SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	Version 1
Service	Minor Eye Care Service (MECS) and COVID-19 Urgent Eye Care Service (CUES)
Commissioner Lead	NHS Bassetlaw CCG
Provider Lead(s)	TBC once contract awarded
Period	Number of years to be confirmed
Date of Review	

Contents

1. Population Needs

1.1 National / local context and evidence base

MECS:

In recent years there has been significant increase in the number of Minor Eye Care Services (MECS) operating throughout England and alongside this, an increasing recognition for the potential to further develop the role of eye health care professionals within primary care.

Whilst the range and way in which these MECS are delivered may differ from one region to another, they are common in their aim to divert the delivery of appropriate eye care practices that do not need to be undertaken in secondary care and rather could effectively and more efficiently be provided within the community.

The demand for eye care is set to increase as the population ages. There are around 2 million people in the UK living with sight loss (RNIB 2018)[1]. For many years the Department of Health has been trying to encourage the delivery of more routine and minor emergency eye care outside hospital. The aim, to free up hospital capacity to cope with increasing demand from both the ageing population and new technologies.

CUES:

Alongside this, in response to the coronavirus (COVID-19) pandemic, NHS England / Improvement stipulated that routine sight testing is ceased (NHS England Publication approval reference: 001559[2]), and COVID-19 urgent and emergency eye care will need to be commissioned and delivered through a contract with local commissioners.

The covid urgent eye care service will:

- safely deliver urgent eye care in the community
- deliver remote triage and consultations (by telephone or video) to minimise face-to-face appointments.
- make use of technology to reduce patient – practitioner contact time
- reduce the expected burden on the rest of primary care (GP practices) and reduce pressures on ophthalmology departments within secondary care

[1] https://help.rnib.org.uk/help/newly-diagnosed-registration/registering-sight-loss/statistics
[2] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/06/C0810-standard-operating-procedure-primary-care-optical-settings.pdf

- maintain local access to quality eyecare services for local populations.

In some regions where Minor Eye Conditions services are already commissioned by CCGs, services are being changed to support the delivery of urgent eye care from optical practices. For NHS Bassetlaw CCG, this was not applicable and so the CUES was commissioned as a distinct service. For clarification, Covid-19 Urgent Eye Care Service (CUES) is not a Minor Eye Conditions Service (MECS). However NHS Bassetlaw CCG believes that there is merit in commissioning both a MECS and a CUES on an ongoing basis.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	Yes
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	Yes
Domain 4	Ensuring people have a positive experience of care	Yes
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	Yes

2.2 Local defined outcomes

Outcome	Applicable to		
	MECS	CUES	Both
More comprehensive community eye care service			X
Increased choice of providers giving patients greater opportunity to be treated in their local geography in line with 'Care Closer to Home'			X
Timely access to clinical expertise in primary care for triage			X
Increased range of diagnostic and treatment services in primary care			X
Development of primary care eye health care professional skill sets			X
Better utilisation of both primary and secondary care eye health professional skill sets			X
More effective utilisation of funding			X
Reduction in GP and outpatient referrals to acute hospital services			X
Consequent reduction in hospital follow ups			X
Reduced inappropriate use of secondary care which release hospital workforce for more complex ophthalmic care and potential for front-line COVID-19 response			X
Improved working between optometrists, GPs and ophthalmologists in secondary care			X
Reduce coronavirus infection risk by minimising patient travel and patient – practitioner contact time			X
Provide a rapid, safe access, high quality service for patients			X
Direction to self-care e.g. patient leaflets, websites, online symptom checker			X
Provide accurate data about outcomes and patient satisfaction across multiple providers			X
Provide outcome data to providers to enable quality improvement			X

3. Scope

3.1 Aims and objectives of service

3.1.1 Aims

MECS:

The MECS allows for the assessment, treatment and management of recent minor onset eye conditions within primary care.

CUES:

The CUES aims to ensure people can access urgent eyecare within primary care, utilising the established trained workforce in optical practices which will reduce demand on general practice and pharmacy as well as ease the pressures on the hospital eye services during the coronavirus (Covid-19) pandemic. Results will inform the requirements for service development for the recovery phase that will follow.

Both services aim to:

- Increase the range and number of eye health care services and providers in the community;
- Improve the flow of patients between primary and secondary care;
- Maintain high levels of patient satisfaction;
- Meet national access targets;
- Utilise primary and secondary care eye health care professional skill sets more efficiently and effectively;
- Reduce the number of referrals that are being made in secondary care that could have been treated in primary care;
- Reduce patient waiting times for treatments;
- Reduce the overall spend on lower complexity ophthalmic services by providing a more cost-effective and timely service in the community instead of in secondary care.

3.1.2. Objectives

MECS:

The objectives of the MECS are to:

- Deliver a minor eye care service to Bassetlaw patients
- Increase the range of eye health care services that can be delivered within primary care;
- Increase the number of primary care eye health care service providers that can deliver;
- Increase the geographical spread of services so that patients have a choice of local providers that they can access;
- Clarify the primary and secondary care eye health care service remits;
- Establish pathways for treating patients in the right place i.e. primary care conditions in primary care and secondary care conditions in secondary care

CUES:

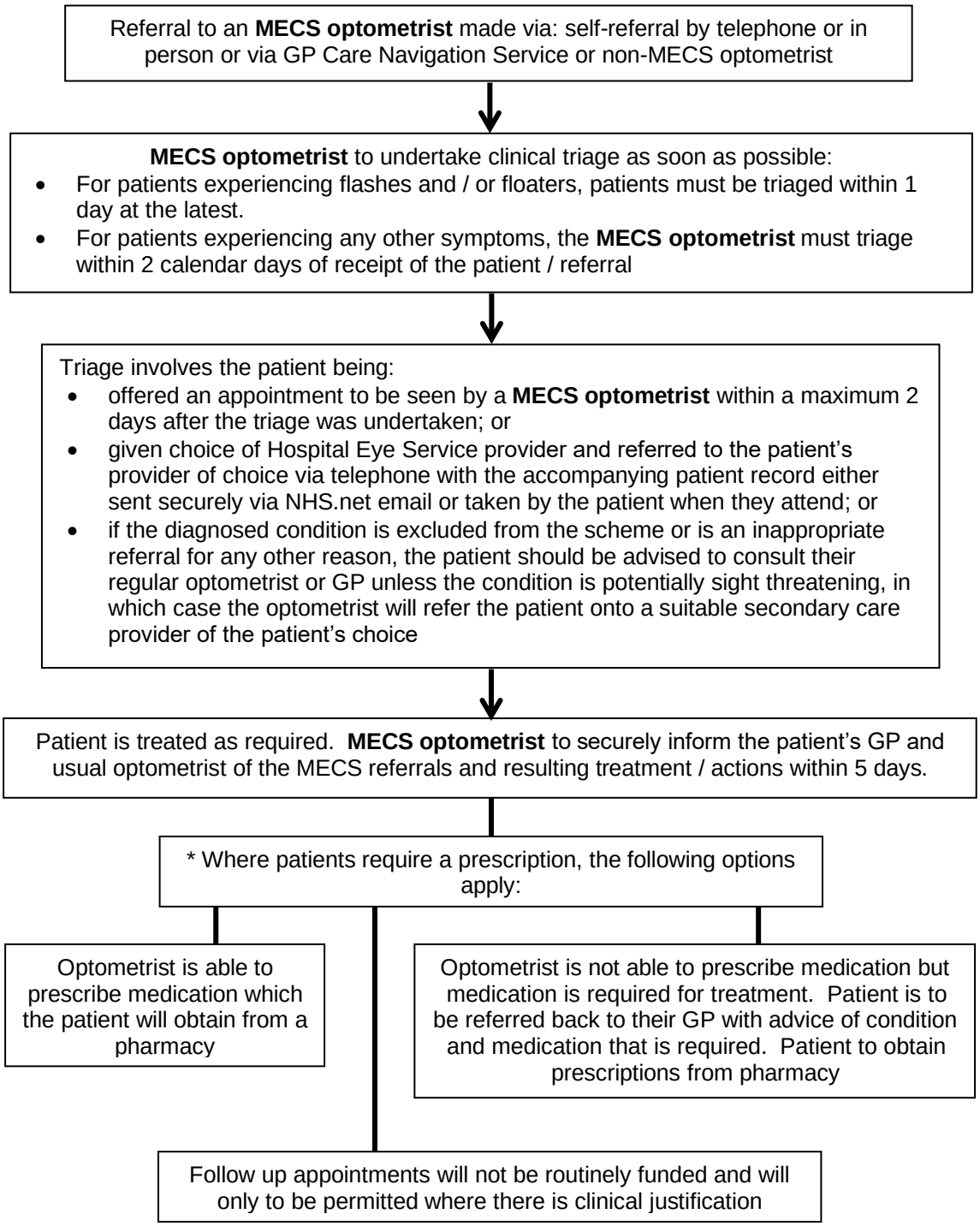
The objectives of the CUES are to:

- Deliver a COVID-19 urgent eye care service to people, from optical practices, acting as urgent eye care hubs, in the community as set out in NHS England Publication approval reference: 001559.
- Improve access to local timely care for patients with urgent ocular presentations, reducing the need to travel to the hospital
- Identify at risk and confirmed people with COVID-19 and, where patient needs aren't met by remote consultation within the service, refer to appropriate services with advice on restrictions to access.
- Deliver clinical triage, assessment, treatment and advice by telephone or video to reduce the need for face-to-face contact, where appropriate, avoiding the need for many patients to leave their home.
- Provide face-to-face consultations where required in some optical practices.
- Apply appropriate social distancing and infection control measures where a face-to-face consultation is required.
- Facilitate urgent and emergency eye referrals, where necessary, following local referral protocols (Alerting where the patient reports symptoms of Covid-19, or is in an at-risk group)
- Ensure the knowledge and skills of the optical practice workforce (Optometrists, Dispensing Opticians and Contact lens Opticians) are utilised as primary health care providers.
- Provide an equivalent remote service to people who are house-bound or shielding during the period of COVID-19.
- Provide access to specialist ophthalmic advice and guidance and remote prescribing when required to support practitioner clinical decision making and treatment.
- Support compliance with COVID-19 control measures and follow best practice PPE guidance relating to infection control (Service policies and protocols will be regularly updated in line with national Public Health England (PHE) guidance)
- Consider a single point of access (SPoA) when required to ensure patients are directed to the most suitable care setting/service with the appropriate level of urgency.

3.2 **Service description / Care pathway**

MECS:

The MECS is described in more detail below. The list of MECS optometrists will be made available to prospective patients both electronically and in paper form confirming locations and opening hours to encourage uptake of this pathway.



CUES:

The CUES will provide initial contact, telephone triage, remote consultations and where necessary face-to-face assessments and management of recent onset symptomatic or urgent ocular presentations.

The Service will maintain a minimum number of face-to-face patient interactions by:

- adopting remote consultation by the most appropriate clinician
- triage to the most appropriate clinician if a face-to-face appointment is necessary
- optimising each consultation with ophthalmologist, or optometrist with independent prescribing advice & guidance, where appropriate.

