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Extended Primary Eyecare Services

Minor Eye Conditions Service

Service Delivery Proposal

Contents

1. Introduction

In this proposal, [Primary Eye Care Company] sets out its high-level approach to the delivery of the Minor Eye Conditions Service (MECS) in [Name] CCG.

The service uses the skills of primary eye care practitioners to triage, manage and prioritise patients presenting with a minor eye condition.

A MECS examination will provide a timely assessment of the needs of a patient presenting with an eye condition. This will be undertaken by an accredited practitioner within suitably equipped premises who will manage the patient appropriately and safely. Management will be maintained within the primary care setting for as many patients as possible, thus avoiding unnecessary referrals to hospital services. Where referral to secondary care is required it will be to a suitable specialist with appropriate urgency.

2. Contractual Model

It is proposed that [Name] CCG contracts directly with the Local Optical Committee's Single Provider Company, [Primary Eye Care Company], as the prime contractor.

[Primary Eye Care Company] will sub-contract with the optical practices serving the CCG area, and as set out in Appendix 1; and will provide a fully co-ordinated and managed service, meeting all the requirements set out in the business case and/or the service specification [delete as applicable].

This arrangement provides the most straightforward commissioning solution and has the advantage of significantly reducing the administrative burden, for the CCG, compared with a model which relies on contracting with each and every optical practice.

3. Delivery of the Managed Service

[Primary Eye Care Company] will provide a full administration service for the management of the MECS in conjunction with the Local Optical Committee Support Unit.

3.1. Scope of the Managed Service

The fully managed service includes the following:

- Oversight of the service provided by the participating practices, including ensuring that all premises, equipment and practitioners meet the requirements set out in section 4; and appendices 2 & 3
- A single point of contact for communications and queries relating to the service
- The IT platform

- Supply of case data (monthly)
- Supply of the contract performance monitoring information with a covering report (quarterly)
- Exception reports, the format of which, and frequency, will be agreed with the CCG
- Co-ordination of any remedial actions necessary
- Attendance at four contract management meetings, per year, with CCG
- Report of the annual audit of service

3.2. IT Platform

Participating practices will utilise a secure, web-based management solution (OptoManager®) which has been developed by the Local Optical Committee Support Unit and Webstar Health Ltd specifically for the MECS pathway.

The OptoManager® software automatically generates secure activity and outcomes reports, including referrals, invoices and robust audit data. As such, it facilitates the performance management of the MECS and eliminates the need for any manual data processing.

The use of the software reduces cost and time for the CCG as well as underpinning robust contract and performance monitoring.

The cost of using this software is included within the overall price for the MECS.

3.3. Referrals and Triage

Participating practices will accept referrals from all referrers, including patient self-referrals.

Patients can be referred by their GP, Pharmacist, eye care practitioner, NHS111, A&E or Eye Clinic/Eye Casualty by arrangement. Patients can also be signposted to the service by care navigators within primary care (usually within the GP practice team).

The patient is provided with a list of participating practices and asked to telephone a practice of their choice to book an appointment directly. If an appointment is not available, the practice will support the patient to find a suitable appointment within the service.

All referrals will be read and prioritised via a triage process within 24 hours; for patient self-referrals, the prioritisation will be undertaken whilst the patient is on the premises.

An algorithm within the IT platform will support the triage process (See Diagram in appendix 2).

It will:

- Ensure presentations are appropriate, meeting the inclusion criteria (appendix 3)
- Identify the appropriate practitioner.
- Support a prioritisation of appointments

An appointment will be offered, based on the prioritisation, as follows:

- For potentially sight threatening eye conditions, the patient will either be seen by the participating practitioner within 24 hours or they will refer the patient directly to urgent eye care services
- For acute minor eye conditions, an appointment will be offered within 48 hours
- For routine minor eye conditions, an appointment will be offered within 5 Days

3.4. Consultation

The level of examination should be appropriate to the reason for referral. All procedures are at the discretion of the practitioner and undertaken as deemed clinically necessary after assessment of the *patient's* History and Symptoms.

The following guidelines should be adhered to:

- Fundus examination should be through a dilated pupil when required or appropriate.
- Examination of an uncomfortable red eye must involve a slit-lamp examination used in conjunction with a staining agent.
- Visual field examination results must be in the form of a printed field plot rather than a written description.
- Symptoms of a sudden reduction in vision should be investigated by the examination of the macula and retina using binocular indirect ophthalmoscopy
- Symptoms of sudden onset flashes and floaters should be investigated by an examination of the anterior vitreous and peripheral fundus using binocular indirect ophthalmoscopy. Adequate dilation, following relative afferent pupil defect (RAPD) testing, is essential.
- Epilation of eyelash capability is essential.

