NHS Standard Contract 2019/20

Particulars (Shorter Form)

Contract title / ref: **South East London Minor Eye Conditions Scheme and Optometrist Triage Service (MECS SEL 01)**

NHS Standard Contract 2019/20

Particulars (Shorter Form)

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Contract Reference	MECS SEL 01
DATE OF CONTRACT	**1st July 2019**
SERVICE COMMENCEMENT DATE	**1st July 2019**
CONTRACT TERM	**3 years commencing 1 July 2019 subject to extension in accordance with Schedule 1C**
COMMISSIONERS	**NHS Bromley Clinical Commissioning Group (ODS 07Q)** **NHS Greenwich Clinical Commissioning Group (ODS 08A)** **NHS Lambeth Clinical Commissioning Group (ODS 08K)** **NHS Lewisham Clinical Commissioning Group (ODS 08L)** **NHS Southwark Clinical Commissioning Group (ODS 08Q)**
CO-ORDINATING Commissioner	**NHS Southwark Clinical Commissioning Group (08Q)**
PROVIDER	**Primary Ophthalmic Solutions Limited (ODS T289) Principal and/or registered office address:** **Registered: 95 High Street, Beckenham, BR3 1AG** **Principal: Unit 3, 2 Thayers Farm Road, Beckenham, BR3 4LZ** **[Company number: [10654683]**

CONTENTS

PARTICULARS

SCHEDULES

SCHEDULE 1 – SERVICE COMMENCEMENT AND CONTRACT TERM (Schedule 1B Intentionally Omitted)
A. Conditions Precedent
C. Extension of Contract Term

SCHEDULE 2 – THE SERVICES (Schedule 2C, 2E, 2F, 2H, 2I Intentionally Omitted)
A. Service Specifications
B. Indicative Activity Plan
D. Essential Services
G. Other Local Agreements, Policies and Procedures
J. Transfer of and Discharge from Care Protocols
K. Safeguarding Policies and Mental Capacity Act Policies

SCHEDULE 3 – PAYMENT (Schedule 3D, 3E Intentionally Omitted)
A. Local Prices
B. Local Variations
C. Local Modifications
F. Expected Annual Contract Values

SCHEDULE 4 – QUALITY REQUIREMENTS (Schedule 4B Intentionally Omitted)
A. Operational Standards and National Quality Requirements
C. Local Quality Requirements
D. Commissioning for Quality and Innovation (CQUIN)

SCHEDULE 5 – INTENTIONALLY OMITTED

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS (Schedules 6B, 6D, 6E Intentionally Omitted)
A. Reporting Requirements
C. Incidents Requiring Reporting Procedure
F Provider Data Processing Agreement

SCHEDULE 7 – PENSIONS

SCHEDULE 8 – TUPE

SERVICE CONDITIONS

(Service Conditions 7, 9, 14, 18-20, 22, 26-27, 31 intentionally omitted)

SC1 Compliance with the Law and the NHS Constitution
SC2 Regulatory Requirements
SC3 Service Standards
SC4 Co-operation
SC5 Commissioner Requested Services/Essential Services
SC6 Choice and Referrals
SC8 Making Every Contact Count and Self Care
SC10 Personalised Care Planning and Shared Decision Making
SC11 Transfer of and Discharge from Care
SC12 Communicating With and Involving Service Users, Public and Staff
SC13 Equity of Access, Equality and Non-Discrimination
SC15 Urgent Access to Mental Health Care
SC16 Complaints
SC17 Services Environment and Equipment
SC21 Antimicrobial Resistance and Healthcare Associated Infections
SC23 Service User Health Records
SC24 NHS Counter-Fraud and Security Management
SC25 Procedures and Protocols
SC28 Information Requirements
SC29 Managing Activity and Referrals
SC30 Emergency Preparedness, Resilience and Response
SC32 Safeguarding and Mental Capacity
SC33 Incidents Requiring Reporting
SC34 Care of Dying People
SC35 Duty of Candour
SC36 Payment Terms
SC37 Local Quality Requirements and Quality Incentive Schemes
SC38 Commissioning for Quality and Innovation (CQUIN)

GENERAL CONDITIONS

(General Conditions 6-7, 34-35 intentionally omitted)

GC1 Definitions and Interpretation
GC2 Effective Date and Duration
GC3 Service Commencement
GC4 Transition Period
GC5 Staff
GC8 Review
GC9 Contract Management
GC10 Co-ordinating Commissioner and Representatives
GC11 Liability and Indemnity
GC12 Assignment and Sub-Contracting
GC13 Variations
GC14 Dispute Resolution
GC15 Governance, Transaction Records and Audit
GC16 Suspension
GC17 Termination
GC18 Consequence of Expiry or Termination
GC19 Provisions Surviving Termination
GC20 Confidential Information of the Parties
GC21 Patient Confidentiality, Data Protection, Freedom of Information and Transparency
GC22 Intellectual Property
GC23 NHS Identity, Marketing and Promotion
GC24 Change in Control

GC25 Warranties
GC26 Prohibited Acts
GC27 Conflicts of Interest and Transparency on Gifts and Hospitality
GC28 Force Majeure
GC29 Third Party Rights
GC30 Entire Contract
GC31 Severability
GC32 Waiver
GC33 Remedies
GC36 Notices
GC37 Costs and Expenses
GC38 Counterparts
GC39 Governing Law and Jurisdiction

Definitions and Interpretation

CONTRACT

This Contract records the agreement between the Commissioners and the Provider and comprises

1. these **Particulars**;
2. the **Service Conditions (Shorter Form)**;
3. the **General Conditions (Shorter Form)**,

as completed and agreed by the Parties and as varied from time to time in accordance with GC13 (*Variations*).

IN WITNESS OF WHICH the Parties have signed this Contract on the date(s) shown below

SIGNED by	**……………………………………………………….** **Signature**
ROSS GRAVES for and on behalf of NHS SOUTHWARK CLINICAL COMMISSIONING GROUP	**……………………………………………………….** **Title** **……………………………………………………….** **Date**
SIGNED by	**……………………………………………………….** **Signature**
CHARLES GREENWOOD for and on behalf of PRIMARY OPHTHALMIC SOLUTIONS LIMITED	**……………………………………………………….** **Title** **……………………………………………………….** **Date**

SERVICE COMMENCEMENT AND CONTRACT TERM	
Effective Date	**1st July 2019**
Expected Service Commencement Date	**1st July 2019**
Longstop Date	**1st September 2019**
Service Commencement Date	**1st July 2019**
Contract Term	**3 years commencing 1st July 2019 Subject to extension in accordance with Schedule 1C**
Option to extend Contract Term	**YES for a further two years.**
Notice Period (for termination under GC17.2)	**6 months**
SERVICES	
Service Categories	**Indicate all that apply**
Continuing Healthcare Services (CHC)	**NO**
Community Services (CS)	**YES**
Diagnostic, Screening and/or Pathology Services (D)	**NO**
End of Life Care Services (ELC)	**NO**
Mental Health and Learning Disability Services (MH)	**NO**
Patient Transport Services (PT)	**NO**
Service Requirements	
Essential Services (NHS Trusts only)	**NO**
Is the Provider acting as a Data Processor on behalf of one or more Commissioners for the purposes of the Contract?	**NO**
PAYMENT	
National Prices Apply to some or all Services (including where subject to Local Modification or Local Variation)	**NO**
Local Prices Apply to some or all Services	**YES**
Expected Annual Contract Value Agreed	**NO**

GOVERNANCE AND REGULATORY	
Provider's Nominated Individual	**Charles Greenwood** **Email: charles.greenwood@nhs.net** **Tel: 020 86639014**
Provider's Information Governance Lead	**Tina Futcher-Smith** **Email: tina.futcher-smith@nhs.net** **Tel: 020 86639014**
Provider's Data Protection Officer (if required by Data Protection Legislation)	**James Samarasinghe** **Email: jsamara@gmail.com** **Tel: 07595 389369**
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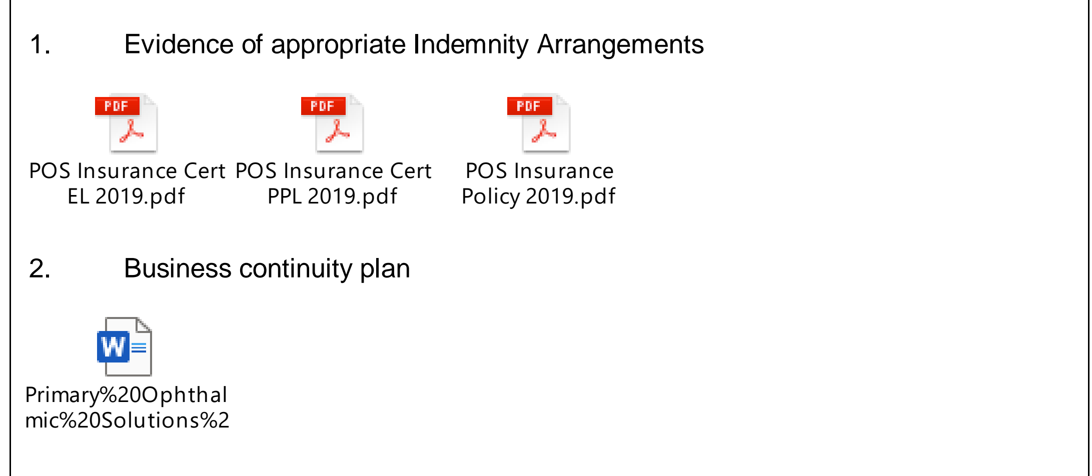
Provider's Mental Capacity and Deprivation of Liberty Lead	**Joanna Cashell** **Email: jo.cashell@nhs.net** **Tel: 07919 104792**
Provider's Freedom To Speak Up Guardian(s)	**Joanna Cashell** **Email: jo.cashell@nhs.net** **Tel: 07919 104792**
CONTRACT MANAGEMENT	
Addresses for service of Notices	**Co-ordinating Commissioner: NHS Southwark Clinical Commissioning Group** **Address: 160 Tooley Street, London, SE1 2TZ** **Commissioner: David Smith** **Address: NHS Southwark Clinical Commissioning Group** **Email:** **Provider: Primary Ophthalmic Solutions** **Address: Unit 3, 2 Thayers Farms Road, Beckenham, BR3 4LZ** **Email: charles.greenwood@nhs.net**

Commissioner Representative(s)	**David Smith** **Associate Director – Planned Care** **Address: 160 Tooley Street, London, SE1 2TZ** **Email:** David.smith47@nhs.net **Tel: 0207 525 2193**
Provider Representative	**Charles Greenwood** **Address: Unit 3, 2 Thayers Farms Road, Beckenham, BR3 4LZ** **Email: charles.greenwood@nhs.net** **Tel: 020 8663 9014**

1 SCHEDULE 1 – SERVICE COMMENCEMENT AND CONTRACT TERM

A. Conditions Precedent

The Provider must provide the Co-ordinating Commissioner with the following documents and complete the following actions:



C. Extension of Contract Term

1. As advertised to all prospective providers during the competitive tendering exercise leading to the award of this Contract, the Commissioners may opt to extend the Contract Term by two years.

2. If the Commissioners wish to exercise the option to extend the Contract Term, the Co-ordinating Commissioner must give written notice to that effect to the Provider no later than six months before the original Expiry Date.

3. The option to extend the Contract Term may be exercised:

   3.1 only once, and only on or before the date referred to in paragraph 2 above;

   3.2 only by all Commissioners; and

   3.3 only in respect of all Services

4. If the Co-ordinating Commissioner gives notice to extend the Contract Term in accordance with paragraph 2 above, the Contract Term will be extended by the period specified in that notice and the Expiry Date will be deemed to be the date of expiry of that period.

SCHEDULE 2 – THE SERVICES

A. Service Specifications

1 Population Needs

1.1 National/local context

The rising number of older people living with eye health problems, and an increase in new treatments for conditions has increase the demand for Hospital Eye Services. Improving eye health and preventing avoidable sight loss will benefit lives and will reduce the direct pressures on hospital eye departments in South East London.

1.2 MECS and Single Provider Contracts

The Minor Eye Conditions Service (MECS) will provide a timely and effective assessment of the needs of a patient presenting with an eye condition. The assessment will be undertaken by an accredited optometrist within suitably equipped premises who will manage the patient appropriately and safely. The aim of the Service is to maintain as many patients as possible in the primary eye care setting and avoid unnecessary referrals to acute hospital services.

The Single Provider Contract Model allows Commissioners to use Primary Eye Care Companies to work with all optical practices in the area without having to manage individual contracts. The model has been developed by the Local Optical Committee Support Unit (LOCSU). The five CCGs (Bromley, Greenwich, Lambeth, Lewisham and Southwark) will implement a single provider contract which will be delivered through a Primary Eye Care Company who will then sub-contract with the Optical Practice Providers.

1.3 Optometrist Triage Service

The Optometrist Triage Service will ensure that all ophthalmology referrals are triaged and directed to the most appropriate setting, increasing utilisation of the community service (MECS) and reducing demand and pressure on secondary care.

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 a safe environment and protecting them from avoidable harm	

2.2 Locally defined outcomes

The service will provide:

- Excellent patient experience
- Deliver better clinical outcomes
- Ensuring people have timely access to care
- Care closer to home
- Reduction in first outpatient referrals to acute hospital services
- Reduction in unnecessary follow-ups
- Closer working and networking between primary care, the trusts, the CCG and local optical practices

3 PART A: MECS and Single Provider Contract

3.1 Definitions

- **Lead Provider:** Primary Eye Care Company
- **Sub-contractor:** Individual Optometric Practice
- **Commissioner:** NHS Bromley CCG, NHS Greenwich CCG, NHS Lambeth CCG, NHS Lewisham CCG, NHS Southwark CCG

3.2 Aims and objectives of service

The aims of the service are as follows:

- The service aims to improve eye health and reduce inequalities by providing increased access to eye care in the community.
- The service utilises the knowledge and skills of primary care optometrists to triage, manage and prioritise patients presenting with an eye condition.
- Access to eye care for the conditions described in the specification will enable more patients to receive treatment closer to their homes.
- The service is expected to reduce the number of unnecessary referrals from primary care to secondary care, supported by the provision of more accurate referral information if referral is made.

3.3 Lead Provider Responsibilities

The Lead Provider is contracted to ensure delivery of all aspects of the specification (Part A). This includes the day to day management, payments, monitoring and reporting of the MECS scheme.

3.4 Service description/care pathway

3.4.1 Minor eye conditions

3.4.1.1 Symptoms at presentation

This service provides for the assessment and management of patients presenting with any of the following minor eye conditions:

- Loss of vision including transient loss – [consider differential diagnosis (TIA, Temporal Arteritis)]
- Ocular pain
- Systemic disease affecting the eye
- Differential diagnosis of 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 [consider stroke; binocular diplopia always significant]
- Flashes/floaters
- Retinal lesions
- Field defects

3.4.1.2 Conditions likely to require onward referral from MECS

The following conditions require the patient to attend a hospital ophthalmic department, eye casualty or A&E:

- Severe ocular pain requiring immediate attention
- Severe infection
- Suspected retinal detachment

- Retinal artery occlusion
- Chemical injuries
- Penetrating trauma
- Orbital cellulitis
- Temporal arteritis
- Ischaemic optic neuropathy
- Binocular double vision

3.4.1.3 Conditions excluded from the service

The treatment of long-term chronic conditions is not included within the service:

- Diabetic retinopathy
- Long standing adult squints
- Long standing diplopia

3.4.2 Glaucoma repeat measurement

3.4.2.1 Background

A high number of patients are referred for suspected chronic open angle glaucoma and then found to have no glaucoma. These false positive referrals cause unnecessary anxiety to the patient, paperwork for the practitioner and are a waste of NHS resources. In order to reduce this occurrence, Sub-Contractors will repeat IOP measurements using an applanation method (Goldmann or Perkins tonometer), and repeat visual field tests on a separate occasion. This scheme will also help optometrists to ensure that they are complying with NICE guidance (NICE Guideline NG81), regarding the diagnosis and management of chronic open angle glaucoma (COAG) and ocular hypertension (OHT).

