**South Staffordshire MECS**

***Minor Eye Conditions Service***

**MECS – Guidance for Participating Optometrists (April 2017)**

Following the success of the Stafford & Cannock PEATS pilot launched in July 2015, Staffordshire LOC is pleased to confirm that the service will be re-commissioned under the new name of **South Staffordshire MECS (Minor Eye Conditions Service)** from 1 April 2017. The service will simply be rolled on in the existing Stafford & Surrounds CCG and Cannock Chase CCG area PEATS practices. However, South Staffordshire MECS is being expanded to also include practices from South East Staffordshire & Seisdon Peninsula CCG area, the first of which will go live with MECS on 20 April 2017.

Each accredited practice has a contract with Staffordshire LOC’s contracting vehicle/limited company, Primary Eye Care [Shropshire & Staffordshire] Ltd (also known as SASPEC). SASPEC will provide an end-to-end managed service which includes referral triage, offering patient choice of time and location of appointment, community assessment and/or onward referral as appropriate.

The following guidance mirrors the contract between SASPEC and Stafford & Surrounds, Cannock Chase, and SE Staffordshire & Seisdon Peninsula Clinical Commissioning Groups (CCGs). Please read it and ensure that you understand what is required of the contractor and each MECS practitioner.

**Why MECS?**

SASPEC decided to rename PEATS as MECS, because this is the name by which it is known nationally, and it will ensure a stronger branding and simplification of understanding. The guidelines from ophthalmology commissioning mention MECS, and increasingly GPs understand what is meant by MECS. Furthermore, the accreditation is the LOCSU MECS certificate from WOPEC, in line with the national training model. Using the name MECS will also help to reduce cross-border issues.

MECS enables the triaging of both acute and non-acute referrals by suitably trained accredited optometrists located in convenient high street optical practices. Consequently, GPs can choose to send referrals from non MECS-accredited optometrists into the service for refinement. In addition, MECS enables the treatment of minor eye conditions (e.g. allergic and infective conjunctivitis), and the carrying out of minor eye procedures (e.g. corneal foreign body removal and eyelash epilation).

**Purpose**

The prime purpose of MECS is to reduce onwards referrals to secondary care. Where referral to secondary care is required, it will be to a suitable specialist with appropriate work up, initial diagnosis and urgency. Experience in other similar services, such as the Welsh PEARS scheme, is that 75-80% of patients are managed in the practice, and only 20-25% are referred to secondary care. You should use this as your benchmark - there is no point in seeing these patients and then referring the majority anyway. The IT system will be monitoring this, both by practice and by practitioner.