It is recommended that practitioners utilise the College of Optometrists' Clinical Management Guidelines which can be found on their website www.college-optometrists.org/en/professional-standards/clinical_management_guidelines/index.cfm.

Practitioners should recognise their limitations and where necessary seek further advice or refer the patient elsewhere

Outcomes resulting from the consultation are likely to be one of the following:

- The practitioner decides to manage the condition and offers the patient advice and/or prescribes/recommends medication. A follow-up consultation may be necessary
- The practitioner carries out a minor clinical procedure e.g. eyelash removal or foreign body removal. A follow-up consultation may be necessary

- The practitioner diagnoses the condition and suggests/prescribes appropriate medication, or the GP is requested to prescribe
- The practitioner makes a tentative diagnosis and refers the patient urgently/non-urgently for further investigation and/or treatment
- The practitioner reassures the patient and discharges him/her

A GOS sight test or private eye examination may also be recommended but it would be unusual for this to be carried out at the same time as a MECS examination. The patient's details should NOT be added to the practice reminder system for the purpose of sending recall letters for regular eye examinations, unless the patient expressly requests it.

3.5. Diagnosis and Treatment

The practitioner will diagnose the condition and will manage the patient based on the College of Optometrists' Clinical Management Guidelines.

MECS consultation performed by MECS accredited Optometrist:

- Where a medicine is required, this will normally be supplied or prescribed by the optometrist, as part of the consultation, using one of the following routes, as agreed with the CCG: [Delete as applicable for local optical practices / CCG model].
- Through the issue of a signed order for supply by the community pharmacist of the patient's choice; or by directly supplying or selling, "Pharmacy only" (P) medicines and General Sales List (GSL) medicines; and the following POMs: chloramphenicol, cyclopentolate hydrochloride, fusidic acid and tropicamide. *Participating optometrists would be happy to support any scheme, offered by the CCG, to provide medicines free of charge to those patients who do not pay for prescription charges.*
- [Independent Optometrist prescribers will issue an FP10 prescription, for dispensing by a community pharmacist].
- [Prescription only medicines, and other medicines for patients who do not pay prescription charges, will be supplied directly from the optical practice, under the CCG's relevant patient group direction].

An approved list of medicines, in line with the CCG formulary, will be agreed and regularly updated. All participating optometrists will only prescribe, supply or issue signed orders for medicines which are included on the CCG's local formulary or approved list, unless there is a clinical reason not to do so.

MECS consultation performed by MECS accredited Contact Lens Optician (CLO):

> A CLO can supply or sell General Sales List (GSL) medicines within their consultation. For the management of acute conjunctivitis only, a CLO can sell or supply Chloramphenicol, within its P licence (0.5% drops or 1% ointment). For any other

medication, or where there is clinical uncertainty, a CLO will consult the MECS accredited Optometrist. Under these circumstances, the Optometrist assumes clinical responsibility and if required, the medicine will be supplied or prescribed by the Optometrist as detailed above.

3.6. Referrals to other services

Practitioners will make direct referrals as required by a patient's specific clinical circumstances:

a. Following triage, a same day referral to the local urgent eye care services for patients who may have a sight threatening condition
b. Following provisional diagnosis of a condition which requires onward referral to hospital eye care services (this may be an urgent or non-urgent referral as applicable)
c. Back to the GP, where the participating practitioner has concerns that the patient may have a systemic condition

3.7. Records

Practitioners will make contemporaneous electronic records using the secure, web-based platform OptoManager®.

3.8. Patient Information

A copy of the consultation report will be forwarded to the patient's GP within 48 hours. Where applicable, a copy will be sent to the original referrer and also offered to the patient.

At the end of the consultation the practitioner will summarise and discuss their findings and recommendations with the patient. Information, relevant to their condition, will be provided in order to promote their active participation in care and self-management.

The patient will be provided with both oral and written information and offered a copy of any letters between healthcare professionals regarding their care.

A range of relevant leaflets will be available in practice.

4. Clinical Governance

4.1. Workforce

A MECS team may include:

- MECS accredited Optometrist (required)

- MECS accredited Contact Lens Optician
- Triage staff

Participating practices will be required to appoint a MECS accredited Optometrist. A practice may also choose to appoint a MECS accredited Contact lens Optician.