3.4.2.2 Glaucoma Repeat Measurement – IOP

NICE guidance states that patients with IOP, measured with Goldmann-type applanation tonometry that is consistently or recurrently >23mmHg, in the absence of any other signs or symptoms of glaucoma, should be referred for a differential diagnosis of OHT, COAG, or suspected COAG. For diagnosis, examination should include applanation tonometry (Goldmann), gonioscopy, visual fields, optical coherence tomography, examination of the optic nerve head and pachymetry, and should be undertaken by a healthcare practitioner with a specialist qualification and relevant experience. (See NICE Guideline NG81 for full details, available at www.nice.org.uk).

All patients with IOP > 31mmHg should be referred for OHT diagnosis without further measurement.

If the IOP measured at the patient's eye examination is >23mmHg, and in order to avoid unnecessary false positive referrals, optometrists should repeat this measurement using slit-lamp mounted Goldmann tonometry or hand held Perkins tonometry[1]. This can be done at the same appointment as the patient's eye examination. If the IOP is still only slightly raised, and discs and fields are normal, optometrists are encouraged to ask the patient to return on a second occasion for a further applanation measurement preferably at a different time of day, to determine whether this IOP is a repeatable measurement. Only if the IOP is consistently or recurrently above 23mmHg (with normal discs and fields), and meets the criteria set out below, should the patient be referred for a diagnosis of OHT as per the NICE guidance.

Practitioners should consider IOP measurements as part of a routine sight test in ALL black African and black African-Caribbean adults to ascertain whether repeat testing is required.

Where the initial IOPs are measured with a non-contact tonometer, they should be the average of 4 readings per eye.

[1] Slit lamp mounted Goldmann applanation tonometry is the preferred method of IOP measurement. However, Perkins tonometry is acceptable for the purposes of the repeat measurement Scheme.

3.4.2.3 Glaucoma Repeat Measurement – Visual fields

It is the clinical decision of the optometrists whether to undertake a further visual field assessment. However, this may be appropriate where they were measured as part of an initial sight test and:

- the discs and angles are normal and the IOPs are <24mmHg
- and
- the visual fields are 'suspicious' or 'defect' using the Humphrey, Henson, Dicon or equivalent visual field screener,

or

- there is a significant defect on the FDT (without a known cause)
- and
- the optometrist feels that a further visual field test is necessary in support of their referral

This applies whether the apparent visual field defect is suggestive of glaucoma or other pathology. The repeated field test must be conducted using a suprathreshold technique, or full threshold technique, and be supervised by an optometrist.

The aim of this is to determine whether the patient has a repeatable visual field defect which may be due to glaucoma or other pathology, or whether the patient is simply performing badly at the test on the day. Repeat field tests must be done on a different occasion to reduce the effects of patient fatigue.

All repeat field tests are expected to be carried out using a threshold controlled method and not using frequency doubling technology (FDT) perimetry.

3.4.2.4 Glaucoma Referral Filtering: Suspected Glaucoma and Ocular Hypertensive Referrals from other practitioners

As described above, the number of patients referred for suspect glaucoma and then found to have none is high. The aim of this pathway is to reduce the number of inappropriate glaucoma and OHT referrals by reassessing the suspected glaucoma and OHT referrals sent by GPs and non-accredited Optometrists for ophthalmological assessment.

Eligible patients

Patients eligible for this service are:

1. Patients who have been routinely referred for glaucoma assessment <u>by another practitioner</u>

- AND who have high intra-ocular pressures that have not been measured using a Goldmann or Perkins applanation tonometer
- AND who have no other significant clinical signs of glaucoma
- AND who are registered with a Bromley, Greenwich, Lambeth, Lewisham or Southwark GP

2. The patient's GP feels for any reason that this patient should have a glaucoma assessment.

OR the patient has been through a triage process and referred to a MECS practice for this workup.

Eligible practices

Optometrists (Subcontractors) will have gained accreditation for this scheme by undertaking:

- The WOPEC glaucoma distance learning modules

- Goldmann assessment, organised by Primary Ophthalmic Solutions or LSL or BBG LOCs, OR WOPEC (e.g. WOPEC Part 2 glaucoma OSCE assessments), OR a consultant ophthalmologist

Or

- Have a Professional / Higher certificate / Diploma in glaucoma

Patients must be booked in for a glaucoma referral filtering appointment.

Glaucoma Referral Filtering

At the appointment the patient will have the following assessments:

- History and symptoms
- Goldmann or Perkins applanation tonometry
- Visual field test (which will be repeated if the first performance is unreliable or abnormal)
- Anterior chamber angle assessment using the Van Herrick method or gonioscopy
- Indirect fundus examination with a Volk lens, with dilation where appropriate

The MECS Optometrist will then make a decision on all the clinical information as to the patient outcome.

Patient destinations

The patient will either be discharged from the service (no onward referral), recalled for repeat readings or referred to a glaucoma clinic.

When to consider referral to a glaucoma clinic

1. Based on IOP[2] alone if IOP is consistently or recurrently measured >23mmHg by applanation

2. Visual field alone:

A repeatable glaucomatous-type defect using automated supra-threshold or threshold-measuring visual fields device

   a. The visual fields device must not be based on the frequency doubling theory (No FDT)
   b. The visual field plot should ideally have good reliability scores (<20% fixation losses / false positives etc.)

3. Optic disc appearance alone:
   a. Pathological cupping, taking into account disc size (large cups on large discs are less suspicious than large cups on small discs)

   b. Disc asymmetry greater than 0.2 difference between optic nerve heads

   c. Notching / nerve fibre layer defects

   d. Disc haemorrhage (within 1DD of ONH)

4. Narrow anterior angle based on Van Herrick technique/gonioscopy giving the patient an increased risk of angle closure

[2] Slit lamp mounted Goldmann applanation tonometry is the preferred method of IOP measurement. However, Perkins tonometry is acceptable here.

5. The patient has conditions often associated with glaucoma (e.g. pigment dispersion syndrome or pseudoexfoliation).

6. Discs & fields: If both show glaucomatous change, regardless of IOP

7. Change to optic disc: documented change in disc appearance (C:D change, neuroretinal rim configuration, new haemorrhage, notching, loss of nerve fibre layer etc.)

   There could be occasions where a practitioner participating in the referral refinement scheme has asked a patient to return for repeat pressures or fields, and the patient fails to attend for these measurements. In the first instance, the practitioner would be expected to contact the patient to make a further appointment. However, if the patient still fails to attend, the practitioner should consider his/ her duty to make a routine referral of the patient to their GP.

This guidance does not remove a practitioner's individual clinical responsibility. Each patient should be dealt with on a case-by-case basis.

If there is any doubt, refer for further investigation and include information on what the concern is.

3.4.3 Direct Cataract Referral Scheme

3.4.3.1 Referral to accredited optometrists

GPs in Bromley, Greenwich, Lambeth, Lewisham, and Southwark, who suspect the presence of a cataract or receive a cataract referral from an unaccredited (in terms of this scheme) optometrist, can redirect the patient to an accredited (in terms of this scheme) optometrist, for a full Direct Cataract Referral Assessment. Such referrals will include a copy of the original referral letter and/or GOS18 and all relevant drug information. In this instance, the accredited optometrist will conduct a Direct Cataract Referral Assessment ONLY, and not a sight test.

GPs should have tried to ensure that the patient is willing to have surgery and given them a cataract information leaflet, before offering them a choice of accredited optometric practices to be referred to. The GP should have then informed the practice that the patient wishes to have a Direct Cataract Referral Assessment. The optometric practice is then responsible for contacting the patient and scheduling an appointment within 21 days of the notification by the GP.

Optometrists will then refer the patient to secondary care for their first cataract appointment and pre-assessment for cataract surgery, if appropriate (see 3.4.3.2).

Optometrists (Sub – Contractors) may still claim the private/GOS examination fee in addition to the fee for this scheme, unless, as stated above, one has already been carried out by an unaccredited optometrist, from whom the cataract referral emanated. All payments to the Sub – Contractor will be managed and paid by the Lead Provider.

3.4.3.2 Clinical Protocol

The Direct Cataract Referral Scheme enables optometrists to discuss cataract surgery and yttrium-aluminium-garnet (YAG) laser treatment with the patient, and explain the risks and benefits involved. Armed with this information, the patient can then decide whether or not the degree of visual difficulty they experience, and their appetite for surgery, inclines them towards having the surgery.

The cataract assessment will involve:

- Confirmation from the patient that they are able to lie flat and still during the procedure
- Mandatory dilated fundal examination using indirect ophthalmoscopy
- Slit lamp anterior eye examination of the patient

- Discussion of relevant medical history and complete current medication[3]. If the patient is unable to provide this in full, it must be obtained from their GP using the MECS Request Form for Patient Information from the GP.
- History of long-term conditions

Following assessment, the following must be carried out:

- Completion of Cataract referral refinement record/referral form
- Copy of referral form emailed to the hospital of the patient's choice using with original copy retained in the practice records. [If the patient wishes to be referred to a hospital not listed on the form, a copy of the form can be sent to the patient's GP for referral under the NHS E-Referral Scheme.]
- Copy of referral form emailed to the patient's GP.
- Copy of referral form given to the patient.
- Patient Information Leaflet supplied to the patient.
- Patient evaluation form filled out (if evaluation process underway at the time).

3.4.3.3 Additional guidance

Just because a patient has a cataract, it does not mean that s/he needs to be seen by the hospital.

It is most important that patients are only referred for cataract or YAG laser capsulometry if they are having problems caused by their cataract and that these are serious enough for them to want secondary care intervention.

A number of patients are referred to hospital with relatively good VAs (6/12, or better) and then decline to have the operation when the risks are fully explained to them. It may be that these patients experience symptoms, but not to the extent that they wish to accept the risk of surgical complications albeit small. These patients should not be referred.

One of the main purposes of the scheme is that the optometrist discusses the 2% risk of complications following the operation, most of which are treatable.

Patients with better VAs can be referred but will need a full supporting history documented in the referral.

The cataract assessment enables participating optometrists to perform an anterior eye and dilated fundal examination to exclude other pathology. If other pathology is observed, then this should be indicated on the referral form.

3.4.3.4 YAG Laser Capsulotomy

Cataract surgery involves the insertion of a synthetic lens, replacing the natural lens of the eye. The intra-ocular lens is held in position by the capsule which constitutes the outer membrane of the lens. The capsule may, in time (usually over a 2 year period) develop scarring which is noticed as a gradual blurring of vision. This posterior capsular thickening is more common in younger patients, in certain types of cataract (posterior sub capsular), and can be affected by the type of synthetic lens.

Treatment is with an Nd: YAG (neodymium doped: yttrium-aluminium-garnet) laser, which creates an opening in the posterior capsule, thus restoring vision. The laser treatment is painless and is performed at an outpatient visit during which eye drops will be applied prior to the treatment and, in some cases, for a short time afterwards.

The risks of the procedure are retinal detachment, damage to the synthetic lens and inflammation.

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[3] The referral form requires you to note any relevant medication that the patient is currently taking. In particular, Flomax and Tamsulosin (for prostate problems), or similar drugs, need to be highlighted. These medications can cause 'Floppy iris Syndrome', which makes cataract surgery more complicated.

To reduce the risk of retinal detachment, a YAG laser is not performed until at least 6 months after surgery, though there is no upper limit. The overall risk of retinal detachment after capsulotomy is approximately 1%, although the risk is greater in highly myopic patients or in those who had a surgical complication.

It is not reported how often minor inflammation and synthetic lens damage occur, but serious cases are extremely rare.

3.4.3.5 Contraindications for the pathway

- Patients with some cataract present, but whose symptoms are not being caused by the cataract, should be examined in the normal way, and referred for other co-morbidity if appropriate.
- Patients should only receive an assessment if a decision to refer for cataract surgery is being seriously considered, and then only after assessment indicates that:
- they are symptomatic of cataract
    - AND
- have some impairment of lifestyle (typically involving a reduction in visual acuity)
    - AND
- are willing and able to have the surgery within the next 3 months.
- Patients with complicated cataract requiring treatment (e.g. damaged pupil, previous injury, who should be referred in the normal way and NOT through this pathway.
- Patients with co-morbidity found during the assessment which then forms the major reason for referral (e.g. ARMD), who should be referred in the normal way and NOT through this pathway.
- Patients meeting the above referral criteria but are unable to make an informed decision (e.g. Alzheimer sufferers), who should be referred in the normal way and NOT through this pathway.

3.4.4 Procedures

- Such procedures will be undertaken as deemed clinically necessary by the relevant optometrist after assessment of the patient’s history and symptoms.
- All tests undertaken, and results obtained, must be recorded on the Optometric Service Record, even if the results are normal.
- Any drugs or staining agents used during the examination or prescribed must be recorded on the Optometric Service Record.
- All advice given to the patient (verbal or written) must be recorded on the Optometric Service Record.
- All detailed retinal examinations will be undertaken under mydriasis using either 0.5% or 1.0% Tropicamide, from a single dose unpreserved unit (Minim), unless this is contraindicated. The reason for not dilating must be recorded on the Optometric Service Record.

The level of examination be appropriate for the reason for referrals. All procedures are at the discretion of the optometrist; however, 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, where appropriate, rather than a written description
- Symptoms of a sudden reduction in vision should be investigated by the examination of the macula and retina using a Volk or similar lens
- Symptoms of sudden onset flashes and floaters should be investigated by an examination of the anterior vitreous and peripheral fundus with a Volk or similar lens; relative afferent pupil defect (RAPD) testing is essential
- Epilation of eyelash capability is essential

3.4.5 Clinical management guidelines

http://www.college-optometrists.org/en/professional-standards/clinical_management_guidelines/index.cfm

Clinical Management Guidelines for specific conditions should be adhered to unless this is contraindicated.

All clinical decisions and advice given to patients must be recorded on the Optometric Patient Record.

3.4.6 Equipment

The Lead Provider will ensure all sub-contractors have the following equipment to deliver the MECS scheme:

- Slit lamp
- Contact tonometer
- Visual field equipment with the ability to control threshold and produce a printed field plot
- Ophthalmoscope
- Amsler charts
- Epilation equipment
- Diagnostic drugs (mydriatics, stains, local anaesthetics etc.)
- Volk-type lens
- Equipment to remove foreign bodies

3.4.7 Medication

Optometrists may sell or supply all pharmacy medicines (P) or general sale list medicines (GSL) in the course of their professional remit, including 0.5% Chloramphenicol antibiotic eye drops in a 10ml container and eye ointment (1%).