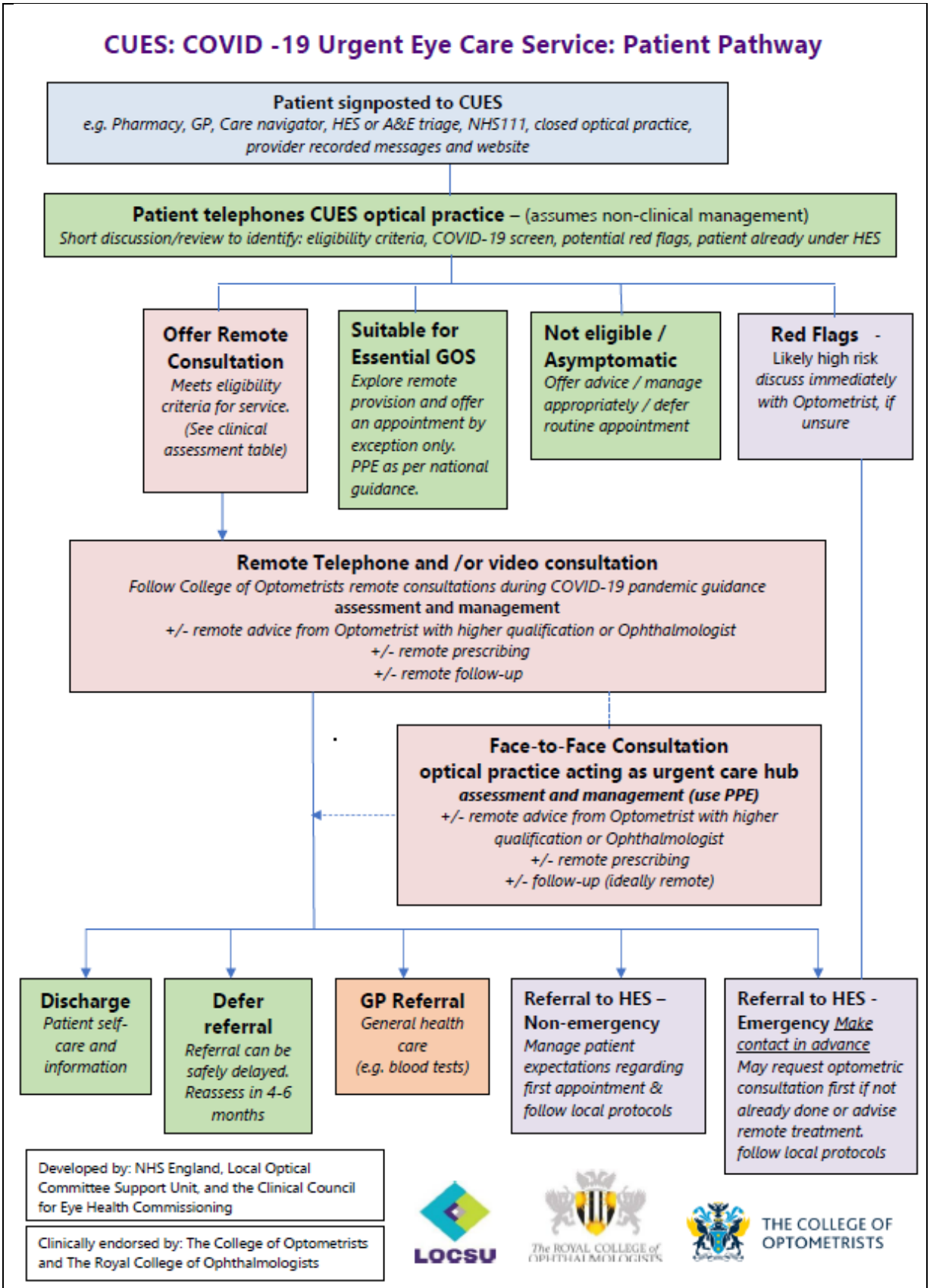
Initial telephone contact and access to clinical triage – access to the Service is restricted to telephone booking only, to:

- identify people with Covid-19 symptoms, at risk /self-isolating people to signpost to appropriate services.
- offer telephone / video consultation and self-care advice or provide signed orders remotely, where appropriate
- offer face-to-face appointments with optometrist following telephone / video consultations for those who are presenting with urgent and higher risk symptoms (observing PPE guidance and social distancing advice)
- Signpost to emergency services, as appropriate.

Urgent Eye Care – see *Patient Pathway on the following page along with the Service Risk Stratification, Conditions and Pathway* documents in section 3.3.

Patients can self-present (by telephone) or be referred / redirected from other services for clinical assessment and management.

- The Service will utilise current clinical capability within optical practice
- Should a local optical practice be closed, a recorded telephone message will redirect the caller to the nearest optical practice, acting as an urgent eyecare hub.
- By accepting redirected referrals from the Hospital Eye Service for assessment / continued care
- The Service will recognise that where available, optometrists with higher qualifications (independent prescribing and higher qualifications from the College of Optometrists e.g. glaucoma qualifications) will be able to manage a broader scope of eye conditions, initiate treatment and deliver care as necessary, as well as supporting other practitioners with advice and guidance as required.
- Optometrists without higher qualifications can be supported in decision making and providing treatment through advice, guidance, and remote prescribing from the hospital eye service
- It is accepted that in many areas, referrals to ophthalmology may require clinical discussion first (or by email if not urgent) with an ophthalmologist to explore alternative management options thereby reducing the need to attend hospital, provide additional advice and guidance, determine the appropriate timing for attendance or agree a collaborative approach for patient management.



Any service requires clinical leadership in enabling and assuring the delivery of high-quality care. The Service will therefore provide effective clinical leadership using the principles of multidisciplinary and organisational collaboration, training, clinical governance and clinical audit.

A locally based clinical lead optometrist will oversee the implementation and performance management of the Service, and will work in partnership with the Trust clinical lead ophthalmologist to agree local pathways; revisions to local ophthalmology triage guidelines, joint care protocols and support responsive service co-developments, as required.

Emergent pandemics are times of high uncertainty, the commissioners and service provider and local ophthalmology department will need to work collaboratively to adapt and develop the service to best meet the immediate and intermediate needs of the local health care system, for the duration of the pandemic.