MECS accredited CLOs will only deliver the service when a MECS accredited Optometrist is also on site. This is not to provide supervision but primarily for ease of transfer of care to ensure all patients are managed in an efficient way, allowing all treatment options to be made available without undue delay.

It is anticipated that most patients triaged to the MECS accredited CLO will be fully managed autonomously by them. Where transfer of care is needed, this will be administered within the IT system. If, for whatever reason, the IT system is not available, a formal referral between practitioners is required.

All MECS practitioners will work within their own competency and experience.

4.2. Accreditation and Training requirements

Skills required for delivery of the MECS service are covered by core competency. To supplement this, the Local Optical Committee Support Unit has worked with the Association of British Dispensing Opticians (ABDO) and Cardiff University* to develop a training and accreditation process, to evidence a revalidation of skills, to participate in a MECS service:

Optometrist:

- Part 1 is the series of distance learning lectures (theoretical training) and multiple-choice questions. This must be successfully completed before progressing to part 2.
- Part 2 of the training is the practical station assessment, which is undertaken by WOPEC Assessors.

For CLOs, MECS accreditation is a 3-part process:

- Part 1 identical to the Optometrist requirement.
- Part 2 is attendance at a practical skills training day, delivered by ABDO in collaboration with WOPEC. This is a mandated training day and must be undertaken before progressing to part 3.
- Part 3 is a series of practical skills assessments (stations). Assessment is undertaken by WOPEC Assessors.

All practitioners will be required to undertake CET/CPD which is relevant to service.

**Other providers now deliver equivalent training and accreditation for MECS.*

4.3. Premises

All participating practices are providers of General Ophthalmic Services. As such, they are required to complete the "Quality in Optometry" toolkit[1] (Appendix 4) which includes:

- Taking steps to improve accessibility for people with disabilities
- Providing a safe, secure, clean & warm environment which protects patients, staff, visitors and their property; and the physical assets of the organisation
- Ensuring patient privacy and confidentiality, protecting patient details (written and on the computer) are not accessible to members of the public
- Conducting patient consultations in private and ensuring any diagnostic tests, performed outside of the consultation room are not undertaken within the view of other patients
- Ensuring that cleanliness levels in clinical and non-clinical areas meet NHS standards for clean premises; and that staff are aware of correct handwashing procedures
- Meeting requirements for safety of equipment and disinfection

This 'Quality in Optometry' clinical governance toolkit will be the benchmark used for the service. Each participating practitioner must adhere to the core standards as set out in the toolkit and be able to provide evidence of this to the CCG if requested to do so.

4.4. Equipment

Participating practices will be expected to have appropriate equipment, as set out in Appendix 5

In addition, practices will be required to:

- Maintain a log detailing all maintenance checks
- Ensure that all members of staff who use equipment are appropriately trained and have access to instruction and other manuals
- Decontaminate equipment needing maintenance or repair beforehand

4.5. Policies and Procedures

Participating practices and practitioners will follow all relevant CCG policies and procedures as required. As a minimum, these will include:

- Patient complaints
- Serious untoward incidents
- Clinical audit
- Information governance

[1] www.qualityinoptometry.co.uk

They will adhere to the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and all local requirements on complaints management and will support the work of the Local Safeguarding Children Boards (LSCBs) and Safeguarding Adults Boards (SABs), as required within the Care Act 2014.

4.6. Patient Experience

Each patient will be provided with a patient experience questionnaire on completion of the examination.

4.7. Service Evaluation and Audit

[Primary Eye Care Company] will ensure that all contract performance management requirements are met and will attend the quarterly performance monitoring meetings.

OptoManager®, the secure IT web-based platform will be used to provide the data required to demonstrate performance against the service KPIs and to facilitate the annual audit.

Where it is identified that the service is not delivering the anticipated activity levels and/or the service outcomes, then the company will work with the CCG to identify, and address, the root cause.

5. Fees

A fee of (insert) for each episode of care will apply. This fee includes all elements of the managed service:

- The professional fee for the first appointment and any follow up appointments (i.e. there will be no additional charge for follow up appointments)
- All administration costs
- Reporting and attendance at contract monitoring meetings
- The use of the OptoManager® IT platform

6. Implementation

Full implementation will take up to 3 months from the date that [name] CCG commissions the service.