Products that can be prescribed:

Drug name	Status	Additional notes
Chloramphenicol eye drops 0.5% 10ml	P	For an emergency situation only Script to be dispensed within 24hours
Chloramphenicol eye ointment 1% 4g	P	For an emergency situation only Script to be dispensed within 24hours
Fusidic acid eye drops 1% 5g	POM	For an emergency situation only Script to be dispensed within 24hours
Hypromellose eye 0.3%, 0.32%, 0.5%	P	Ensure strength is stated and whether preservative free is required. If not stated, then pharmacist will contact the prescriber
Carbomer ‘980’ 0.2% eye Drops 10g	P	
Carmellose 1% eye drops	P	
Lacri-lube eye ointment 3.5g, 5g	P	
Sodium Cromoglicate 2% eye drops 10ml	P	Only 10ml bottle as 13.5ml is a POM
Alomide Allergy™ 0.1% eye drops	P	Prescribe only as Alomide Allergy™ as this is a P. For allergic conjunctivitis only in adults and children over 4 years after sodium cromoglicate 2% eye drops has been tried.

In making the supply to the patient the ophthalmic practitioner must ensure:

- Sufficient medical history is obtained (including allergy status) to ensure that the chosen therapy is not contra-indicated in the patient
- All relevant aspects, in respect of the labelling of medicines outlined in the Medicine Act 1968, are fully complied with
- The patient has been fully advised on the use of the medicine (i.e. method, frequency, duration and storage) and when they should seek medical advice i.e. Chloramphenicol – medical advice should be sought if there is no improvement in the condition after 2 days or if symptoms worsen at any time.

In general, supply via a pharmacist is preferred. The College of Optometrists has produced guidelines on the use and supply of drugs as part of its 'Code of Ethics and Guidelines for Professional Conduct' (section 2.40). If the patient is exempt from prescription charges, supply of appropriate treatments could be covered by a Minor Ailment Services, if applicable, in accordance with The National Pharmacy Enhanced Service Plan already in existence.

Standards:

- All aspects of medicines use comply with legislation, good practice guidelines, local policies, requirements of the NHS Litigation Authority and standards of the Care Quality Commission.
- The provider will have medicines policies and procedures in place which reflect the above standards.
- These standards will apply to all current services and be taken into account when new services are developed.
- All staff who prescribe, administer, supply and/or handle medicines are qualified/registered (if appropriate) as competent, and supported to undertake these duties.
- The provider will develop and provide medicines training to ensure that staff have the appropriate level of knowledge and skills for medicine supply.

Safety:

- The provider will take appropriate action to implement and comply with NPSA alerts, medicines recalls and other medicines safety alerts.
- The provider will have in place a system for staff to report adverse drug reactions.
- The provider will have in place a system to report and investigate untoward incidents involving medicines and will ensure that recommendations and actions are completed.
- The provider will ensure that appropriate medicines are available to treat medical emergencies and that staff have received the appropriate training for their use.

Stock management:

- The provider will have systems in place to ensure robust stock management of medicines, including ordering, transport, storage, supply and disposal.
- The provider will have systems in place to ensure the effective care of medicines requiring special storage (e.g. refrigeration).
- The provider will have in place secure arrangements for prescription pads, which are controlled stationery.

Prescribing

- All patients should receive appropriate drug therapy when necessary and in the most appropriate setting.
- Optometrists may sell or supply all pharmacy medicines (P) or general sale list medicines (GSL) in the course of their professional practice

- This supply should be in accordance with the guidelines that have been produced by The College of Optometrists on the use and supply of drugs as part of its 'Code of Ethics &Guidelines for Professional Conduct' (section 2.40).

Communication with other providers/services

- Any recommendations or changes in a patient's treatment should be communicated as soon as possible (for example to the patient's GP).
- It should include reasons for the recommendations/changes and any required on-going monitoring.

3.4.8 Accreditation – Education and Training

The Lead Provider will be responsible for ensuring all Sub-contractor and all optometrists employed or engaged by the Lead Provider in respect of the provision of the enhanced services, will satisfy the accreditation criteria detailed below.

To become accredited, optometrists must be able to identify a range of ocular abnormalities and must demonstrate proficiency in the use of the above-mentioned equipment. Participating optometrists must be registered with the General Optical Council.

Participating optometrists must complete the WOPEC/LOCSU MECS Distance Learning modules (Part 1) and the associated Practical Skills Demonstration (Part 2), before providing the service. Part 1 must be completed before Part 2.

In addition, each optometrist taking part must complete the WOPEC/LOCSU glaucoma distance learning module (part 1) and have completed a Goldmann applanation tonometry assessment organised by LSLLOC (see 5.2.4 eligible practices). This will need to have been done within 6 months of starting the scheme.

The optometrist may wish to refresh their knowledge of cataracts by completing the WOPEC/LOCSU cataract module.

Information on how to enroll on these modules and become accredited can be sought from the LOC – www.lslloc.org

Equivalent accreditation may be agreed but would need to be agreed in advance of delivering the scheme by the CCG and endorsed by the LOC. An optometrist who has a relevant higher qualification and experience may be exempt from the MECS Distance Learning and/or the Practical Skills Assessment at the discretion of the Clinical Lead.

Optometrists new to MECS will be required to undergo relevant induction sessions which will be provided by the Lead Provider and supported by the CCGs and LOC. The Lead Provider will ensure all aspects to deliver the MECS scheme are covered, primarily to cover the administrative procedures and protocols involved in providing the enhanced service. The training session will cover:

- An introduction to the service
- Administration of the service including protocols, processes and paperwork

These sessions are in addition to the prerequisite assessment, hospital sessions, peer review sessions and education workshops (see below).

All Subcontractors (Optometrists) delivering the MECS scheme will be required to attend the following (as a minimum) every 12 months from commencement of the contract. These sessions will be set up and delivered by either the LOC or the Acute Trusts and dates and attendance must be booked in advance:

- 1 hospital session (either in Eye Casualty or a glaucoma clinic)
- 1 education workshop
- 2 peer review sessions

An optometrist who has relevant higher qualifications and experience may be exempt from attending certain hospital sessions/education workshops/peer review sessions. Please see "Minor Eye Conditions Scheme: Clinical Governance and Oversight Arrangements" document for the criteria for exemption.

The Lead Provider is required to ensure all participating optometrists have successfully completed (and stay up to date with) the training and accreditation process. And to ensure all copies of training and accreditation documentation is available to the CCGs.

The Lead Provider will be required to comply fully with the requests of both the CCGs and the Clinical Audit leads in making patient information and activity data available. This will include ensuring that all sub-contractors (such as Optometrists) comply with this request as and when required for monthly and quarterly monitoring.

The Lead Provider will be responsible for ensuring that all persons employed or engaged by the Lead Provider, in respect of the provision of the services under the Contract, are aware of the administrative requirements of the service and deadlines for submitting monthly activity for MECS.

The Lead Provider, before signing up any new sub-contractors Optometrist Practices to the MECS Scheme, must seek agreement with the Commissioners. The Lead Provider must ensure that any proposed new Sub-Contractors become part of the scheme because they provide good geographical spread across the boroughs.

3.4.9 Patient eligibility

3.4.9.1 Acceptance and exclusion criteria

To be eligible for any of the MECS services (minor eye conditions, glaucoma repeat measurement, glaucoma referral refinement or cataract referral refinement), a patient MUST be registered with a GP either in Bromley, Greenwich, Lambeth, Lewisham or Southwark. No patients registered outside of Bromley, Greenwich, Lewisham, Lambeth or Southwark can be seen under MECS.

If the patient has no GP, they must reside permanently within these boroughs to be eligible.

If a patient is not eligible for the MECS service, they can either be:

- Signposted to a MECS / PEARS service in the borough where they are registered with a GP (if such a service exists there)
- Signposted to their GP
- Seen privately by the optometrist
- Signposted to a Walk-in Clinic / Urgent Care Centre / Eye Casualty / A&E, if appropriate

3.4.9.2 Single exception to eligibility criteria

The one exception to the criteria above is where a patient presents with symptoms indicative of a retinal break (flashes/floaters). These patient types can be considered at very high risk of permanent vision loss, should a retinal break be present, and are the only exception. A patient whose GP is outside of the eligible boroughs can be seen under MECS to rule out a retinal break only. The guidance on seeing patients with flashes and floaters symptoms on page 46 should be followed in these cases. Any claims for patients outside of these eligibility criteria will be rejected.

3.4.9.3 NHS sight tests and MECS

An NHS sight test will not be performed concurrently with assessment or treatment under MECS.

3.4.9.4 Urgency and prioritization

Optometrists will need to prioritise the urgency of the conditions presented. For example, flashes and floaters will need to be seen within 24 hours. If the optometrist cannot see the

patient within this timeframe, then s/he should refer the patient to another MECS optometrist or to Eye Casualty, so that the timescale can be met.

3.4.10 Referral and patient pathway

The Lead Provider will be required to ensure all Sub-contractors are aware of the MECS referral and patient pathway and implement it effectively and appropriately, this will involve the following:

- The service will be provided during the optometry practice's normal opening hours.
- Accredited optometrists will receive referrals from patients themselves, from GPs, from non –MECS optometrists, from pharmacists, from other healthcare professionals and from the Optometrist Triage Service.
- Each patient requiring assessment and/or treatment under the service will be provided with an Information Leaflet describing the service and including a list of MECS Optometrists (sub- Contractors).
- Patients will organise a mutually convenient appointment with the sub-contractor and will be encouraged to telephone the practice to do so.
- If the sub-contractor is unable to see the patient within the appropriate timescale, or to suit the patient, s/he or a delegated practice colleague will direct the patient to an alternative provider of the service, according to the list of contractors supplied by the Lead Provider and agreed by Bromley, Greenwich, Lambeth, Lewisham and Southwark CCG.
- If urgent onward referral to hospital eye services is required, the sub-contractor (optometrist) will advise the relevant hospital eye service via the urgent referral pathway and a copy of the patient's Service Record will be given to the patient for presentation on attendance.
- If an onward referral to hospital eye services is required, the sub-contractor (optometrist) will discuss with the patient their choice of hospital and appointment time and will book the patient into an appropriate clinic via the electronic referral system (e-RS). The Optometrist will ensure that the necessary information is attached to the referral within national timeframes (3 working days).
- Where a sight test/routine eye examination is required, the sub-contractor will direct the patient to their usual community optometrist. A copy of the patient's Service Record will be sent securely via NHSMail within 24 hours to the community optometrist, if they have such an address, or it can be given to the patient to present on attendance.
- The sub-contractor will provide the patient with a paper copy of their Service Record, if requested.
- The sub-contractor will send a copy of each patient's Service Record to the patient's GP (within 24 working hours, where a prescription is required, unless the prescribed medication is part of the agreed formulary in 3.4.7 above, in which case a voucher may be issued for presentation at a Pharmacy First - Common Ailments Scheme).
- The sub-contractor will provide all appropriate clinical advice and guidance to the patient in respect of the management of the presenting condition.
- Where appropriate, the sub-contractor will provide the patient with an Information Leaflet on his/her eye condition.
- Should a patient fail to arrive for an appointment, the optometrist must contact the patient within 24 working hours, informing them that they have missed their appointment, and asking them if they wish to arrange a further appointment.

3.4.11 Follow-up processes

The Lead Provider will be required to ensure treatments conducted by sub-contractors do not routinely attract a follow-up appointment. All follow-up appointments must be clinically justified; follow up rates should be monitored and outlying practices (higher follow-up rate, low follow-up rate) should be contacted to discuss a review of a sample of patients by the Lead Provider.

3.4.12 Interdependencies with other services/providers

MECS providers will play a pivotal role within a whole-system approach to improve ophthalmology care within South East London. MECS providers will be required to establish good working relationships with:

- Bromley, Greenwich, Lambeth, Lewisham and Southwark GP Practices
- Acute Trust Providers – Guy's and St Thomas' NHS Foundation Trust, King's College Hospital NHS Foundation Trust, Lewisham and Greenwich NHS Trust, Moorfields Eye Hospital NHS Foundation Trust
- NHS Bromley CCG, NHS Greenwich CCG, NHS Lambeth CCG, NHS Lewisham CCG, NHS Southwark CCG
- Pharmacies who are part of the MECS scheme

3.4.13 Key Performance Indicators

	Measure and threshold	Reporting Mechanism
1	Maximum 27% patients referred onto secondary care	Monthly Activity Report / Quarterly Summary Report
2	Maximum new to follow-up ratio 1: 0.11	Monthly Activity Report / Quarterly Summary Report
3	95% of patients satisfied with service	Six-month CCG-supported patient surveys
4	90% of patients seen by optometrists within 1 week of contacting them. This includes referral to another optometrist if the patient cannot be seen within the timescale. It is the responsibility of the originating optometrists to ensure that another practice can see the patient within the required timescale.	Monthly Activity Report / Quarterly Summary Report
5	90% of audited referral to secondary care deemed appropriate	Quarterly summary of weekly consultant ophthalmologist reviews of MECS consultations (only to be included if data is available from Secondary Care)
6	100% Correct eligible borough of patient's GP registration recorded for each patient	Monthly Activity Report
7	Maximum 5% of patients seen who would have been more appropriately managed by the GP or a pharmacist	Quarterly summary of weekly consultant ophthalmologist reviews of MECS consultations (only to be included if data is available from Secondary Care)

3.4.14 Reporting requirements

3.4.14.1 Monthly activity report

The Lead Provider will ensure sub-contractors complete a monthly activity report, in the format agreed and provided by the CCG and the Lead Provider. The activity report will be fully, accurately and legibly, completed for each patient managed. The Lead Provider will ensure that Sub-Contractors complete all MECS forms in the same way.

For each appointment the report will detail:

- Type of appointment (e.g. MECS 1st, MECS FU)
- Appointment date

- Optometrist practice
- Optometrist
- Patient ethnicity
- Patient's GP practice
- Patient wait time for appointment
- Patient source of referral (e.g. self-referral, GP, referral from other optometrist)
- Reason referral
- Patient destination (e.g. discharged, routine referral to secondary care, urgent referral to secondary care)
- Amount claimed

3.4.14.2 Contract review meetings

The Lead Provider will prepare and provider the following information for the quarterly contract review meetings:

- Number of referrals (by CCG and individual optometry practice)
- Source of referral (by CCG and individual optometry practice)
- Number of referrals by GP Practice (where source of referral is GP)
- Split by activity type (by CCG and individual optometry practice)
- MECS spend (by CCG and individual optometry practice)
- Reason for referral (by CCG and individual optometry practice)
- Waiting times (by CCG and individual optometry practice)
- Outcome of appointment (by CCG and optometry practice)
- Ethnicity of patients (by CCG and optometry practice)
- Number of Did Not Attends (by CCG and optometry practice)

3.4.14.3 Additional reporting requirements

The Lead Provider will co-operate with the CCGs as reasonably required in respect of monitoring and assessment of the service, including:

- Clinical Governance issues and complaints will be reported by the sub-contractor to the Lead Provider who will ensure all complaints are recorded and dealt with and ensure the CCG is notified monthly.
- Monitor and record the number of MECS vouchers that are prescribed /issued by the sub-contractor for medication and ensure they are appropriate.
- Attending any meeting or ensuring that an appropriate representative of the Lead Provider attends any meeting (if held at a reasonably accessible place and at a reasonable hour, and due notice has been given), if the Lead Provider presence at the meeting is reasonably required by the CCG.