**Key points:**

* All provision of service must be recorded on the IT system (Webstar Health OptoManager MECS module). This system will allow Primary Eyecare (Shropshire & Staffordshire) Ltd to track patients all the way through the pathway and provide the data required by the company’s Clinical Governance and Performance Lead to manage the performance of the service according to the Local Quality Requirements. All provision of service must be recorded on OptoManager. It’s the only way you’ll get paid.
* All contacts regarding MECS should be recorded, even if they don’t result in an appointment. In reality, this means that you must record any cases where you advise the patient to go straight to New Cross Hospital ARC or Queens Hospital, or go back to the original referrer (GP, other optician) without seeing them in MECS. This is for your own protection, so that there is a record.
* From 1 April 2017, the PEATS central hub will cease to exist. However, SASPEC will provide an NHS.net address as a route into MECS for electronic referrals from GPs. This is important, as not all MECS practices have their own NHS.net accounts, and not all GPs will be happy to fax or phone in referrals to MECS practices. A triage clinician will pick up the referral and gauge the urgency, before instructing admin to fax it to one of the participating practices (or email it if the practice has its own NHS.net account). The practice would then be responsible for fitting the MECS referral into its clinics with the appropriate urgency, or finding an alternative provider if it does not have the capacity.
* **Failsafes:** 1) Practices would be required to confirm with Alison that they have fitted the MECS referral into its clinics with the appropriate urgency, or else found an alternative provider. 2) Alison will keep a log of electronic referrals, and chase up practices if she doesn’t hear back from them. 3) If patient can’t be contacted by the MECS practice, or DNA’s twice, then the referring GP must be informed by the MECS practice.
* In addition, MECS referrals will continue to be sent directly to your practice via GPs, pharmacists, and occasionally from non-accredited opticians, plus self-referrals from patients.
* A “MECS Referral Form for GPs” document has been uploaded to the Map of Medicine. This will list the inclusion/exclusion criteria for the service to GPs and to their staff. **All participating MECS practices must triage the referral within 48 hours**. As a minimum, **the patient will be seen by the MECS service within 2 weeks (MECS ROUTINE)**. However, **urgent referrals shall be seen within 24 hours (MECS URGENT)** – see **Appendix 1**. The GP may specify that you see the patient either as MECS URGENT or as MECS ROUTINE, depending on the perceived urgency. SASPEC asks that you kindly comply with all such requests.
* You must complete a triage of referrals into your practice via a MECS reception triage form, so that referrals immediately apparent as inappropriate are sent straight to New Cross ARC or Queens Hospital with appropriate urgency (24 hours or 72 hours) without seeing them in MECS, or bounced back to the original referrer (with comments) without seeing them in MECS. Again, make a note of the contact on the IT system. A MECS reception triage document can be found on the secure page of Staffordshire LOC’s website.
* In instances where the level of urgency is unclear, the triage should then be passed on to a MECS-accredited optometrist. This will spread demand and ensure consistent triage.
* As a MECS practitioner, it is expected that you shall provide assessment and treatment, where appropriate for the following symptoms/conditions:
	+ Distorted vision
	+ Ocular pain
	+ Systemic disease affecting the eye
	+ Differential diagnosis of the red eye
	+ Foreign body and emergency contact lens removal (not by the fitting practitioner)
	+ Dry eye
	+ Epiphora (watery eye)
	+ Trichiasis (in growing eyelashes)
	+ Differential diagnosis of lumps and bumps in the vicinity of the eye
	+ Flashes/floaters
	+ Retinal lesions
	+ Patient reported field defects (NOT FROM SIGHT TEST)
	+ GP referrals (including referral refinement, and raised IOP/suspected raised IOP)
* If the reception triage identifies any symptoms/conditions that are listed below, you will contact the patient the same day and refer to New Cross ARC or Queens Hospital (via fax), with appropriate urgency (to be seen by the eye department within either <= 24 hours or <= 72 hours). Further guidance can be found in the New Cross ARC Urgent Ophthalmological Referrals guidance, which can be found on the MECS OptoManager module and on the secure page of Staffordshire LOC’s website.
* Sudden, persistent loss of vision<48 hours – urgent to ARC or Queens (<24 hours)
* Sudden, persistent loss of vision >48 hours – urgent to ARC or Queens (<72 hours)
* Sudden onset diplopia – urgent to ARC or Queens (<72 hours)
* Injuries: chemical, penetrating or post-operative infection – urgent to ARC or Queens (<24 hours)
* Severe ocular pain requiring immediate attention – urgent to ARC or Queens (<24 hours)
* Suspected retinal detachment – urgent to ARC or Queens (<24 hours)
* Suspected vascular abnormality
* For the time-being, all urgent referrals to ARC and Queens must be via fax. **Please clearly indicate patient’s phone number**. Your practice’s phone number should be included on the referral template also. If referring the patient directly to ARC, don’t give the patient the referral form to take by hand, otherwise they will be sent to the back of the queue at A&E before they can be seen at ARC.
* You must stress to the patient that once the ARC appointment has been booked, the patient will need to attend the allocated slot at that time. ARC has a Zero Tolerance Policy to missed appointments and won't offer the patient another one if that appointment is missed.
* If your urgent referral into ARC or Queens is faxed after 6pm, the criteria for “seen <= 24 hours” won’t start until the following morning. For this reason, if a patient presents to reception at lunchtime with symptoms/condition meriting urgent referral to ARC or Queens <= 24 hours, try to make the referral straight away, rather than wait until the end of the day’s clinic.
* Queens Hospital Eye Casualty closes at 12:00pm on Saturdays. Therefore, any MECS patients seen on Saturday afternoons requiring urgent referral should be faxed to New Cross ARC or Birmingham and Midland Eye Centre (BMEC) City Hospital instead.
* A full list of **South Staffordshire Ophthalmology Referral Routes** (Urgent and Routine) has been uploaded to the module, with details of providers’ email addresses, fax numbers and telephone numbers as appropriate.
* If the reception triage identifies the patient as being suitable for MECS, but you are unable to offer an appointment, you MUST find the patient another practice that can see them within the appropriate timescales of 24 hours or 2 weeks. These timescales apply to working days, which are Monday to Saturday. You will find a full list of practices participating in South Staffordshire MECS in Appendix 2, and on Staffordshire LOC’s website.
* You must complete the Equality & Diversity and Patient Satisfaction Questionnaires (E&D and PROMS) for all MECS patients seen, where possible. The company requires a significant number of questionnaires to be completed so that it can demonstrate the quality, efficacy and safety of MECS to the commissioners. This is also available for download from the secure page of Staffordshire LOC’s website.