During this mobilisation period the company will:

- Support practitioner accreditation and training

- Work with local GPs, ophthalmologists and the CCG lead manager for eye care to finalise the pathway; develop a communications plan and materials for all potential referrers set out within the pathway; and agree all policies and procedures related to the MECS
- Tailor the OptoManager® software to ensure it meets all CCG requirements (if applicable) and develop the monitoring database and audit materials

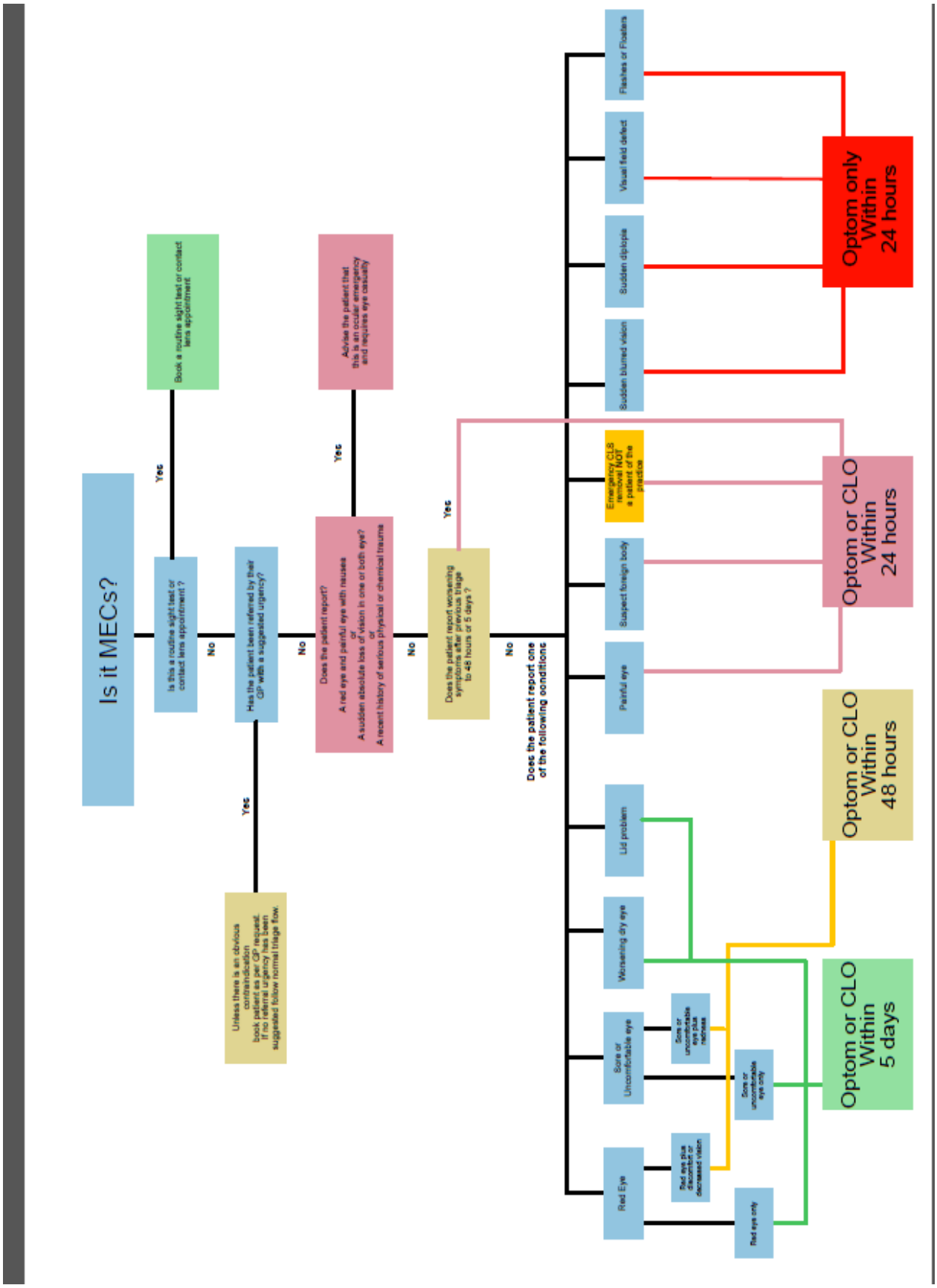
Appendix 1 - Community Optometry Providers

[Name] CCG has [insert number of practices] optical practices currently providing General Ophthalmic Services.

[Primary Eye Care Company] has surveyed these practices and has received Expressions of Interest from [insert number] regarding becoming MECS providers.