3.5 Clinical and information governance

3.5.1 Clinical and quality standards

	Requirements	Evidence
1. Patient safety	a. Incident reporting: clear systems are in place to ensure all clinical untoward incidents/near misses are reported, investigated, actions plans in place, implemented and monitored	• Policy in place • Incidents/significant event reports and reviews evidence of learning and change in practice
	b. Serious untoward incidents	• Practice/team meeting notes • Reported to the CCG
2. Infection control	a. Systems are in place to ensure appropriate	• Infection control policy in place (including sharps)

	infection control procedures are in place	• Waste management and decontamination • Audit reports and action plans
3. Risk management	a. Systems are in place to ensure premises, environment and equipment are fit for purpose	• Evidence of health and safety checks • Risk assessments • Fire safety checks • Equipment maintenance checks • Procedure for reporting RIDDOR • Procedure for safety alert bulletins
4. Clinical effectiveness / audit	a. Systems are in place to deliver best practice	• Protocols/guidelines/policies in place
	b. Annual audit programme is in place	• Audit programmes for national/local priority practices, report and action plans for improvement
5. Education / training	a. Systems are in place to ensure staff receive Continuous Professional Development, relevant training	• Training records for essential training: o Fire o Basic life support o Equipment training records o Child and adult protection • Annual appraisal of staff • Personal development plans • Supervision/mentoring arrangements
6. Patient / public engagement	a. Systems are in place to ensure all complaints are investigated, appropriate action taken and learning takes place	• Policies and procedures • Action plans • Evidence of learning from incidents and/or change in practice
	b. Systems are in place to ensure patient opinion is sought and used for improvement	• Patient input into planning services • Minimum 6 month patient surveys and action plans
7. Staff management	a. Systems are in place to ensure all the necessary employment checks are undertaken	• CRB • Indemnity certificates • Professional registrations • Professional qualifications
	b. Systems are in place to ensure job descriptions and contracts are in place and reviewed appropriately	• Job descriptions • Contracts

3.5.2 Quality in optometry

The Lead Provider is responsible for ensuring that all sub-contractors complete all relevant training and quality requirements for the Service.

Sub-contractors must complete and comply with the 'Quality in Optometry LOC Company Subcontractor' checklist within 30 days of the commencement of the contract and provide evidence of this to the Lead Provider.

3.5.3 Significant incident reporting

A record of all significant incidents (SIs), near misses and potential incidents must be maintained. Any SIs must be reported to the designated CCG lead within 24 hours.

All complications resulting from a MECS examination or treatment must be recorded on the patient record.

3.5.4 Infection control

MECS premises must be kept clean; this includes all areas of public access.

In all consulting and screening rooms used, hard surfaces should be regularly cleaned using appropriate hard surface solution/wides.

Hand washing facilities must be provided in, or near to, consulting/screening rooms. Hot and cold water should be available, and liquid soap and paper towels provided.

All equipment that comes into contact with patients must be cleaned after each patient. This may be by using antiseptic wipes (or similar) for head / chin rests or by using disposable chin rests.

Disposable heads should be used for Tonometer prisms.

Epilation equipment must be sterilised between patients.

3.5.5 Waste management

In accordance with College of Optometrists guidelines used tissues and paper towel can be disposed of in normal 'black bag' waste.

Part-used (or out of date) minims need to be incinerated and can be discarded in a medicine disposal box.

Chloramphenicol is regarded as hazardous waste and requires specialist incineration.

3.5.6 Clinical audit

The Lead Provider will be required to participate in any clinical audit activity as reasonably required by the CCGs and ensure themselves and all sub-contractors maintain appropriate records to evidence and support such activity, including an electronic spread sheet and monitoring sheets showing patient outcomes.

3.5.7 Information governance

The Lead Provider will ensure that they and the sub-contractors meet the following information governance requirements:

- Maintenance of Data Security and Protection (DSP) Toolkit
- Registration with the Information Commissioner's Office (ICO)
- The Lead Provider and all sub-contractors will use e-RS and NHS mail for communication of patient identifiable information

3.6 Activity

The expected annual activity levels are estimated based on the activity of the MECS services in 2017/18 (where MECS services were in place) and additional activity which will result from mandating the Optometrist Triage Service. As the figures below are estimates, they should only provide a rough estimate of expected annual throughput.

	Estimated Annual Throughput				
Function	**Bromley**	**Greenwich**	**Lambeth**	**Lewisham**	**Southwark**
MECS New attendance	4,005	1,292	4,007	2,179	1,974
MECS FU attendance	547	133	734	224	203
Glaucoma full assessment	46	15	46	25	23
Glaucoma refinement IOP only	37	12	37	20	18
Glaucoma refinement fields only	100	32	99	54	49
Glaucoma refinement IOP/fields	90	29	90	49	45
Cataract refinement	306	99	307	167	151

3.7 Finance

3.7.1 MECS activity payments

Payment for the MECS activity is on a cost per case basis:

Activity type	Cost per case
MECS New attendance	£48.00
MECS FU attendance	£28.00
Glaucoma full assessment	£47.00
Glaucoma refinement IOP only	£15.00
Glaucoma refinement fields only	£23.00
Glaucoma refinement IOP/fields	£28.00
Cataract refinement	£25.00

For the avoidance of doubt, no payment will be made by the CCG in respect of DNAs.

3.7.2 Lead Provider payments

Additional payments will be made by the CCGs for MECS service administration and day-to-day management of the scheme. This will cover:

- Quarterly review meetings with the CCGs leads
- Processing of monthly activity reports
- Processing invoices and payments
- Compiling quarterly contract review meeting report
- Set-up of MECS optometry practices
- Monitoring performance of individual optometry practices
- Annual visits and performance review of all MECS optometry practices
- Administration for hospital sessions, peer review and accreditation

No additional funds can be invoiced.

3.7.3 Invoicing

The Lead Provider is responsible for ensuring the sub-contracts check that a patient is registered in a qualifying borough (Bromley, Greenwich, Lambeth, Lewisham and Southwark).

The Lead Provider will be required to submit monthly invoices for payment. The Lead Provider should invoice the Co-ordinating Commissioner (NHS Southwark CCG) for all activity, providing a detailed breakdown of spend and activity by CCG. For each CCG, activity should relate to patients registered or residing within their borough (rather than the location of the MECS practices). The only exception to this is where a patient presents with symptoms indicative of a retinal break (flashes/floaters). A patient whose GP is outside of the eligible boroughs can be seen under MECS to rule out a retinal break only. In these circumstances the CCG where the MECS practice is located will be charged for the appointment.

Invoices should be submitted no later than 20th day of each calendar month for all MECS activity and administration work for the previous month. The Lead Provider is required to ensure each invoice submitted has a unique invoice number and date to ensure payment.

The Lead Provider will also be required to submit a monthly MECS activity report (see 3.4.14.1) to the Co-ordinating Commissioner by the 20th day of each calendar month which match and reflect exactly the amount claimed in the corresponding invoice.

Activity will be closely monitored throughout the contract and the Lead Providers are responsible for ensuring that the scheme is helping to deliver out of hospital treatment, whilst not generating such a level of demand that the scheme is unviable either operationally or financially.

4 PART B: Optometrist Triage Service

4.1 Aims and objectives of service

The aims and objectives of the Optometrist Triage Service are as follows:

- Ensure a consistent use of community alternatives
- Ensure patients are seen in a timelier fashion
- Reduce pressure on acute services
- Ensure patients are able to seek treatment closer to home

4.2 Service description/care pathway

The Optometrist Triage Service will triage all ophthalmology referrals across Bromley, Greenwich, Lambeth, Lewisham and Southwark where the GP is unsure whether their patient has a minor eye condition or believes their patient needs a routine secondary care appointment. Following a clinical triage, the service will do one of three things:

- provide advice and guidance to GPs to support management of the patient in primary care,
- contact the patient to arrange for them to be seen under MECS at a participating local Optician's practice
- refer the patient on to secondary care.

If a GP is confident that their patient has a minor eye condition, they can refer their patient directly to MECS, without needing to go through the Optometrist Triage Service. Adherence to the pathways is mandated, and hospital eye services will redirect those referrals received directly from GP practices to the Optometrist Triage Service. See Figure 1 for the pathway.

The functions of the Optometrist Triage Service are as follows:

- Referrals
- Triage and appointments
- Managing capacity
- Supporting information management and technology (IM&T)
- Supporting audit

4.2.1 Referrals

The service will receive referrals from GPs, other healthcare professionals and MECS providers and will be required to make onward referrals to hospital eye services. The referral routes are set out below.

Referrals to the Optometrist Triage Service:

- GP referrals to the Optometrist Triage Service should be sent via the NHS electronic Referral System (e-RS) only
- Referrals from other healthcare professionals (e.g. optometrist practices not participating in MECS) to the Optometrist Triage Service should be sent via e-RS where possible. If the healthcare professional does not have access to e-RS, the referral should be made via NHS mail.

Onward referrals to secondary care:

- If following the clinical triage the Optometrist Triage Service deems the patient suitable for secondary care, the Optometrist Triage Service should book the patient a secondary care appointment via e-RS.
- If following a MECS appointment the patient needs to be referred to secondary care:
    - If the MECS practice has the facility to book directly with a secondary care provider via e-RS, the practice should book the secondary care appointment via e-RS.
    - If the MECS practice does not have the facility to book directly with a secondary care provider via e-RS, the MECS practice should send the referral to the Optometrist Triage Service, and the Optometrist Triage Service should book the secondary care appointment via e-RS.

Patients must be registered with a GP in Bromley, Greenwich, Lambeth, Lewisham or Southwark. There is no age limit for the Optometrist Triage Service. The provider must ensure that the referrer provides sufficient detail in the referral in order to enable accurate triage. If the referral is incomplete, the Optometrist Triage Service should request additional information from the GP unless the triager suspects that the patient needs emergency care, in which case the patient should be immediately signposted to hospital eye casualty or A&E.

4.2.2 Triage and appointments

The Optometrist Triage Service will operate five days a week. Clinical triage will be completed for all referrals within 1 working day and prioritised in chronological order. Referrals received on Friday will be clinically triaged on the following Monday at the latest. Qualified clinicians will triage and place patients on the appropriate service pathway. This can be either:

1. Directed back to the GP/Optometrist with feedback
2. Directed into MECS
3. Referred to hospital eye services of the patient’s choice
4. Directed to emergency care

4.2.2.1 Patient referred back to the GP/Optometrist with feedback

The clinical triager may refer the patient back to the GP/Optometrist if:

- the triager believes the conditions could be managed in primary care, if so, the triager should provide advice and guidance to support management of the patient in primary care
- the condition is not eye related
- insufficient information is included in the referral

4.2.3 Patient referred to MECS

If the triager deems the patient suitable for MECS, the Optometrist Triage Service should send a letter to the patient notifying them that they are suitable for MECS and need to arrange an appointment with their chosen provider. The letter should include details of all the MECS providers in South East London so the patient can make an informed choice. If there are

specialist MECS practices for certain conditions, the letter should offer a choice of those practices specialised in the patient's condition.

The patient should be sent a letter within 2 working days following clinical triage.

The patient should make contact with their chosen MECS provider to arrange an appointment, and once the patient has booked an appointment, the patient's details should be transferred securely to the MECS provider. The MECS Providers and Optometrist Triage Service should work with the CCG to find a secure and effective method for transferring/retrieving patient information, using e-RS where possible.

If a patient's details have not been transferred to/retrieved by a MECS provider 20 working days following administrative triage (i.e. the patient has not tried to book a MECS appointment), the Optometrist Triage Service should try to contact the patient via telephone to remind them of the need to book an appointment. If the Optometrist Triage Service is unable to make contact via telephone, a reminder letter should be sent to the patient.

If patient's details have not been transferred to/retrieved by a MECS provider by the 40 working days following clinical triage, the patient should be discharged from the Optometrist Triage Service and a letter sent to their GP notifying them that the patient has not been seen.

4.2.3.1 Patient referred to hospital eye services of the patient's choice

If the triager deems the patient suitable for hospital eye services, the Optometrist Triage Service should send a letter to the patient notifying them that they are suitable for a hospital appointment and need to arrange an appointment with their chosen provider. The letter should include the patient's Unique Booking Reference Number (UBRN) and details of how the patient can book their appointment either on online (through Manage Your Referral) or via telephone (e-Referral Service Appointments Line). Where available, the Optometrist Triage Service should shortlist multiple services so the patient has a choice of providers. If details of the patient's preferred hospital eye service have been included in the referral sent to the Optometrist Triage Service, the Optometrist Triage Service should book the patient an appointment with that provider and send the patient a letter detailing how they can amend their booking.

Patients should be sent a letter within 2 working days following clinical triage.

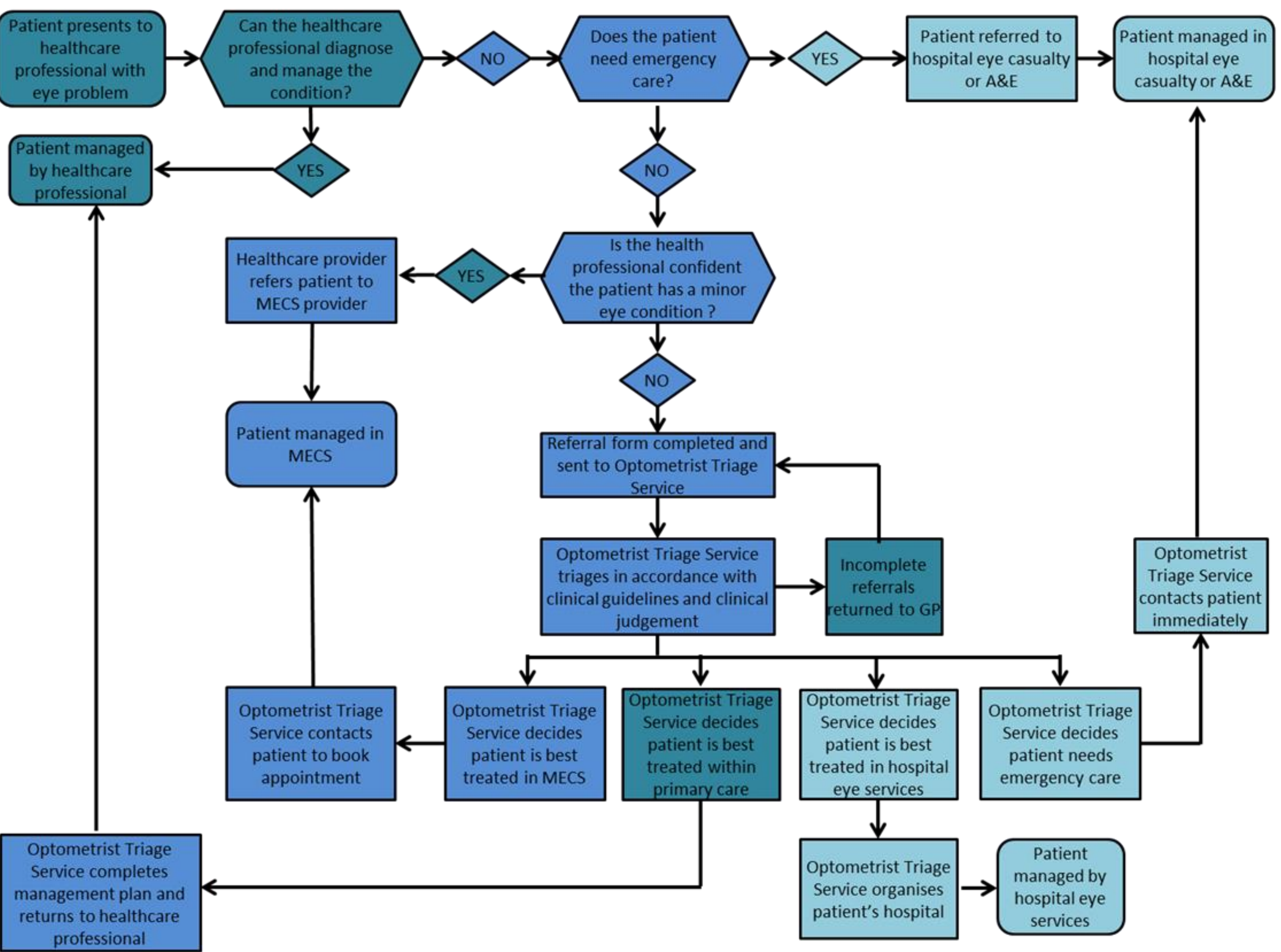
The e-Referral Service will automatically send reminders to patients if an appointment has not been booked at 2 and 4 weeks after the initial letter has been sent to the patient. If 3 weeks after the second reminder has been sent out, the patient has not booked their appointment, the Optometrist Triage Service should contact the patient via telephone and remind the patient to book their appointment, giving them 1 week to do this. If 1 week after this reminder the patient has still not booked an appointment, the referral should be cancelled, and the patient should be discharged back to their GP.

