients who are referred for suspect open angle glaucoma and then found to have no glaucoma is around 40%. These false positive referrals cause unnecessary anxiety to the patient and are a waste of hospital resources. This community based referral refinement service deflects false positive raised intra-ocular pressure (IOP) patients from

	Secondary care to help alleviate some of the issues currently facing the hospital Ophthalmology department. This will be accomplished through enabling community optometrists to refine their own referrals prior to deciding whether or not a patient should be referred for suspected glaucoma. Refinement involves repeating suspicious intraocular pressure (IOP) readings, using contact Applanation Tonometry for either NHS or private optometric patients. It is expected that the scheme will achieve the following outcomes: • Reduce the false positive rate of suspected glaucoma to the hospital eye department • Reduce patients' anxiety resulting from unnecessary secondary care referral as the majority of these patients are elderly • Keep the care of the patient closer to home • Increase choice of provider for patients • Increase choice of appointment times and dates for the patient. It delivers value for money by preventing expensive referrals to / treatment in secondary care, and delivering care closer to the patient in their own practice; improving outcomes and patient satisfaction. These are core objectives of the CCGs commissioning priorities.
How have you involved the public in the decision to commission this service?	Historical contract pre-CCG.
What range of health professionals have been involved in designing the proposed service?	Historical contract pre-CCG.
What range of potential providers have been involved in considering the proposal	Historical contract pre-CCG.
How have you involved your Health and Wellbeing Board? How does the proposal support the priorities in the relevant joint health and wellbeing strategy (or strategies)?	Historical contract pre-CCG.
What are the proposals for monitoring the quality of the service?	A programme of audit and review will be undertaken at predefined intervals to monitor service standards, outcomes, and patient satisfaction. The actual requirements will be discussed and agreed with participating

	optometrists. In order to ensure patients are satisfied with the service, the CCG will undertake a rolling programme of questionnaire that providers will need to distribute to patients. When the provider needs to take part, they will be supplied with a number of paper questionnaires and pre-paid envelopes – patients will return their questionnaires directly to the CCG and the provider will ensure they are encouraged to complete them. The CCG will expect a return rate of approximately 30-40% and will ensure the provider receives the resulting data analysis for their information, as well as a copy of an annual overview.
What systems will there be to monitor and publish data on referral patterns?	Not applicable.
Have all conflicts and potential conflicts of interests been appropriately declared and entered in registers which are publicly available? Have you recorded how you have managed any conflict or potential conflict?	Yes. If any conflicts recorded they would be managed in line with the NHS Rotherham CCG Conflict of Interest Policy and Procedure.
Why have you chosen this procurement route[1]? What additional external involvement will there be in scrutinising the proposed decisions? How will the CCG make its final commissioning decision in ways that preserve the integrity of the decision-making process and award of any contract?	Historical contract pre-CCG.
Additional question when qualifying a provider on a list or framework or pre selection for tender (including but not limited to any qualified provider) or direct award (for services where national tariffs do not apply).	
How have you determined a fair price for the service?	Historical contract pre-CCG.
Additional questions when qualifying a provider on a list or framework or pre selection for tender (including but not limited to any qualified provider) where GP practices are likely to be qualified providers.	
How will you ensure that patients are aware of the full range of qualified providers from whom they can choose?	Participation in the Cataracts service is entirely optional, and Optometrists don't have to sign up.
Additional questions for proposed direct awards to GP providers.	

[1] Taking into account all relevant regulations (e.g. the NHS (Procurement, patient choice and competition) (No 2) Regulations 2013 and guidance (e.g. that of Monitor).

What steps have been taken to demonstrate that the services to which the contract relates are capable of being provided by only one provider?	Historical contract pre-CCG.
In what ways does the proposed service go above and beyond what GP practices should be expected to provide under the GP contract?	This level of care by the Optometrist is not included in the core contract and is an additional service.
What assurance will there be that a GP practice is providing high-quality services under the GP contract before it has the opportunity to provide any new services?	The quality of delivery of core services is determined by a system of contract monitoring, including review visits to the practice. This is the responsibility of NHS England and the CCG would expect to be informed if there was an issue.