Working in an integrated way with local ophthalmology teams the Service has the potential to provide a basis for offering further support during the recovery of routine hospital eye services:

For discussion, the following could include (but should not be limited to):

- **Ophthalmology (or single point of) advice and guidance** (may not be available from service implementation). A dedicated advice & guidance phone line with rapid access to senior clinician/decision maker and prescriber would support collaborative management.
- **Single Point of Access** – to support signposting / transfer of patients between secondary and primary care - this could include redirected referrals following triage by HES urgent care / A&E.
- **Post-operative care** – delivered from optical practice following a hospital-initiated management plan
- **Support for ongoing HES follow up care** - data gathering to support HES virtual assessments (visual acuity / IOP / wound healing / imaging / OCT)
- **Telemedicine** could be explored to further develop the offer in optical practice.

3.3 Service Scope

MECS:

The MECS will be available to any person registered with a Bassetlaw GP or resident within Bassetlaw. Children under 16 years of age should be accompanied by a responsible adult. The service will cover the following conditions:

Inclusions	Exclusions
• Dry eye	• Emergencies
• Non-acute red eye / eyelids (irritation or inflammation)	• Sudden onset double vision
• Itchy eye	• Severe pain requiring immediate attention
• Gritty eye	• Chemical or burn injuries
• Mild pain or discomfort in the eye as experienced by the patient	• Penetrating trauma
• Ingrown eyelash	• Orbital cellulitis
• Flashes and floaters	• Temporal arteritis
• Significant recent sticky discharge from the eye or watery eye	• Sudden loss / dramatic reduction in vision in one eye
• Foreign body in the eye	• Problems arising from recent surgery
• Cysts, lumps and bumps in eyelids	• Acute glaucoma

• Non-specific field defects	• Chalazia requiring surgery
• Unexplained loss of vision including sudden onset of blurred vision	• Ocular Hypertension / Intraocular Pressure Referral Refinement
• Systemic disease	• Cataracts requiring surgery
• Emergency contact lens removal	

MECS optometrists should not accept patients / referrals when it is evident from the outset that the patient has a condition that is outside of the scope of this service. However, where, a **MECS optometrist** discovers following investigation, that the patient has a condition outside of the scope of this service, the **MECS optometrists** will still be paid for the MECS investigations undertaken.

Where the **MECS optometrist** is not contracted to deliver the service that the patient requires, NHS Bassetlaw CCG expects the **MECS optometrist** to refer the patient on. For example, referring patients on to other **participating optometrists** of the 'Ocular Hypertension / Intraocular Pressure Referral Refinement' or Direct Cataract Referral and Post-Operative Assessment' services.

It is not anticipated that patients will be referred to the MECS *following* a sight test but it may be possible that a sight test is required in addition to the MECS investigations that are carried out. **MECS optometrists** must ensure that patients are advised that there is no charge for the MECS service but that patients not eligible for NHS funding may have to pay for their sight tests.

Bassetlaw CCG will monitor the number of these types of referrals to ensure that patients are flowing through the system appropriately.

The **MECS optometrist** shall not carry out, or refer to another provider to carry out, any non-urgent or routine physical treatment and / or care that is unrelated to the patient's original referral or presentation without first referring the matter to the service user's GP / Optometrist.

Furthermore, **MECS optometrist** should respect the patient's loyalty to their usual optometrist and not solicit the provision of services including routine eye tests that fall outside the scope of the service.

Patient details should not be added to the practice reminder system for the purpose of sending recall letters for regular eye examinations, unless the patient expressly requests it.

NHS Bassetlaw CCG would like to utilise as many eye health care Independent Prescribers as possible in order to reduce the need for patients to be referred back to the GP / hospital for a prescription. However, it is accepted that not all eye health care specialists will be Independent Prescribers and therefore in some cases, patients will need to be referred back to their GP / hospital for a prescription.

MECS optometrists are expected to adhere to NHS Bassetlaw CCG's formulary and traffic light system guidance which can be found on: insert link here

MECS optometrists who are Independent Prescribers will need their own prescribing codes so that NHS Bassetlaw CCG has oversight of spend and adherence to the Formulary.

CUES:

The CUES will be available to any person registered with a Bassetlaw GP or resident within Bassetlaw. Children under 16 years of age should be accompanied by a responsible adult. The

service will cover the following:

- Recent onset / urgent eye conditions and for advice to support self-management of less complex eye conditions.
- Patient symptoms typically include the following where patients would otherwise present to general practice, hospital services and A&E:
    - Loss of vision (Sudden or Transient)
    - Visual distortion
    - Red or painful eye
    - Flashes and floaters
    - Double vision
    - Foreign body

CUES Risk Stratification, Conditions and Service Pathway Table:

COVID-19 CUES
Risk Stratification C

3.4 **Referral source**

MECS	CUES
Patients can refer themselves to the **MECS optometrist** of their choice either via telephone or in person. Referrals into the service may also come through any of the following routes: • Self-referral to the service • Referral or signposting via GP (Care Navigation) • Referral from another ophthalmic practitioner who does not provide the service • Other referral sources may include Minor Injuries Unit / Pharmacists, non-participating optometrist etc. Please note this list is not exhaustive. The service will not generally be a walk-in service; patients will need to telephone service provider(s) to book an appointment. However, providers will be permitted to offer an immediate appointment if this available.	• Patient telephones the practice directly. (This will be the majority of referrals and telephone triage occurs immediately) • Referral from GP, care navigator or local referral management service /triage • Referral from Pharmacy deflection • Referral from A&E / MIU / HES deflection • Patient redirected by another ophthalmic practice, or allied health professional • Signposting by NHS111

3.5 **Triage and Consultation Types and Response Times**

MECS:

MECS Initial triage

Patients are to be triaged as soon as possible and at the latest within 48 hours which involves the provider determining the eligibility and suitability of the patient for the MECS service. Triage is to be undertaken as follows:

Patient is experiencing:	MECS optometrist will
• Symptoms that require secondary care treatment	• Refer the patient to a suitable secondary care provider of the patient's choice
• Symptoms which can be suitably seen by a MECS optometrist	• See the patient for treatment within 48 hours of triage
• None of the above types of symptoms i.e. is an inappropriate referral	• advise the patient of the most suitable urgent or routine service to meet their needs and organise onward referral where appropriate

Referrals to a suitable secondary care provider of the patient's choice will be made by telephone and a copy of the urgent referral shall be given to the patient to present on attendance.