All referrals to hospital eye services should be made via e-RS. The only exceptions to this are certain urgent pathways and where sub-specialty clinics have not set-up on e-RS by hospital eye services.

4.2.3.2 Patient referred to emergency care

Any patient whom the triager believes needs emergency care must be immediately signposted to hospital eye casualty or A&E (i.e. within 1 working day from receipt of referral).

Figure 1: Patient pathway



4.3 Manage capacity
The Optometrist Triage Service should manage capacity and signpost to the appropriate services based on the availability of optometrist or ophthalmologists available to deliver the service at the time. The Provider will keep an updated list of optical practices providing MECS services.

4.4 Support information management and technology (IM&T)
The Provider will use e-RS for referral management, clinical triage and communication. The provider and all subcontractors will use NHS mail for communication of patient identifiable information. The CCGs will support access to e-RS and mobilisation to the e-RS platform.

4.5 Support audit
The Provider will adhere to pathways provided by the CCGs where appropriate and will undertake regular audits on triaged referrals. These audits will be review by a lead clinician and anonymised data shared with commissioners.

4.6 Population covered
The Optometrist Triage Service will be for patients registered with a General Practitioner within Bromley, Greenwich, Lambeth, Lewisham and Southwark.

4.7 Any acceptance and exclusion criteria
Patients requiring an urgent emergency care are not suitable for the Optometrist Triage Service and should bypass the triage to access emergency care.

For example:

- Detached retina
- Chemical injury

Please see sections 3.4.1, 3.4.2, 3.4.3 and 3.4.9 of this service specification for the MECS acceptance and exclusion criteria and referral pathways.

4.8 Interdependence with other services/providers
The Optometrist Triage Service will play a pivotal role within a whole-system approach to improve ophthalmology care within South East London. The Optometrist Triage Service will be required to establish good working relationships with:

- Bromley, Greenwich, Lambeth, Lewisham and Southwark GP Practices
- Acute Trust Providers – Guy's and St Thomas' NHS Foundation Trust, King's College Hospital NHS Foundation Trust, Lewisham and Greenwich NHS Trust, Moorfields Eye Hospital NHS Foundation Trust
- NHS Bromley CCG, NHS Greenwich CCG, NHS Lambeth CCG, NHS Lewisham CCG, NHS Southwark CCG
- Optometry practices who are part of MECS
- Optometry practices within Bromley, Greenwich, Lambeth, Lewisham and Southwark

4.9 Location of provider premises and days/hours of operation
4.9.1 Location of Provider premises
There are no specific location requirements; however, the provider will need to operate from premises where there is an N3/Health and Social Care Network (HSCN) connection or other means by which to safely and securely use NHS email and e-RS.

4.9.2 Days/hours of operation
The Optometrist Triage Service must be contactable and able to receive and review referrals daily (Monday to Friday) during normal working hours (9am to 5pm).

4.10 Key response times

The Optometrist Triage Service will offer the following response times at key points in the triage. Times are measured from the date a complete referral is received from the GP (and may be delayed if the referral form is incomplete).

Process	Timescales
Clinical triage decision made on all referrals	1 working day from receipt of referral
Patients requiring emergency care signposted to hospital eye casualty or A&E	1 working day from receipt of referral
Additional information requested for incomplete referrals	2 working days from receipt of referral
Letter sent to patients requiring MECS appointment	2 working days following clinical triage
Letter sent to patients requiring hospital eye services.	2 working days following clinical triage
Reminder to patients who haven't booked MECS appointment: 1 telephone call and letter sent to patient if unable to contact via telephone	20 working days following admin triage
Reminder to patients who haven't booked hospital eye services appointment: 1 telephone call to patient	35 working days following admin triage
Patient discharged from OTS and letter sent to GP notifying them that the patient has not been seen (for hospital eye services patients).	40 working days following admin triage
Patient discharged from OTS and letter sent to GP notifying them that the patient has not been seen (for MECS patients).	40 working days following admin triage

4.11 Monitoring and evaluation

The Service will gather activity data to a level which enables the impact of the Optometrist Triage Service to be evaluated. In addition, the service will conduct an annual GP and patient evaluation and demonstrate that they have considered and, where appropriate, acted on feedback.

4.11.1 Evaluation of impact

The following broad measures will be used by Commissioners to evaluate the overall impact of the service within the health economy:

i) Utilisation of the Optometrist Triage Service per month, in total and from each GP practice
ii) Referral destinations at triage, as a whole and by GP practice
iii) Impact on total ophthalmology activity per year for Bromley, Greenwich, Lambeth, Lewisham, and Southwark
iv) Impact on total ophthalmology spend per year
v) Impact on referral rates into acute trusts

4.11.2 Key performance indicators

Performance management of the Service will be carried out quarterly and will focus on the following KPIs:

	Indicator	Tolerance	Consequences of breach
1	Triage turnaround times (per month)	• Triage to be completed within 1 working day from receipt of referral	Failure for 1 month will result in discussion in contract management meetings. Failure to

		• 3 working days of referral for patient to be contacted for MECS appointment/ hospital eye services	comply for 2 consecutive months will require the provider to produce a written action plan detailing mitigating steps Failure to comply for 3 consecutive months will result in a formal contractual review which may lead to termination of the contract.
2	e-RS utilisation	100% (excludes urgent referrals)	Should e-RS compliance fall below 90% then the provider will work with the CCG and acute providers to develop rectification plan
3	GP satisfaction in respect of referral process, waiting times and quality of information given back from the service	90% of GP practice respondents report satisfaction with the services they receive 100% of GP practices are offered an opportunity to complete a GP satisfaction survey annually	Should satisfaction fall below 85% then the provider will be required to produce a rectification plan. Should patient satisfaction be consistently below expectations, a formal contractual review will be initiated.
4	Mandatory staff training	100% compliance	Zero tolerance approach will be taken in respect of mandatory training. The CCG reserves the right to suspend the service should evidence not be provided that mandatory training has been completed.

4.11.3 Key quality and safety indicators

	Indicator	Tolerance	Consequences of breach
1	Number and severity of complaints	n/a	All complaints and incidents should be graded and investigated and reported as part of contract monitoring. The provider should share any action plans in relation to the findings of these investigations with the CCG. Repeated incidents around common themes

			will lead to a formal contractual review where the contract could be terminated.
2	Serious incidents	0. The service should meet national requirements in reporting any serious incidents to the CCG.	All complaints and incidents should be graded and investigated and reported as part of contract monitoring. The provider should share any action plans in relation to the findings of these investigations with the CCG. Repeated incidents around common themes will lead to a formal contractual review where the contract could be terminated.

4.11.4 Data requirements from the service

The following data should be complied in order to measure KPIs and support furthers service evaluation.

High level activity:

- Number of referrals received from each GP practice
- Number of referrals received from other sources

Number and percentage of referrals that are:

- Returned to GP for further information
- Referred to MECS for an appointment
- Referred to hospital eye services for routine appointment
- Referred to hospital eye casualty or A&E for emergency care

Turnaround times:

- Number and percentage of referrals triaged within 1 working day
- Number and percentage of referrals triaged outside of 1 working day (broken down by days)
- Number and percentage of (MECS and hospital eye services) referrals actioned 2 working days following clinical triage
- Number and percentage of (MECS and hospital eye services) referrals actioned outside 2 working days following clinical triage

Satisfaction:

- Number and percentage of GPs who are satisfied with the service they received
- Number and percentage of patients who are satisfied with the service

4.12 Activity

The expected annual activity levels are estimated based on activity from 2017/18. As the figures below are estimates, they should only provide a rough estimate of expected annual throughput.

Triage activity:

	Estimated annual throughput
Bromley	6,662
Greenwich	3,839
Lambeth	2,527
Lewisham	3,597
Southwark	2,402

4.13 Finance

- The provider will submit monthly invoices, one month in arrears to each of the CCGs. The invoice must specify activity levels for triage. Invoices should be submitted no later than 20th day of each calendar month for all triage activity and administration work for the previous month.
- Payment will be made when invoices have been reconciled with activity reports provided by the provider.

4.14 Accreditation

All clinical staff involved in the triage should be qualified optometrists/consultant ophthalmologists who have full membership of the appropriate relevant medical council and who have undertaken WOPEC training (or equivalent).

The provider is responsible for ensuring all clinical staff have the necessary qualifications and continuing professional development required to maintain their qualification.

4.15 Clinical and information governance

The Provider is responsible for all aspects of clinical governance through an effective system of quality and risk management in line with the requirements of Standards for Better Health. The provider shall nominate a senior manager or clinician who shall have responsibility for ensuring the effective operation of clinical governance.

The Provider must provide an up-to-date document outlining clinical governance arrangements to the CCGs prior to service commencement. This will include details of any sub-contract arrangements associated with the service.

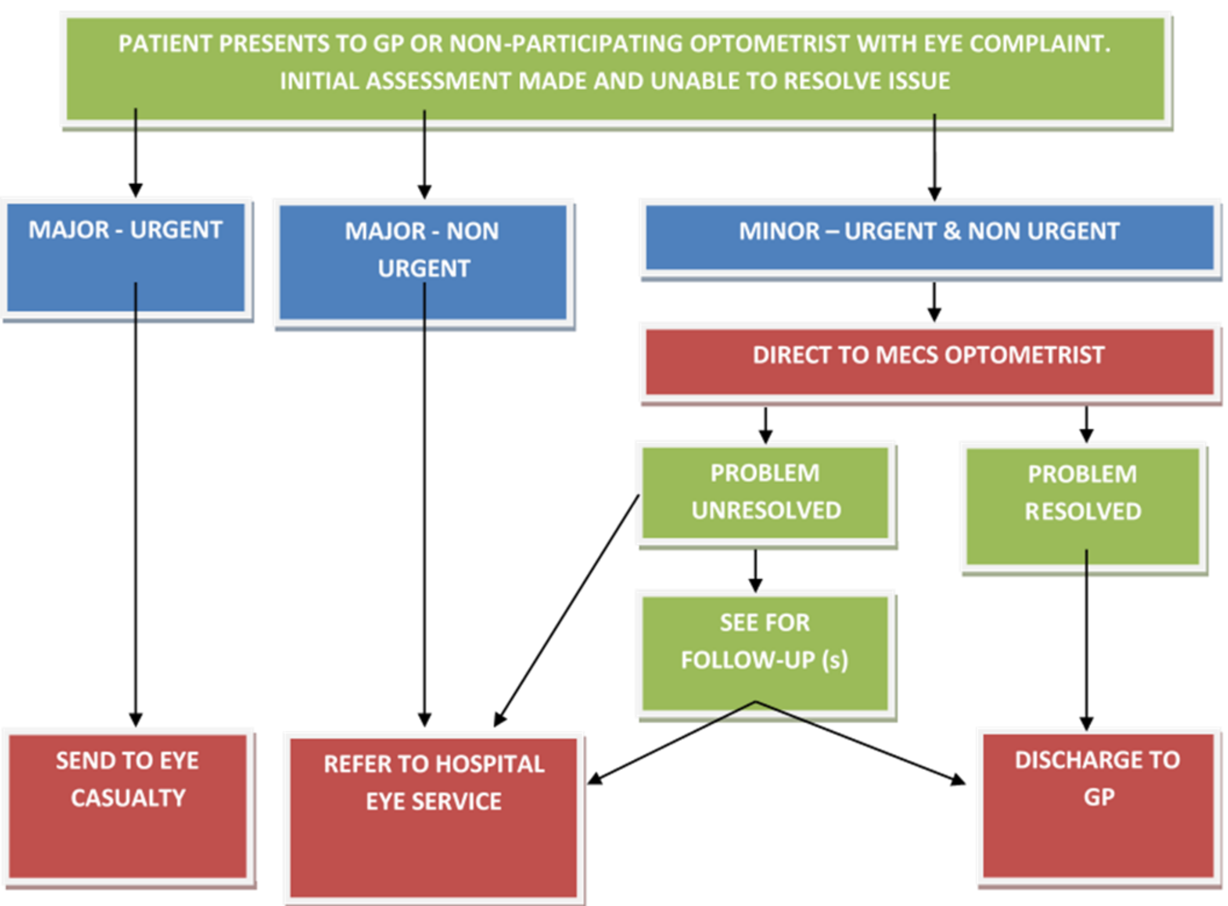
The provider will provide the CCGs with evidence that all practitioners providing the service meet the accreditation requirements appropriate to their role.