**Use of MECS**

The development of MECS enables contractors to be paid for consultations that were previously private, passed on to secondary care or simply provided out of charity. It is important that the service is not abused. You can certainly refer in to MECS a case that you might otherwise have referred urgently, such as recent onset flashes and floaters, but it is not suitable for every slightly out of the ordinary case that crops up during a routine sight test.

MECS follow-up appointments are occasionally desirable, but are not normally necessary: only 5% of patients seen in the Stafford and Cannock PEATS pilot were requested to attend for follow-up. A follow-up appointment will be offered, where clinically necessary, by the MECS-accredited optometrist within 2 weeks of the initial consultation. Follow-up consultations will be logged, and the new to follow-up rate will be monitored by the Clinical Governance & Performance Lead. There is no payment for follow-up visits in South Staffordshire MECS, nor can you charge the patient a private fee.

MECS should not normally be used in the following cases:

* Flashes and/or floaters if < 1 month has elapsed since the first full MECS consultation for the same issue
* For removing in-growing eyelashes if < 4 months have elapsed since the first full MECS consultation for the same issue
* For repeat dry eye / blepharitis consultations if < 4 months have elapsed since the first full MECS consultation for the same issue
* And in similar situations to the previous 2 points, e.g. transient loss of vision
* Where the patient’s reported symptoms indicate that a sight test is more appropriate than MECS
* Adult squints, long standing diplopia
* Removal of suture
* Repeat field tests to aid diagnosis following an eye examination (unless referred in by a non-accredited optometrist from a different practice)
* Age related macular degeneration (unless disciform changes of recent onset are suspected)

You may repeat a MECS consultation after a short period for a different problem. The use of MECS is constantly monitored within the IT system and outliers may be asked for explanations.

There are other specific exclusions to MECS:

* Patients identified to have severe eye conditions which need hospital attention, e.g. orbital cellulitis, temporal arteritis
* Eye problems relating to Herpes zoster
* Suspected cancers of the eye

Patients cannot be treated under MECS if their signs or symptoms indicate they are more suitable for the following locally enhanced services:

* South Staffordshire Direct Access Cataract (DAC) pathway
* South Staffordshire Glaucoma Referral Refinement (GRR) service
* Staffordshire Diabetic Eye Screening Programme

It is recognised that as patients are self-referring, it is possible that they may attend the service with a condition which is excluded for treatment, but requires assessment and onward referral to an appropriate eye service. In these cases, patient assessment by MECS is classed as an episode of care and a payment will be made.

The key here is prior knowledge. If a patient books a MECS appointment with sudden vision loss and it turns out to be wet AMD, the consultation fee will be paid. However, if the wet AMD is identified during a sight test, then MECS may not be used. If you already know that you will be referring as a result of the sight test, then MECS cannot be used.

Please also refer to the documents **“Referral from non MECS-accredited registered opticians into MECS”**, and **“Use of MECS and Sight Tests”**. These have been uploaded to the MECS module also.

**Referrals**

**Routine referrals**

Routine referrals are made to the GP automatically from the MECS system. In all consultations a report is generated to the GP. There are text boxes you can fill in to provide more detailed information. These routine referrals may be either to the GP (not for onward referral) or via the GP to ophthalmology.