All of the practitioners involved would undergo the accreditation programme as previously described**.**

Appendix 2 – MECS flowchart



Appendix 3 – Eligibility Criteria

Criteria for inclusion

The criteria for inclusion of patients may include the following:

- Loss of vision including transient loss
- Sudden onset of blurred vision (unless a sight test would be more appropriate)
- Ocular pain or discomfort
- Systemic disease affecting the eye
- Differential diagnosis of the red eye
- Foreign body and emergency contact lens removal (not by the fitting practitioner)
- Dry eye
- Epiphora (watery eye)
- Trichiasis (in growing eyelashes)
- Differential diagnosis of lumps and bumps in the vicinity of the eye
- Recent onset of Diplopia
- Flashes/floaters
- GP Referral (may include retinal lesions)
- Patient reported field defects

Same day referral

The following cases should be referred directly to the nearest Eye Casualty:

- Severe ocular pain requiring immediate attention
- Suspect Retinal detachment
- Retinal artery occlusion
- Chemical injuries (after First aid measures)
- Penetrating trauma
- Orbital cellulitis
- Temporal arteritis
- Ischaemic optic neuropathy
- Sudden loss/dramatic reduction in vision in one eye

Exclusions

Other conditions excluded from the service:

- Diabetic retinopathy
- Adult squints, long standing diplopia
- Repeat field tests to aid diagnosis following an eye examination

Appendix 4 – Governance: Quality in Optometry

Many aspects of clinical governance in optometric practice are enshrined in legislation or regulation as well as in the College of Optometrists' *Guidance for Professional Practice, the Association of British Dispensing Opticians Advice and Guidelines* and in other guidance documents.

GOS contract compliance checklist. This level is used by NHS England Area Teams for the purposes of checking and monitoring GOS contract compliance. Contractors are required to complete and submit a Level 1 report every three years, together with an action plan for rectifying any non-compliant issues. Practices that flag as outliers on this and other criteria, together with a small random selection of others, may receive compliance visits.

NHS Standard Contract compliance checklists are clinical governance tools specifically designed for optometry community services (previously enhanced services).

There are **audits toolkits** available such as record keeping and infection control.

Practitioner and non-clinical staff checklists summarise the knowledge that a contractor will require of employees and practitioners as a part of complying with the GOS contract.

Community Services

Quality in Optometry NHS Standard Contract **compliance** checklists covers clinical governance with a particular emphasis on community services. The funding for this level of clinical governance is included as part of our proposal.

Appendix 5 - Equipment

All optical practices will have the following equipment, which will be appropriately maintained and fit for purpose:

- Means of indirect ophthalmoscopy to allow a suitable field of view (Volk/headset indirect ophthalmoscope)
- Slit lamp
- Applanation Tonometer
- Distance test chart (Snellen/LogMAR)
- Near test type
- Equipment for epilation
- Threshold fields equipment to produce a printed report
- Amsler Charts
- Equipment for FB removal
- Appropriate ophthalmic drugs
    - Mydriatic
    - Anaesthetic
    - Staining agents
- Access to the Internet

Appendix 6 – Key Drivers

The national key drivers include:

- NHS Standard Contract 2018-19
- Systems and Assurance Framework for Eye health (May 2018)
- ABDO – Extended role for contact lens Opticians – England (November 2017)
- RCOphth The Way Forward (January 2017)
- Delivering the Forward View: NHS Shared Planning Guidance 2016/17-2020/21 (December 2015)
- HM Treasury Spending Review and Autumn Statement (November 2015)
- Clinical Council for Eye Health Commissioning Community Ophthalmology Framework (July 2015)
- NHS Annual Report 2014-15 (July 2015)
- NHS Commissioning for Quality and Innovation (CQUIN) Guidance for 2015/16 (March 2015)
- NHS Serious Incident Framework (March 2015)
- NHS England Business Plan (March 2015)
- National Information Board Personalised Health and Care 2020 (November 2014)
- NHS Five Year Forward View (October 2014)
- NHS Outcomes Framework 2015 to 2016 (December 2014)
- NHS Constitution (March 2013)
- Safeguarding Vulnerable People in the Reformed NHS (March 2013)
- The Information Governance Review (March 2013)
- Commissioning Better Care: Urgent Care (February 2013)
- NHS (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013
- Everyone Counts: Planning for Patients 2013/14 (December 2012)
- Securing excellence in commissioning primary care (June 2012)
- Health & Social Care Act 2012
- Equity & Excellence: liberating the NHS (2010)
- Right Care: Increasing Value – Improving Quality (June 2010)
- NHS 2010-15; from good to great (January 2010)
- Quality Innovation Productivity & Prevention (QIPP) agenda
- Implement care closer to home; convenient quality care for patients (April 2007)
- The UK Vision Strategy 2013-2018