In addition, the provider must ensure that the service meets the following information governance requirements:

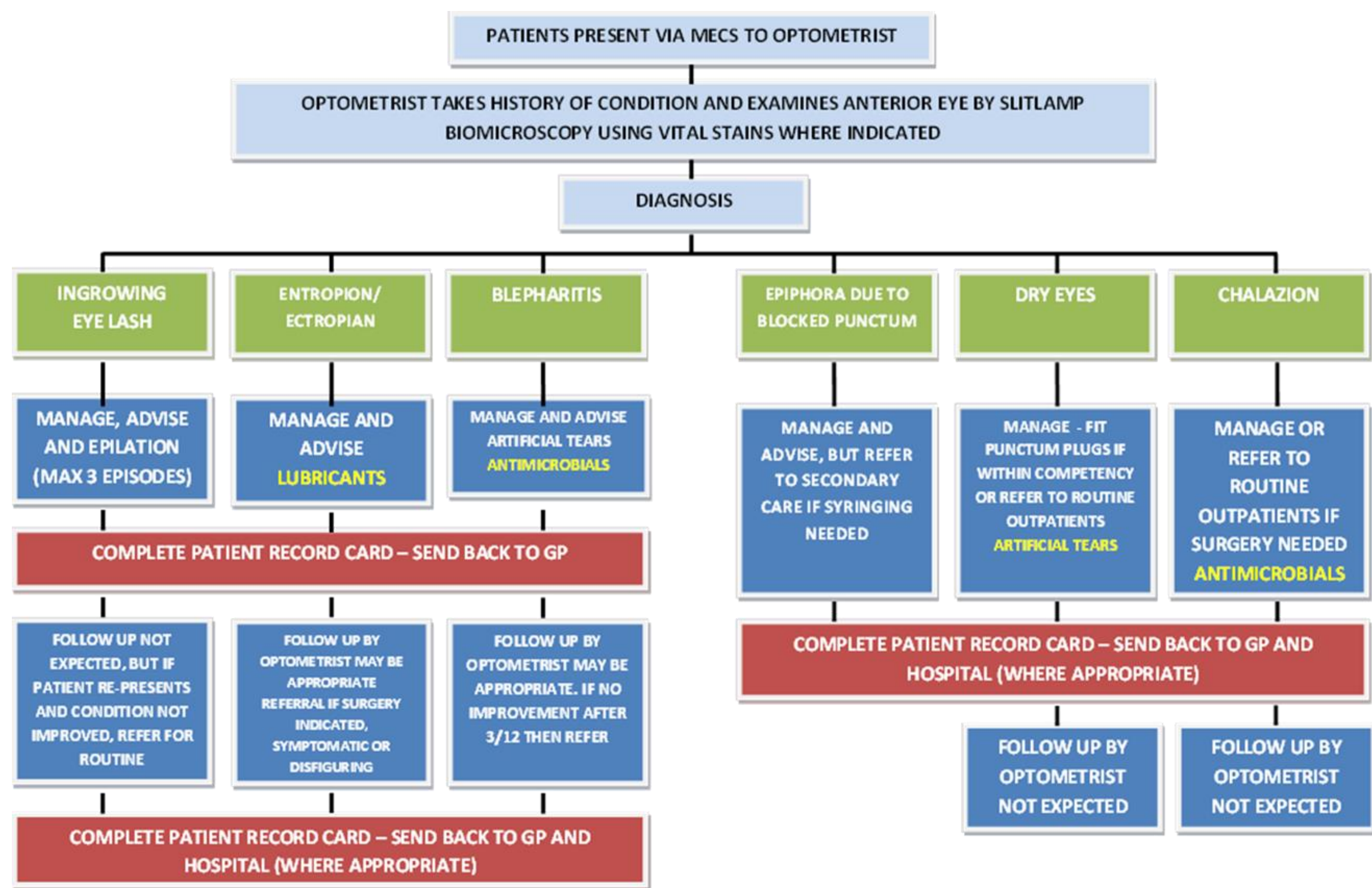
- Maintenance of Data Security and Protection (DSP) Toolkit
- Registration with the Information Commissioner's Office (ICO)
- Care Quality Commission (CQC) registration (where appropriate)

Appendix A: Patient pathways

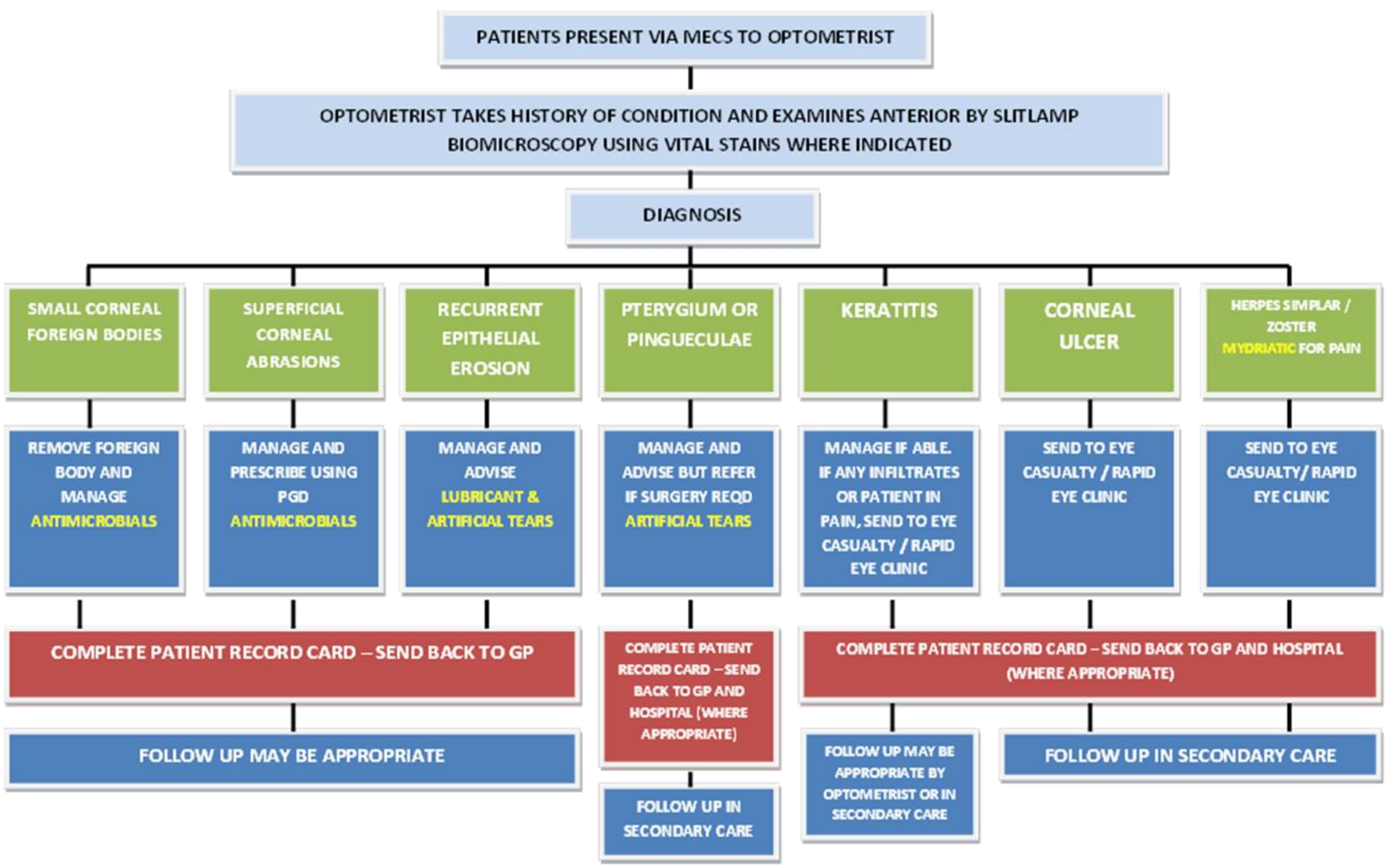
Patient pathway 1: MECS pathway



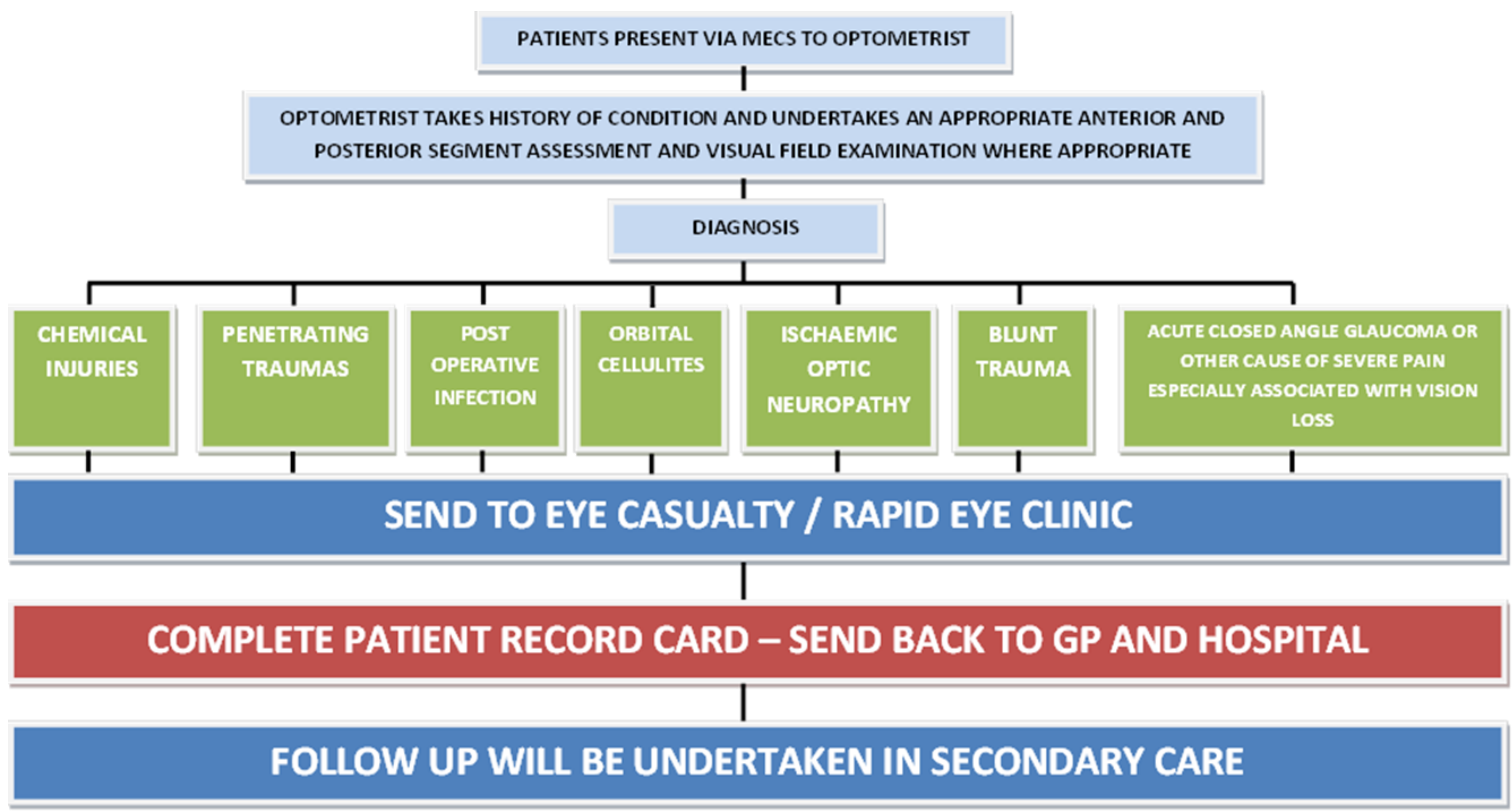
Patient pathway 2: Lids, lashes and tears pathway