MECS First appointments

In the instances of symptoms which may require urgent attention (potentially sight-threatening conditions), the provider will advise attendance at a suitable secondary care provider of the patient's choice in accordance with agreed protocols.

For symptoms which are suitable for treatment by the MECS optometrist, the **MECS optometrist** will be expected, within reason, to provide the patient within an appointment to be seen within 48 hours of triage.

Patients must be advised about the probable length of their appointment and that they will not be able to drive home after dilation if dilation is required.

Where patients are not suitable for treatment under the MECS service, the provider should advise the patient of the most suitable urgent or routine service to meet their needs and organise onward referral where appropriate.

MECS Follow-up appointments

It is anticipated that the majority of patients will not need a follow-up appointment therefore follow up appointments will **not** be funded without written approval from the contract / commissioning manager at the CCG. However, where a follow up is clinically required, appointments are to be offered within a timeframe deemed appropriate and justification provided in the monthly report to the CCG.

MECS 'Did Not Attend' (DNA)

Should a patient fail to arrive for an appointment, the **MECS optometrist** must contact the patient within 24 working hours to discuss the missed appointment, and ask whether a rearranged appointment would be required and if not, why not i.e. attended Hospital Eye Service or problem resolved itself etc.

If this is not possible, a letter should be sent and any referring clinician should be notified (not applicable for self-referrals).

A record of DNAs and the reasons for them should be reported to the CCG for monitoring purposes.

CUES:

CUES Telephone triage

Short initial telephone assessment to identify: service eligibility criteria, screen for COVID-19, potential red flag check list, and understand if the patient is already under the hospital eye service. Where the patient calls the practice directly, the telephone triage occurs immediately.

Where the referral is received in any other way (e.g. email from GP; telephone from HES transferring care) telephone triage will usually be delivered by the practitioner to allow for remote consultation to occur concurrently, if necessary. A call to the patient will be made within 2 hours of the referral being received by the practice.

Where the practitioner is delivering the telephone triage, and identifies the need for a remote consultation, it is expected that this will be offered at the same time. Where a team member is delivering the telephone triage and identifies the need for a remote consultation and the practitioner is available, the remote consultation will be offered immediately.

Outcomes of telephone triage:

- Identify people with COVID -19 symptoms, at risk /self-isolating people and signpost to appropriate service (or offer a remote consultation if appropriate)
- Identify patients calling for other reasons and address appropriately (i.e. trying to book a routine sight test or for advice following a postponed outpatient appointment)
- Identify patients who are eligible for a sight test under GOS essential care and offer an appointment (as set out in NHS England Publication approval reference: 001559)
- Identify patients who have an urgent eye care need, offer and book a telephone/ video consultation with an optometrist / suitable team member (may result in the offer of a face to face appointment)
- Identify “red flag” symptoms and signpost to emergency services, as appropriate (It may be necessary to first speak with an Optometrist and / or book an immediate remote consultation).

Where the remote consultation is separate to the telephone triage, an appointment is booked, and email or SMS confirmation is sent to the patient which includes time and date of the consultation and includes the link to the video conferencing facility and/ or confirming the telephone number the practitioner will call on.

CUES Remote consultation

The service aims to deliver care safely and remotely wherever possible, avoiding the need for the patient to leave their home / place of isolation.

The consultation will be delivered in line with *College of Optometrists Remote consultations during COVID-19 pandemic guidance https://www.college-optometrists.org/the-college/media-hub/news-listing/remote-consultations-during-covid-19-pandemic.html*

The appointment will be delivered by telephone and/or video link and risk-prioritised on the basis of clinical need. Same day appointments will be offered if the patient reports symptoms suggestive of a sight threatening condition that would require an urgent referral.

All remote consultations will occur within 48hours of telephone triage.

For people who are hard of hearing or have communication needs, the patient should be able to nominate a support person/advocate who can also be invited to the consultation to support the patient.

The remote consultation will include the following, as appropriate:

1. Confirm with the patient that the consultation will only be able to discuss symptomatic urgent eye care needs and ensure that the patient happy to proceed on this basis.
2. Complete full online consultation, which will likely include (but is not limited to) capturing patient details, presenting symptoms and recent history, current medication, current health and past ocular history.
3. If appropriate, use video-conferencing facility to permit a gross external examination of the eye (as far as practicable).
4. Analyse findings and discuss and share the working diagnosis with the patient.
    i. Where available, it might be necessary to seek advice and guidance from an ophthalmologist / optometrist with higher qualifications, who will be able to support with decision making relating to both diagnosis and the establishment of an appropriate management plan.
5. Discuss and agree a management plan with the patient which may include self-care advice, therapeutic recommendation, face to face consultation (identifying the optical practice hub with the appropriate equipment and practitioner available), or urgent referral to the Hospital Eye Services as per local protocols. Verify patient's understanding of management plan.
    i. If a face to face appointment is offered, as much clinical detail as possible will be gathered during the remote consultation to minimise the face to face contact time.
    ii. The appointment will be booked with an Optometrist with the appropriate level of qualification and equipment and/ or access to ophthalmology A&G to help ensure the patient is fully managed within the service.
6. Where a 'virtual care and management plan' or 'self-care' plan has been agreed, a follow-up consultation may be arranged with the patient where appropriate and required.
7. Provide patient information by SMS, email and/or post, to support the individual management plan. This will include information on how to contact the service and/or other services if the condition fails to improve.
8. Ensure that the patient's clinical records are completed/updated as appropriate and update the patients GP and original referrer by email / post (A copy should be offered to the patient).

<u>CUES face-to-face consultation</u>

Appointments will be prioritised based on clinical need. Same day appointments will be offered if the patient reports symptoms suggestive of a sight threatening / urgent condition.

Practitioners will follow general advice from NHS England & NHS Improvement, Health England and Department of Health and Social Care on appropriate COVID-19 measures.

Practitioners will also follow advice from the College of Optometrists (and where appropriate RCOphth) on measures for restricting clinical activity in all eye care services, and for appropriate use of Personal Protective Equipment (PPE); mitigating risk of infection to patients and staff.

People who are vulnerable / house bound / shielding should not be offered a face to face consultation (Case-by-case basis. It is unlikely the risk of sight loss outweighs the risk to general

health – seek consultant advice if uncertain). https://www.gov.uk/government/publications/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19

The level of examination should be appropriate to the reason for referral.

Contact time with the patient should be kept to a minimum and performed by a single practitioner. (e.g., reduce practitioner-patient contact time by making use of Imaging and OCT in place of direct ophthalmoscopy and slit-lamp bio microscopy (with shield), where appropriate, and discussing the outcome remotely following the consultation).

All procedures are at the discretion of the practitioner and undertaken as deemed clinically necessary after assessment of the *patient's* History and Symptoms, appropriately mitigating for risk of infection.

Practitioners will work within their own competency and experience. Where available, they may seek advice and guidance (A&G) from an ophthalmologist / optometrist with higher qualifications, who will be able to support with decision making relating to both diagnosis and the establishment of an appropriate management plan.

Depending on availability, A&G may be delivered at the time of the consultation (by video link) or a later time (by NHSmail or telephone) and the outcome communicated to the patient remotely (telephone or video call).

3.6 Interdependencies with other services

The Provider will be expected to interface with the following agencies.

- Acute Hospital Trusts
- General Practitioners
- Secondary Care Consultants
- Optometrists
- Pharmacy / drug suppliers
- NHS Bassetlaw CCG and in particular the Commissioning Lead regarding quality and performance and will be expected to report activity, service user satisfaction reports and outcome measures as appropriate.

3.7 Access and accessibility

MECS:

The MECS service is to operate across the borough of Bassetlaw for all Bassetlaw GP registered patients during normal opening hours: Monday to Friday 9.00am – 5.00pm and Saturday 9.00am – 1.00pm as a minimum. Sundays would be desirable but are not essential.

CUES:

The CUES service will be available across the week from across a network of optical practices, acting as urgent eye care hubs. It is expected the majority of appointments locally will be between the hours of 9am and 5pm. Same day appointments will be available which will include evening and weekend provision to meet patient needs following telephone triage - subject to

current COVID-19 related challenges, changes in workforce and / or government strategy.

3.8 **Examination and treatment**

The MECS / CUES optometrist is expected to:

- Deliver the service in a consultation room ensuring patient confidentiality is maintained at all times;
- Ensure they have correctly recorded patient's GP practice details;
- Note on the patient record that the patient has consented to:
    - examination;
    - any subsequent treatment; and
    - their records being shared with the patient's GP / optometrist / ophthalmologist as appropriate.
- Determine the level of examination that is appropriate to the reason for referral.
- Give clinical advice and guidance in respect of the management of the patient's presenting condition. Written literature / patient leaflets may also be supplied.
- Where the optometrist is a licensed prescriber, they will be able to prescribe medication for the patient to obtain from a pharmacy
- Where the optometrist is not a licensed prescriber, they are to advise the patient's GP and request that the GP prescribe the required medication on behalf of the optometrist.

Members of the College of Optometrists can access Clinical Management Guidelines which are available on their website.

3.9 **Consultation outcomes and onward referral**

MECS:

All of the following must be recorded on the patient's record:

- Tests undertaken and results obtained (even if the results are normal);
- Drugs or staining agents; and
- Verbal or written advice given.

The **MECS optometrist** must keep the patient's GP informed of the patient's appointment and whether they have been referred onto a suitable secondary care provider of the patient's choice or discharged. This information is to be sent securely within 5 days of the patient's appointment.

If urgent onward referral to a suitable secondary care provider of the patient's choice is required, either at triage or during the initial or follow up assessment, the **MECS optometrist** shall inform the a suitable secondary care provider of the patient's choice by telephone: DBTH will provide ongoing telephone support for community providers via the eye clinic during office hours. For out-of-hours and weekends via the on-call Middle Grade Clinician, access is via the DBTH Switchboard on 01302 566666. A copy of the referral shall be forwarded by NHS.net email or given to the patient to take with them on attendance.

For non-urgent referrals, the **MECS optometrists** will refer back to the patient's GP as applicable. The GP may utilise the hospital advice and guidance service as appropriate.

CUES:

It is expected that the patient will have one of the following outcomes following consultation:

- The practitioner decides to manage the condition and offers the patient advice and/or prescribes/recommends medication. Management may include a minor clinical procedure e.g. foreign body removal. A remote follow-up consultation may be necessary.
- The practitioner refers the patient for an eye casualty / emergency consultation at the local hospital eye service, contacting the service in advance of referral to confirm appropriate referral management and booking if accepted.
- The practitioner determines the condition (and subsequent referral) is non-urgent and can be safely delayed until following the pandemic. A further appointment is recommended e.g. 4-6 months.
- The practitioner has concerns that the patient may have a systemic condition and makes a referral to their GP.
- The practitioner refers the patient non-urgently for further investigation and/or treatment in line with local referral pathways and protocols. Managing the patient expectations relating to appointment availability in the current pandemic.
- Where appropriate, the patient should also be directed to the College of Optometrist resources to help patients with their self-care and understanding. https://lookafteryoureyes.org/eye-conditions/

3.10 **Equipment required**

MECS:

Optometrists are expected to have the following:

- Goldman type applanation tonometer (or portable equivalent)
- Threshold visual field analyser to produce a printed field plot
- Amsler charts
- Snellen / LogMAR charts
- Epilation equipment
- Diagnostic drugs (mydriatics, stains, local anaesthetics etc) as set out in the formulary on the Local Optical Committee website (http://www.locsu.co.uk/)
- Slit lamp with up to x40 magnification (or portable version)
- Condensing lenses
- Colour vision tests

Medication requirements:

- Mydriatic
- Anaesthetic
- Staining Agents

CUES:

Providers delivering the service will be expected to have appropriate equipment available for the safe and effective delivery of the service. This should be used, maintained, calibrated and cleaned

in line with industry standards and up to date infection control requirements that will continue to be updated throughout the COVID-19 pandemic.