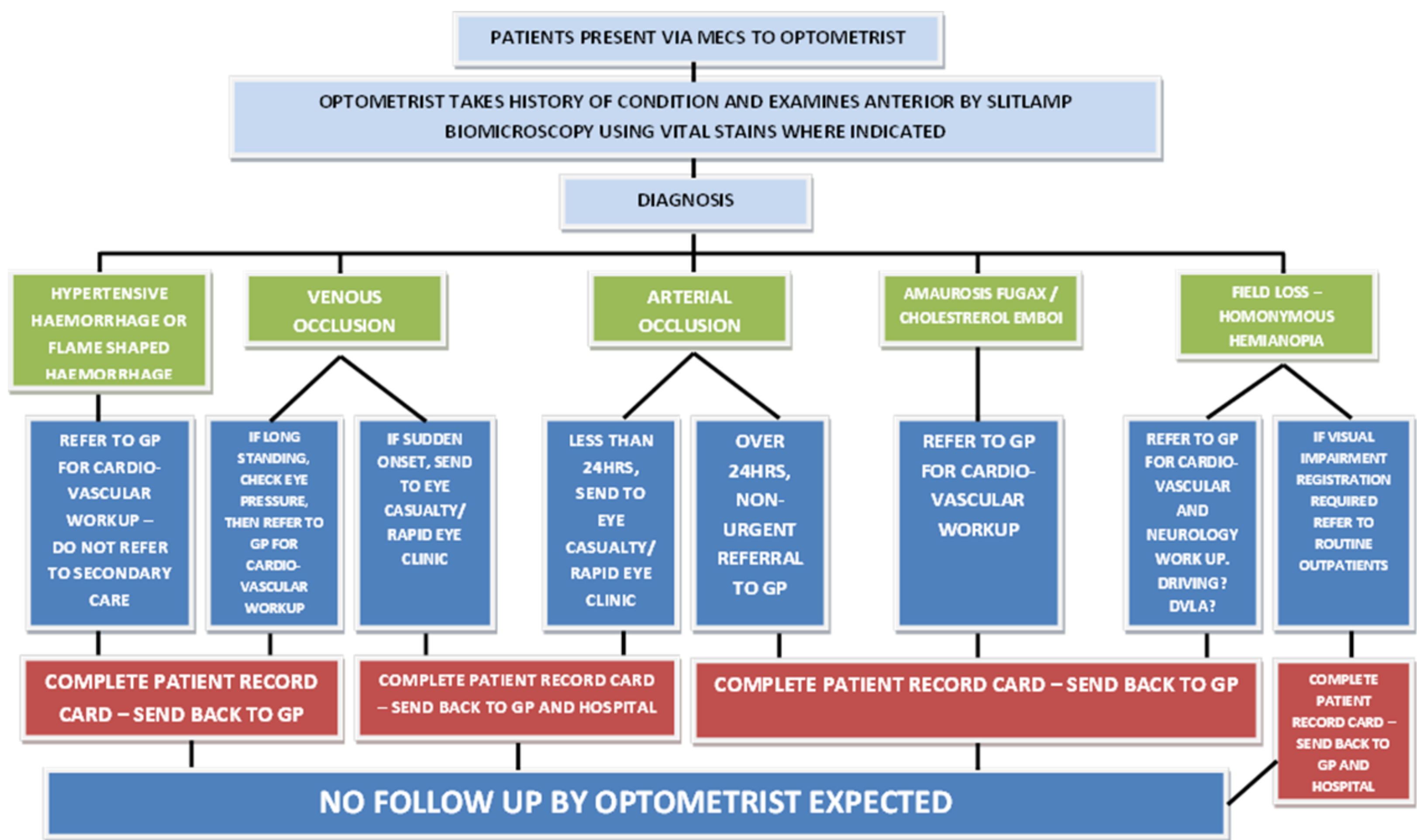
Patient pathway 3: Corneal pathway



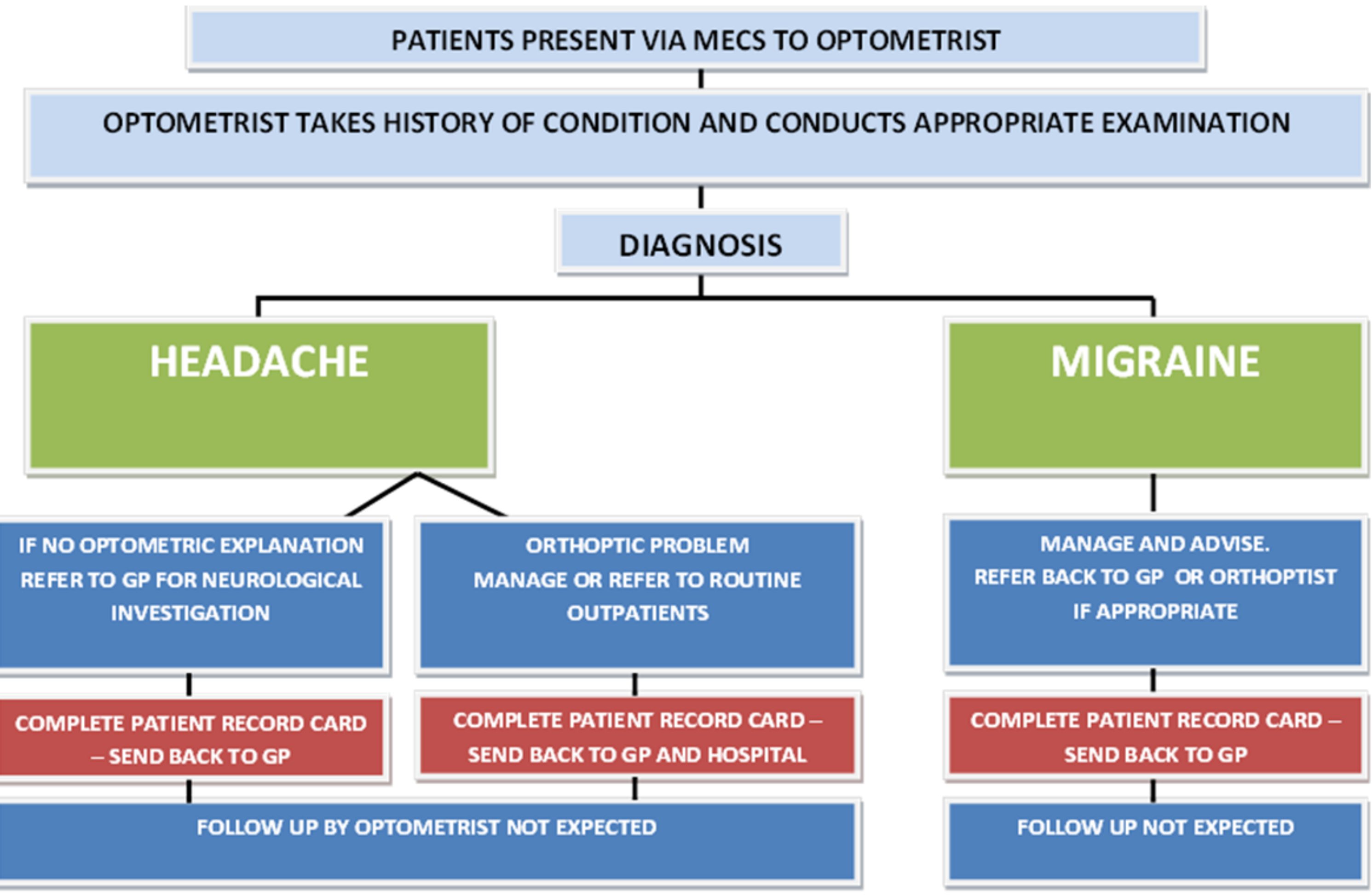
Patient pathway 4: Other ocular emergencies (for flashes and floaters see Appendix B)



Patient pathway 5: Vascular abnormalities



Patient pathway 6: Headache and migraine pathway



Appendix B: Flashes and Floaters Management Guidelines

Terminology
The following terms are important in this text:

- Retinal break: this is a retinal hole or tear
- Retinal detachment: this is any type of retinal detachment including rhegmatogenous, traction or exudative

Optometric Assessment
History and Symptoms - A full and thorough history and symptoms is essential. In addition to the normal history and symptoms, careful attention must also be given to the following:

History

- Age
- Myopia
- Family history of retinal break or detachment
- Previous ocular history of break or detachment
- Systemic disease
- History of recent ocular trauma, surgery or inflammation

Symptoms

- Loss or distortion of vision (a curtain / shadow / veil over vision)
- Floaters
- Flashes

For symptoms of floaters these additional questions should be asked:

- Are floaters of recent onset?
- What do they look like?
- How many are there?
- Which eye do you see them in?
- Any flashes present?

For symptoms of flashes these additional questions should be asked:

- Describe the flashes?
- How long do they last?
- When do you notice them?

For symptoms of a cloud, curtain or veil over the vision these additional questions should be asked:

- Where in the visual field is the disturbance?
- Is it static or mobile?
- Which eye?
- Does it appear to be getting worse?

Symptoms of less concern

- Long term stable flashes and floaters
- Symptoms >2 months
- Normal vision

Clinical examination
All patients presenting for a MECS examination with symptoms indicative of a potential retinal detachment should have the following investigations (in addition to such other examinations that the optometrist feels are necessary):

- Tests of pupillary light reaction including swinging light test for Relative Afferent Pupil Defect (RAPD), prior to pupil dilation
- Visual acuity recorded and compared to previous measures
- Contact tonometry, noting IOP discrepancy between eyes
- Visual Field examination at discretion of optometrist
- Slit lamp bio microscopy of the anterior and posterior segments, noting:
  - Pigment cells in anterior vitreous, 'tobacco dust' (Shafer's sign)
  - Vitreous haemorrhage
  - Cells in anterior chamber (mild anterioruveitic response)
- Dilated pupil fundus examination with slit lamp binocular indirect ophthalmoscopy using a Volk or similar fundus lens (wide field fundus lens optimal) asking the patient to look in the 8 cardinal directions of gaze and paying particular attention to the superior temporal quadrant as about 60% of retinal breaks occur in that area. Noting:
  - Status of peripheral retina, including presence of retinal tears, holes, detachments or lattice degeneration
  - Presence of vitreous syneresis or Posterior Vitreous Detachment (PVD)

Management

If local protocols for the referral of retinal detachment are in place, then these should be followed. If not, you should note that some HES ophthalmology departments will not have RD surgery facilities. In these cases it is best to telephone the department first to find out what procedures to follow.

Symptoms requiring referral within 24 hours:

1) Sudden increase in number of floaters, patient may report as "numerous", "too many to count" or “sudden shower or cloud of floaters” Suggests blood cells, pigment cells, or pigment granules (from the retinal pigment epithelium) are present in the vitreous. Could be signs of retinal break or detachment present.
2) Cloud, curtain or veil over the vision. Suggests retinal detachment or vitreous haemorrhage – signs of retinal break or detachment should be present

Signs requiring referral within 24 hours:

1) Retinal detachment with good vision unless there is imminent danger that the fovea is about to detach i.e. detachment within 1 disc diameter of the fovea especially a superior bullous detachment, when urgent surgery is required.
2) Vitreous or pre-retinal haemorrhage
3) Pigment 'tobacco dust' in anterior vitreous
4) Retinal tear/hole with symptoms

Signs requiring referral ASAP next available clinic appointment:

1) Retinal detachment with poor vision (macula off) unless this is long standing Retinal hole/tear without symptoms
2) Lattice degeneration with symptoms of recent flashes and/or floaters

Require discharge with SOS advice (verbal advice and a leaflet)

1) Uncomplicated PVD without signs and symptoms listed above
2) Signs of lattice degeneration without symptoms listed above

Explain the diagnosis and educate the patient on the early warning signals of further retinal traction and possible future retinal tear or detachment:

- Give the patient a Retinal Detachment warning leaflet
- Instruct the patient to return immediately or go to A&E if flashes or floaters worsen

Referral Letters

Patients requiring referral for retinal breaks or detachment must have the following noted on the referral form to the ophthalmologist. Letters should be typed whenever possible and may be faxed or sent with the patient in urgent cases.

- A clear indication of the reason for referral. e.g. Retinal tear in superior temporal periphery of Right eye
- A brief description of any relevant history and symptoms
- A description of the location of any retinal break / detachment / area of lattice
- In the case of retinal detachment whether the macula is on or off.
- The urgency of the referral

Appendix C: Age-related Macular Degeneration Management Guidelines

Terminology
The following terms are important in this text & for differential diagnosis:

- Wet (exudative) AMD: this can progress very rapidly causing loss of central vision & metamorphopsia (distortion). It is characterised by sub retinal neovascular membrane, macular haemorrhages & exudates.
- Dry (atrophic) AMD: a slowly progressive disease characterized by drusen & retinal pigment epithelial changes.

Optometrist assessment
History and Symptoms
A full and thorough history and symptoms is essential. In addition to the normal history and symptoms, careful attention must also be given to the following:

History

- Age
- Family history of maculopathy
- Previous ocular history
- Systemic disease e.g. hypertension, diabetes
- History of ocular surgery- cataract extraction, retinal detachment repair
- Myopia
- Medication e.g. chloroquine derivatives, tamoxifen
- Smoking status
- Excessive exposure to sunlight/UV

Symptoms

- Loss of central vision
- Spontaneously reported distortion of vision

These additional questions should be asked:

- Is loss of vision of recent onset?
- In which eye are symptoms present?
- Has the loss of vision occurred suddenly or gradually?

Clinical examination
All patients presenting for a MECS examination with symptoms indicative of a potential macular degeneration should have the following investigations (in addition to such other examinations that the optometrist feels are necessary):

- Tests of pupillary light reaction including swinging light test for Relative Afferent Pupil Defect (RAPD), prior to pupil dilation
- Visual acuity recorded and compared to previous measures
- Refraction as a hyperopic shift can be indicative of macular oedema
- Amsler grid or similar assessment of central vision

- Dilated pupil fundus examination with slit lamp binocular indirect ophthalmoscopy using a Volk or similar fundus lens noting:
    - Status of macula, including presence of drusen (&size), haemorrhages, pigment epithelial changes i.e. hyper or hypo pigmentation, exudates, oedema, signs of sub retinal neovascular membrane

Management
If local protocols for the referral of AMD are in place, then these should be followed. If not, you should note that some HES ophthalmology departments will not have the facilities to deal with wet age related macular degeneration. In these cases it is best to telephone the department first to find out what procedures to follow.

Symptoms requiring referral ASAP next available clinic appointment:

1) Sudden deterioration in vision + VA better than 3/60 in affected eye
2) Spontaneously reported distortion in vision + VA better than 3/60

Signs requiring referral ASAP next available clinic appointment:

1) Sub retinal neovascular membrane
2) Macular haemorrhage
3) Macular oedema

Requiring routine referral:

1) Patient eligible & requesting certification of visual impairment
2) Patients requesting a home visit from Social Services to help them manage their visual impairment in their home.
3) Patients who require an assessment for LVA
4) Patients likely to benefit from an intra-ocular Galilean telescope system

Low Vision Aids may be available in the community or hospital eye service - this varies in different areas.

Requires routine follow up but provide an Amsler chart, verbal advice and a leaflet (see sheet appended).

- Dry AMD, drusen &/or pigment epithelial changes
- Explain the diagnosis and educate the patient on the early warning signs of wet AMD.
- Give stop smoking advice via leaflet if appropriate + advice on healthy diet + protection from blue light
- Use 4 point scale to assess risk of AMD progression. Count one point for large drusen of 125 microns or larger (about the size of a vein at the disc margin) and one point for any pigmentary change. Score each eye separately and then add them together for a score out of 4. A full score of 4 points means a 50% chance of progressing to advanced AMD in the next 5 years. 3 points gives a 25% chance, 2 points a 12% chance and with 1 point the risk is just 3%.
- For those at intermediate risk of AMD progression give information on AREDS findings & leaflet on anti-oxidant supplements
- Give information on local services for the visually impaired- public and third sector.
- Give appropriate information on national voluntary agencies e.g. RNIB, Macular Disease Society
- Instruct the patient to inform the practice or GP immediately if vision suddenly deteriorates or becomes distorted.

Referral Letters
Patients requiring referral for macular degeneration must have the following noted on the referral form to the ophthalmologist. Letters should be typed whenever possible and may be faxed or sent with the patient in urgent cases. The Royal College of Ophthalmologists fast track referral form for AMD can be used.

www.college-optometrists.org/en/utilities/document-summary.cfm/docid/81143450-07B2-4A16-BA3ED6F3F7A86D77

- A clear indication of the reason for referral. e.g. macular haemorrhage
- A brief description of any relevant history and symptoms
- A description of the type of macular degeneration or signs of drusen, pigment epithelial changes, sub retinal neovascular membrane, haemorrhages, exudates, macular oedema.
- The urgency of the referral

Appendix D: Differential diagnosis

Macular hole

This is a hole at the macula caused by tangential vitreo-retinal traction at the fovea. Causes impaired central vision & typically affects elderly females

Macular epiretinal membrane

Can be divided into cellophane maculopathy & macular pucker

Central serous retinopathy

Typically sporadic, self-limited disease of young or middle-aged adult males. Unilateral localised detachment of sensory retina at the macula causing unilateral blurred vision.

Cystoid macular oedema

An accumulation of fluid at the macula most commonly due to retinal vascular disease, intra-ocular inflammatory disease or post cataract surgery.

Myopic maculopathy

Chorio-retinal atrophy can occur with high myopia, usually > 6.00D, which can involve the macula.

Solar maculopathy

Due to the effects of solar radiation from looking at the sun causing circumscribed retinal pigment epithelium mottling or a lamellar hole at the macula.

Drug-induced maculopathies

Antimalarials e.g. chloroquine, hydroxychloroquine

Phenothiazines e.g. thioridazine (melleril), chlorpromazine (Largactil)

Tamoxifen

Appendix E: Expected competencies of sub-contractors

1) The ability to take an accurate history from patients with a range of optometric conditions
2) The ability to elicit significant symptoms
3) The ability to elicit relevant family history
4) The ability to elicit issues pertaining to the patient's general health, medication, work, sports, lifestyle and special needs
5) The ability to impart to patients an explanation of their physiological or pathological eye condition
6) An ability to understand a patient's fears, anxieties and concerns about their visual welfare, the eye examination and its outcome
7) The ability to discuss with a patient the importance of systemic disease and its ocular impact, its treatment and the possible ocular side effects of medication
8) An ability to understand the patient's expectations and aspirations and manage empathetically situations where these cannot be met

9) The ability to communicate bad news to patients in an empathetic and understandable way
10) The ability to interpret and investigate the presenting symptoms of the patient

11) The ability to develop a management plan for the investigation of the patient
12) The ability to identify external pathology and offer appropriate advice to patients not needing referral
13) An understanding of risk factors for common ocular conditions
14) The ability to recognise common ocular abnormalities and to refer when appropriate
15) The ability to manage a patient presenting with a red eye
16) The ability to manage a patient presenting with reduced vision
17) The ability to manage a patient presenting with macular degeneration
18) The ability to evaluate and manage a patient presenting with symptoms suggestive of retinal detachment
19) The ability to examine fundi using direct and indirect techniques
20) The ability to complete the MECS Activity Report
21) The ability to refer on to appropriate hospital eye services using e-RS.

B. Indicative Activity Plan

PART A: MECS and Single Provider Contract

The expected annual activity levels are estimated based on the activity of the MECS services in 2017/18 (where MECS services were in place) and additional activity which will result from mandating the Optometrist Triage Service. As the figures below are estimates, they should only provide a rough estimate of expected annual throughput.

	Estimated Annual Throughput				
Function	**Bromley**	**Greenwich**	**Lambeth**	**Lewisham**	**Southwark**
MECS New attendance	4,005	1,292	4,007	2,179	1,974
MECS FU attendance	547	133	734	224	203
Glaucoma full assessment	46	15	46	25	23
Glaucoma refinement IOP only	37	12	37	20	18
Glaucoma refinement fields only	100	32	99	54	49
Glaucoma refinement IOP/fields	90	29	90	49	45
Cataract refinement	306	99	307	167	151

PART B: Optometrist Triage Service

Triage activity:

	Estimated annual throughput
Bromley	6,662
Greenwich	3,839
Lambeth	2,527
Lewisham	3,597
Southwark	2,402

D. Essential Services (NHS Trusts only)

Not Applicable

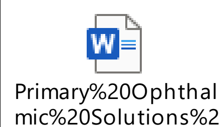
G. Other Local Agreements, Policies and Procedures

Data Protection policy	GDPR-DOC-04-2%2 0Data%20Protection
Equal Opportunities policy	Primary%20Ophthal mic%20Solutions%2
Complaints policy	Primary%20Ophthal mic%20Solutions%2
Managing Subcontractor Performance policy	Primary%20Ophthal mic%20Solutions%2
Health and Safety policy	Primary%20Ophthal mic%20Solutions%2
Infection Control policy	Primary%20Ophthal mic%20Solutions%2
Risk and Issue Management policy	Primary%20Ophthal mic%20Solutions%2
Service User Consent policy	Primary%20Ophthal mic%20Solutions%2

J. Transfer of and Discharge from Care Protocols

As per service specification patient pathways set out in Appendix A.

K. Safeguarding Policies and Mental Capacity Act Policies



5 SCHEDULE 3 – PAYMENT

A. Local Prices

Payments will be made to the Lead Provider based on activity reports submitted to the Co-ordinating Commissioner (NHS Southwark CCG). The monthly activity reports need to be received by the Co-ordinating Commissioner on or before 20th day of the month following the month in which the patients received the service (month of claim). The invoice needs to be sent to the appropriate payment body confirmed by the CCG.

1. Set-up costs:

The initial one-off set-up costs of £20,250 can be billed in the first month of the contract. The set-up costs will be split evenly across the five CCGs at £4,050 per CCG.

2. PART A: MECS and Single Provider Contract

MECS:

Payment for the MECS activity is on a cost per case basis for patients pertaining to each CCG (i.e. location of registered GP):

Activity type	Cost per case
MECS New attendance	£48.00
MECS FU attendance	£28.00
Glaucoma full assessment	£47.00
Glaucoma refinement IOP only	£15.00
Glaucoma refinement fields only	£23.00
Glaucoma refinement IOP/fields	£28.00
Cataract refinement	£25.00

For the avoidance of doubt, no payment will be made by the CCGs in respect of DNAs.

Single Provider Contract:

£63,120 per annum (£1,052.00 per CCG per month).

3. PART B: Optometrist Triage Service

Activity based:

Payment is on a cost per referral basis:

Activity type	Cost per referral
Clinical triage	£3.00
Admin triage	£4.80

Non-activity based:

£15,016.20 per annum (£250.27 per CCG per month).

B. Local Variations

For each Local Variation which has been agreed for this Contract, copy or attach the completed publication template required by NHS Improvement (available at: https://www.gov.uk/guidance/nhs-providers-and-commissioners-submit-locally-determined-prices-to-monitor) – or state Not Applicable. Additional locally-agreed detail may be included as necessary by attaching further documents or spreadsheets.

Not Applicable

C. Local Modifications

For each Local Modification Agreement (as defined in the National Tariff) which applies to this Contract, copy or attach the completed submission template required by NHS Improvement (available at: https://www.gov.uk/guidance/nhs-providers-and-commissioners-submit-locally-determined-prices-to-monitor). For each Local Modification application granted by NHS Improvement, copy or attach the decision notice published by NHS Improvement. Additional locally-agreed detail may be included as necessary by attaching further documents or spreadsheets.

Not Applicable

F. Expected Annual Contract Values

Expected annual contract values:

Y1	£996,741.90
Y2	£976,491.90
Y3	£976,491.90
Y4	£976,491.90
Y5	£976,491.90
Total	**£4,902,709.50**

A detailed breakdown is provided below:

1. Set-up costs:
The initial one-off set-up costs of £20,250.00 to be billed in the first month of the contract.

2. MECS and Single Provider Contract:

Activity based costs:

	Tariff	Activity	Total value per annum
MECS 1st	£48.00	13,457	£645,925.15
MECS FU	£28.00	1,841	£51,548.00
Glaucoma full assessment	£47.00	155	£7,283.61
Glaucoma refinement IOP only	£15.00	124	£1,856.64
Glaucoma fields only	£23.00	334	£7,688.81
Glaucoma refinement IOP/fields	£28.00	303	£8,486.85
Cataract refinement	£25.00	1030	£25,752.04
Total		**17,244**	**£748,541.10**

Non-activity based costs:

	Bromley	Greenwich	Lambeth	Lewisham	Southwark	Total value per annum
Non-activity	£12,624.00	£12,624.00	£12,624.00	£12,624.00	£12,624.00	**£63,120.00**

Non-activity based costs are paid on a monthly basis as 1/12 of the total amount and split evenly across the five CCGs.

3. Optometrist Triage Service:

Activity based costs:

	Tariff	Activity	Total value per annum
Clinical triage	£3.00	19,207	£57,621
Admin triage	£4.80	19,207	£92,193.60
Total			**£149,814.60**

Non-activity based costs:

	Bromley	Greenwich	Lambeth	Lewisham	Southwark	Total value per annum
Non-activity	£3,003.24	£3,003.24	£3,003.24	£3,003.24	£3,003.24	**£15,016.20**

Non-activity based costs are paid on a monthly basis as 1/12 of the total amount and split evenly across the five CCGs.

6 SCHEDULE 4 – QUALITY REQUIREMENTS

A. Operational Standards and National Quality Requirements

Ref	Operational Standards/National Quality Requirements	Threshold	Guidance on definition	Consequence of breach	Timing of application of consequence	Applicable Service Category
E.B.4	*Percentage of Service Users waiting 6 weeks or more from Referral for a diagnostic test*	*Operating standard of no more than 1%*	*See Diagnostics Definitions and Diagnostics FAQs at: https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/monthly-diagnostics-waiting-times-and-activity/*	*Where the number of Service Users waiting for 6 weeks or more at the end of the month exceeds the tolerance permitted by the threshold, £200 in respect of each such Service User above that threshold*	*Monthly*	*CS D*
E.B.S.3	*Care Programme Approach (CPA): The percentage of Service Users under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care*	*Operating standard of 95%*	*See MHPC Guidance at: https://www.england.nhs.uk/statistics/statistical-work-areas/mental-health-community-teams-activity/*	*Where the number of Service Users in the Quarter not followed up within 7 days exceeds the tolerance permitted by the threshold, £200 in respect of each such Service User above that threshold*	*Quarterly*	*MH*

Ref	Operational Standards/National Quality Requirements	Threshold	Guidance on definition	Consequence of breach	Timing of application of consequence	Applicable Service Category
	Duty of candour	Each failure to notify the Relevant Person of a suspected or actual Notifiable Safety Incident in accordance with Regulation 20 of the 2014 Regulations	See CQC guidance on Regulation 20 at: https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour	Recovery of the cost of the episode of care, or £10,000 if the cost of the episode of care is unknown or indeterminate	Monthly	All
E.H.4	***Early Intervention in Psychosis programmes: the percentage of Service Users experiencing a first episode of psychosis or ARMS (at risk mental state) who wait less than two weeks to start a NICE-recommended package of care***	***Operating standard of 56%***	***See Guidance for Reporting Against Access and Waiting Time Standards and FAQs Document at: https://www.england.nhs.uk/mental-health/resources/access-waiting-time/***	***Issue of Contract Performance Notice and subsequent process in accordance with GC9***	***Quarterly***	***MH***
E.H.1	***Improving Access to Psychological Therapies (IAPT) programmes: the percentage of Service Users referred to an IAPT programme who wait six weeks or less from referral to entering a course of IAPT treatment***	***Operating standard of 75%***	***See Contract Technical Guidance Appendix 3***	***Issue of Contract Performance Notice and subsequent process in accordance with GC9***	***Quarterly***	***MH***

Ref	Operational Standards/National Quality Requirements	Threshold	Guidance on definition	Consequence of breach	Timing of application of consequence	Applicable Service Category
E.H.2	***Improving Access to Psychological Therapies (IAPT) programmes: the percentage of Service Users referred to an IAPT programme who wait 18 weeks or less from referral to entering a course of IAPT treatment***	***Operating standard of 95%***	***See Contract Technical Guidance Appendix 3***	***Issue of Contract Performance Notice and subsequent process in accordance with GC9***	***Quarterly***	***MH***

The Provider must report its performance against each applicable Operational Standard and National Quality Requirement through its Service Quality Performance Report, in accordance with Schedule 6A.

In respect of the Operational Standards and National Quality Requirements shown in ***bold italics*** the provisions of SC36.28 apply.

SCHEDULE 4 – QUALITY REQUIREMENTS

C. Local Quality Requirements

Quality Requirement	Threshold	Method of Measurement	Consequence of breach	Timing of application of consequence	Applicable Service Specification
See 3.5.1 and 4.11.3 within the service specification					

SCHEDULE 4 – QUALITY REQUIREMENTS

D. Commissioning for Quality and Innovation (CQUIN)

CQUIN Table 1: CQUIN Indicators

Not applicable

7 SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

A. Reporting Requirements

	Reporting Period	Format of Report	Timing and Method for delivery of Report
National Requirements Reported Centrally			
1. As specified in the DCB Schedule of Approved Collections published on the NHS Digital website at https://digital.nhs.uk/isce/publication/nhs-standard-contract-approved-collections where mandated for and as applicable to the Provider and the Services	As set out in relevant Guidance	As set out in relevant Guidance	As set out in relevant Guidance
National Requirements Reported Locally			
1. Activity and Finance Report *(note that, if appropriately designed, this report may also serve as the reconciliation account to be sent by the Provider under SC36.22)*	Monthly	Monthly monitoring report	No later 20th day of the month following the month in which the patients received the service.
2. Service Quality Performance Report, detailing performance against Operational Standards, National Quality Requirements, Local Quality Requirements, Never Events and the duty of candour	Monthly	Monthly monitoring report	No later 20th day of the month following the month in which the patients received the service.
3. CQUIN Performance Report and details of progress towards satisfying any Quality Incentive Scheme Indicators, including details of all Quality Incentive Scheme Indicators satisfied or not satisfied	Not applicable	Not applicable	Not applicable
4. Complaints monitoring report, setting out numbers of complaints received and including analysis of key themes in content of complaints	Quarterly	Contract review template	No later than 1 week before scheduled Contract Review Meeting.
5. Summary report of all incidents requiring reporting	Monthly	Monthly monitoring report	No later 20th day of the month following the month in which the patients received the service.
Local Requirements Reported Locally			
See 3.4.14 and 4.11.4 within the service specification	Monthly/Quarterly	Monthly monitoring	No later 20th day of the

	Reporting Period	Format of Report	Timing and Method for delivery of Report
		report / Contract review template	month following the month in which the patients received the service./No later than 1 week before scheduled Contract Review Meeting.

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

C. Incidents Requiring Reporting Procedure

Procedure(s) for reporting, investigating, and implementing and sharing Lessons Learned from: (1) Serious Incidents (2) Notifiable Safety Incidents (3) Other Patient Safety Incidents
Primary%20Ophthalmic%20Solutions%2

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

F. Provider Data Processing Agreement

Not Applicable

8 SCHEDULE 7 – PENSIONS

Not Applicable

9 SCHEDULE 8 – TUPE*

1. The Provider must comply and must ensure that any Sub-Contractor will comply with their respective obligations under TUPE and COSOP in relation to any persons who transfer to the employment of the Provider or that Sub-Contractor by operation of TUPE and/or COSOP as a result of this Contract or any Sub-Contract, and that the Provider or the relevant Sub-Contractor (as appropriate) will ensure a smooth transfer of those persons to its employment. The Provider must indemnify and keep indemnified the Commissioners and any previous provider of services equivalent to the Services or any of them before the Service Commencement Date against any Losses in respect of:

    1.1 any failure by the Provider and/or any Sub-Contractor to comply with its obligations under TUPE and/or COSOP in connection with any relevant transfer under TUPE and/or COSOP;

    1.2 any claim by any person that any proposed or actual substantial change by the Provider and/or any Sub-Contractor to that person's working conditions or any proposed measures on the part of the Provider and/or any Sub-Contractor are to that person's detriment, whether that claim arises before or after the date of any relevant transfer under TUPE and/or COSOP to the Provider and/or Sub-Contractor; and/or

    1.3 any claim by any person in relation to any breach of contract arising from any proposed measures on the part of the Provider and/or any Sub-Contractor, whether that claim arises before or after the date of any relevant transfer under TUPE and/or COSOP to the Provider and/or Sub-Contractor.

2. If the Co-ordinating Commissioner notifies the Provider that any Commissioner intends to tender or retender any Services, the Provider must within 20 Operational Days following written request (unless otherwise agreed in writing) provide the Co-ordinating Commissioner with anonymised details (as set out in Regulation 11(2) of TUPE) of Staff engaged in the provision of the relevant Services who may be subject to TUPE. The Provider must indemnify and keep indemnified the relevant Commissioner and, at the Co-ordinating Commissioner's request, any new provider who provides any services equivalent to the Services or any of them after expiry or termination of this Contract or termination of a Service, against any Losses in respect any inaccuracy in or omission from the information provided under this Schedule.

3. During the 3 months immediately preceding the expiry of this Contract or at any time following a notice of termination of this Contract or of any Service being given, the Provider must not and must procure that its Sub-Contractors do not, without the prior written consent of the Co-ordinating Commissioner (that consent not to be unreasonably withheld or delayed), in relation to any persons engaged in the provision of the Services or the relevant Service:

    3.1 terminate or give notice to terminate the employment of any person engaged in the provision of the Services or the relevant Service (other than for gross misconduct);

    3.2 increase or reduce the total number of people employed or engaged in the provision of the Services or the relevant Service by the Provider and any Sub-Contractor by more than 5% (except in the ordinary course of business);

    3.3 propose, make or promise to make any material change to the remuneration or other terms and conditions of employment of the individuals engaged in the provision of the Services or the relevant Service;

3.4 replace or relocate any persons engaged in the provision of the Services or the relevant Service or reassign any of them to duties unconnected with the Services or the relevant Service; and/or

3.5 assign or redeploy to the Services or the relevant Service any person who was not previously a member of Staff engaged in the provision of the Services or the relevant Service.

4. On termination or expiry of this Contract or of any Service for any reason, the Provider must indemnify and keep indemnified the relevant Commissioners and any new provider who provides any services equivalent to the Services or any of them after that expiry or termination against any Losses in respect of:

4.1 the employment or termination of employment of any person employed or engaged in the delivery of the relevant Services by the Provider and/or any Sub-Contractor before the expiry or termination of this Contract or of any Service which arise from the acts or omissions of the Provider and/or any Sub-Contractor;

4.2 claims brought by any other person employed or engaged by the Provider and/or any Sub-Contractor who is found to or is alleged to transfer to any Commissioner or new provider under TUPE and/or COSOP; and/or

4.3 any failure by the Provider and/or any Sub-Contractor to comply with its obligations under TUPE and/or COSOP in connection with any transfer to any Commissioner or new provider.

5. In this Schedule:

COSOP means the Cabinet Office Statement of Practice *Staff Transfers in the Public Sector* January 2000

TUPE means the Transfer of Undertakings (Protection of Employment) Regulations 2006 and EC Council Directive 77/187

**Note: it may in certain circumstances be appropriate to omit the text set out in paragraphs 1-5 above or to amend it to suit the circumstances - in particular, if the prospect of employees transferring either at the outset or on termination/expiry is extremely remote because their work in connection with the subject matter of the Contract will represent only a minor proportion of their workload. However, it is recommended that legal advice is taken before deleting or amending these provisions.*

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