In addition to equipment already available for the delivery of GOS services, this should include:

- Access to the internet (for data reporting and referral system)
- Access to NHS.net
- Access to telephone/video consultation functionality
- Slit lamp BIO or indirect
- Slit lamp breath shields
- Applanation Tonometer (Goldmann or Perkins) or Icare
- Appropriate diagnostic ophthalmic drugs
  - Mydriatic
  - Anaesthetic
  - Staining agent
- Access to imaging / OCT
- Suitable Personal Protective equipment (PPE)
- Equipment for foreign body removal

Supply & Use of Medicines following consultation:

- Where a medicine is required, this will normally be supplied or prescribed by the optometrist, as part of the consultation, through the issue of a signed order for supply by the community pharmacist of the patient's choice; or by directly supplying or selling (where appropriate), "Pharmacy only" (P) medicines and General Sales List (GSL) medicines, and the following POMs: chloramphenicol, cyclopentolate hydrochloride, fusidic acid and tropicamide.
- Independent optometrist prescribers will ideally have access to FP10 prescription, for dispensing by a community pharmacist.

An approved list of medicines will be agreed. All participating clinicians will only prescribe, supply or issue signed orders for medicines included on the approved formulary, unless there is a clinical reason not to do so.

Example Formulary:

Formulary.pdf

Where patients are eligible for free NHS prescriptions a written order with a pro forma claim form will be provided to the patient to take to the pharmacy to have dispensed and the Pharmacy will claim their fees from the commissioner.

Example Written order template:

Written Order April 2019.docx

It should be noted that many recommended therapeutic drugs will be available over the counter (OTC) and in line with NHS England Guidance should be purchased where appropriate. However, it

should be noted some preparations such as Chloramphenicol maybe a POM classification for conditions other than bacterial conjunctivitis and as such cannot be purchased OTC and a written order or FP10 is required for patient access from pharmacy.

Some OTC recommended products will be available for purchase by the patient from the optical practice acting as the urgent eye care hub – thus minimising onward contacts with other healthcare settings where possible.

Where an optometrist has independent prescriber (IP) status the commissioner will enable them to receive an FP10 prescribing pad and assign an additional prescribing budget for IP optometrists to enable greater care to be delivered in primary care within this service.

The clinical lead Optometrist and ophthalmologist will work together with pharmacy colleagues to explore routes to remote prescribing locally.

The use of medicines

Providers will be expected to:

- Maintain their skills and knowledge with regards the use of drugs
- Demonstrate continuous professional development in line with their professional requirements
- Inform patients of the any adverse reactions prior to application and provide them with the appropriate information
- Record all batch numbers and expiry dates of drugs in the patients notes
- Ensure that all drugs are stored according to the manufacturer's instructions.

3.11 **Workforce, Education and Training**

MECS:

All participating optometry practitioners must:

- Be registered with the General Optical Council or General Medical Council for Ophthalmic Medical Practitioners
- Keep up-to-date with current guidelines and undertake Continuing Education and Training no less than 36 points over a 3 year period.
- Be registered on an NHS England Performers List
- Have appropriate indemnity insurance and submit evidence to the CCG on an annual basis
- Have successfully undertaken Safeguarding Adults and Children training
  Be subject to a satisfactory valid enhanced disclosure check for regulated activity undertaken through the Disclosure and Barring Service (DBS). As the role of optometrists is covered by the Exceptions Order, both spent and unspent convictions must be declared. Optometrists must inform the contract holder if they are convicted of any criminal offence, including driving offences. The right to withdraw an offer of employment or terminate employment, with or without notice, is reserved where it is discovered that there is unspent/spent conviction. The contractor must consider the relevance of any conviction to the role undertaken.

The skills required to deliver this scheme are within the remit of the core skills of optometrists as guided by the College of Optometrists. **MECS optometrists** must ensure that they fulfil The College

of Optometrists' guidelines on qualifications i.e. WOPEC Minor Eye Care Conditions Service and ongoing education and training needs.

Practitioners will be encouraged to become Independent Prescribers.

Annual updates of training undertaken for all participating optometrist staff must be submitted to the CCG.

CUES:

The service should have effective clinical leadership with principles of training, clinical governance, and clinical audit central to this.

The service will recognise current capability in optical practice and will not require any additional accreditation for service delivery.

The initial telephone triage may be delivered by optical practice staff, working to an agreed protocol, under the supervision of an optometrist.

Remote consultation, and/or face to face consultation will be delivered by appropriately trained Practitioners, who have:

- Registered with the General Optical Council (GOC)
- Registered on the NHS England Performers List (Optometrist only)
- Have an enhanced DBS check (or application in progress)
- Have completed Safeguarding Level 2 (Adults), and Safeguarding Level 2 (Children)
- Appropriate levels of Indemnity (including Medical Negligence insurance)
- Have completed GOC continuing education and training requirements to demonstrate up to date competency.

For optometrists, existing accreditation processes enable the optometrist to revisit core learning and demonstrate that their core skills are up to date. At this current time, all practical skills assessments have stopped. For the purposes of this proposal, optometrists who haven't already completed the accreditation process will be able to deliver the service but will be expected to self- assess. All Optometrists will be expected to:

- Recognise their own learning needs and identify appropriate resources to meet these needs. All DOCET / WOPEC distance learning is still available.
- Work within their own competency and experience.
- If required, on a case-by-case basis, make use of the mentorship and guidance available within the network of local primary care optical practice and through advice and guidance processes delivered by optometrists with higher qualifications.
- Make use of Ophthalmology advice and guidance, on a case-by-case basis, where available

For CLOs, the MECs accreditation process delivers new learning beyond core competency. CLOs without MECs accreditation can still deliver care within a MEC service if supervision is provided by a MECs accredited Optometrist.

The service will utilise Optometrists with higher qualifications, where available.

3.12 **Population covered**

Both services are available for any patients registered with a Bassetlaw GP.

An out of area optometrist who has a patient who is registered with a Bassetlaw GP would be required to refer the patient onto an **MECS / CUES optometrist** of the patient's choice. This list can be obtained by contacting NHS Bassetlaw CCG Primary Care Team on xxx of via email: xxx

3.13 Contract Management Meetings

The commissioner reserves the right to request meetings which the provider must make all reasonable efforts to attend.

3.14 Records & Patient information (applicable to both MECS and CUES)

3.14.1 Record keeping

Complete and accurate records will be held for each patient to include clinical information by the provider in either paper or electronic format and stored securely. Information within records should be processed with regard to the principles expressed in the Data Protection Act 2018.

Records will clearly state where a remote consultation (telephone or video consultation) has occurred (as appropriate) because of the COVID-19 pandemic.

The Information Commissioner's office has stated that practitioners need to consider the same kinds of security measures for home working that would be in use in normal circumstances https://ico.org.uk/for-organisations/data-protection-and-coronavirus/

3.14.2 Patient information

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

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

The patient will be provided with both oral and written information and offered a copy of any letters between healthcare professionals regarding their care (ideally by email, alternatively by post).

The primary source of information to support patients with their self-care and understanding will be College of Optometrist resources: https://lookafteryoureyes.org/eye-conditions/

3.15 Premises, Policies and Procedures, Infection Control / PPE and clinical waste

3.15.1 Premises

All participating practices need to be providers of General Ophthalmic Services. As such, they are required to complete the "Quality in Optometry" toolkit https://www.qualityinoptometry.co.uk/ which includes:

- Taking steps to improve accessibility for people with disabilities

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

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

https://www.qualityinoptometry.co.uk/

All locations delivering the service are subject approval by the Commissioners in advance of service commencement and should include the following:

- Enclosed reception and/or waiting facilities (provision of seating as a minimum)
- Suitable private room for assessment and treatment

It is the responsibility of the Provider to make available, maintain to a high standard and replace all relevant equipment required to provide the service.

3.15.2 Policies and procedures

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

- Serious untoward incidents
- Clinical audit
- Information governance

3.15.3 Infection control

Service delivery must use robust infection control procedures, including:

- Using a breath guard on slit lamps. The Royal College of Ophthalmologists has advice on how temporary breath guards can be made
- Wiping clinical equipment and door handles after every patient, as well as other surfaces that may have been contaminated with body fluids using a suitable disinfectant such as an alcohol wipe. All surfaces must be clean before they are disinfected
- Sanitising frames before patients try them on. If a focimeter needs to be used on patients' spectacles, the patient should be asked to take them off and should be provided with a wipe to sanitise their frames before these are touched by the professional
- Supporting good tissue practice (catch it, kill it, bin it) for patients and staff by having tissues and covered bins readily available
- Ensuring that thorough hand washing techniques are adhered to.

Personal Protective Equipment (PPE) – national PPE guidance:

- COVID-19 Infection Prevention and Control (update 12 April 2020) https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control
- COVID-19 Infection Prevention and Control (update 12 April 2020)- Table 2 (primary care settings – possible or confirmed case) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/878750/T2_poster_Recommended_PPE_for_primary__outpatient__community_and_social_care_by_setting.pdf
- COVID-19 Infection Prevention and Control (update 12 April 2020)- Table 4 (any setting – currently not a possible or confirmed case): https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/879111/T4_poster_Recommended_PPE_additional_considerations_of_COVID-19.pdf

3.15.4 Disposal of clinical waste

This is the responsibility of the provider and should meet legal requirements.

3.16 Patient Complaints and Compliments

Practices will be expected to display information on complaints procedures and make them available to patients and to manage patient complaints in accordance with NHS complaints procedures. www.dh.gov.uk/health/contact-dh/complaints

Patient compliments and feedback will be encouraged. To minimise contact collection of feedback should be facilitated remotely.

3.17 Service Evaluation and Audit

The single provider lead organisation will ensure all practices and practitioners meet the requirements and provide assurance to the commissioner of this.

A secure IT web-based platform will be used to provide the data required to demonstrate performance against the service KPIs and to facilitate regular audit.

The provider will ensure that all contract performance management requirements are met and will attend virtual performance monitoring meetings with the CCG contract manager as, as necessary. The Provider is expected to undertake regular internal clinical audit and review and to take action to implement any learning acquired during this process. The key findings of the clinical audit and actions taken from learning must be reported to the commissioner.

Where it is identified that the service is not delivering the anticipated activity levels and/or the service outcomes, then the provider will work with the CCG to identify, and address, the root cause. The single provider organisation will report to the commissioner regarding quality and performance of the service at regular intervals as agreed with the commissioners – supported by a network of local and regional leads.

4. Applicable Service Standards

4.1 **Applicable national standards (e.g. NICE)**

- Not applicable

4.2 **Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)**

- The College of Optometrists
- Local Optical Committee Support Unit
- Standard General Optometric Contract

4.3 **Applicable local standards**

- See sections 4 and 6 of the contract particulars. See sections 4 and 6 of the contract particulars. Providers will be expected to be able to provide high quality, accurate and timely performance information in the format and frequency stated by the commissioner.

5. Applicable quality requirements and CQUIN goals

5.1 **Applicable Quality Requirements (See Schedule 4A-C)**

- See section 4A-C of the contract particulars

5.2 **Applicable CQUIN goals (See Schedule 4D)**

- See section 4D of the contract particulars

6. Location of Provider Premises

The Provider's Premises are located at:

To be inserted once the contract has been awarded