**Urgent referrals**

Occasionally, symptoms/conditions more appropriate for ARC than MECS will bypass both the reception triage and the hub. When this happens, the patient can be seen under MECS and then referred appropriately. Urgent referrals to New Cross ARC or Queens Hospital should be made by sending a fax (with the referral notes entered on either the urgent <24 hours or urgent <72 hours template – these have been uploaded to the OptoManager IT platform). You may then wish to phone New Cross ARC or Queens Hospital to make sure that the fax has been received.

Don’t forget:

* **Please clearly indicate patient’s phone number**. Your practice’s phone number should be included on the referral template also. If referring directly to ARC, don’t give the patient the referral form to take by hand, otherwise they will be sent to the back of the queue at A&E before they can be seen at ARC.
* You must stress to the patient that once the ARC appointment has been booked, the patient will need to attend the allocated slot at that time. ARC has a Zero Tolerance Policy to missed appointments and won't offer the patient another one if that appointment is missed.
* If your urgent referral into ARC or Queens is faxed after 6pm, the criteria for “seen <24 hours” won’t start until the following morning. For this reason, if a patient presents to reception at lunchtime with symptoms/condition meriting urgent referral to ARC <24 hours, try to make the referral straight away, rather than wait until the end of the day’s clinic.

Please refer to the New Cross ARC Urgent Ophthalmological Referrals guidance document (see secure page of the Staffordshire LOC website) when deciding whether an urgent referral to ARC needs to be seen <24 hours or <72 hours. This guidance is not intended to be prescriptive. For example, not all corneal foreign bodies need to be referred <24 hours to ARC – in many circumstances, corneal FB’s can be safely removed by the MECS practitioner. In a similar vein, the IP optometrist can treat certain corneal ulcers and some instances of recurrent uveitis. The inclusion/exclusion protocol for such cases is clearly defined by The College of Optometrists’ Clinical Management Guidelines (CMGs) and should always be adhered to.

**Primary Eye Care (Shropshire & Staffordshire) Ltd**

SASPEC is a company that has been created as a contracting vehicle for MECS, GRR, Post-operative Cataract and other services to follow. It is run as a as a company limited by guarantee, a not for profit organisation run by its directors on behalf of optometrists accredited to the community pathways, and it addresses the preference of CCGs to contract with a single entity – a consortium of local contractors - rather than multiple contracts with individual practices as before.

By contracting with SASPEC, the CCGs hope to improve outcomes and efficiencies. Much of the responsibility for this lies with the Clinical Governance & Performance Lead (CGPL) and deputy CGPL. They are accountable to the LOC Company Board of Directors, and are responsible for providing clinical leadership and oversight of service delivery. They are tasked with the following:

1. Oversee the accreditation process
2. Ensure subcontractor practices meet all the governance requirements before being accredited for the service
3. Monitor clinical governance and quality assurance arrangements
4. Monitor and manage subcontractor performance
5. Attend review meetings with the commissioner to discuss performance of the service against local quality requirements (LQRs, also known as KPIs)

The LQRs will be revealed at the service re-launch meetings. As MECS practices and practitioners, your performance will be measured on a monthly basis against the LQRs. Any practices and/or practitioners who breach any LQRs will be answerable to the CGPL.

Five local optometrists are directors of the company and are this taking responsibility for the actions of all practices involved. They have had to put in a lot of work, and take out a considerable amount of time from their own practices. They are therefore likely to have a low tolerance for anyone who does not comply with the contracting requirements.

The 3 Staffordshire directors are:

Stewart Townsend (also Chairman and IG Lead)

Irfan Razvi (also Clinical Governance & Performance Lead for Glaucoma)

Mark McCracken (also Clinical Governance& Performance Lead for MECS)

Please feel free to contact them with any questions. We suggest you start with Alison Lowell (SASPEC secretary), or you can go straight to Mark as Clinical Governance & Performance Lead (CGPL) for MECS.

**Useful Resources**

College of Optometrists’ Clinical Management Guidelines: *provide a reliable source of evidence-based information on the diagnosis and management of 56 eye conditions that present with varying frequency in primary and first-contact care.*

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

The Optometrists’ Formulary: *consists of data sheets that provide prescribing information on all drugs currently available to optometrists.*

<https://www.college-optometrists.org/guidance/optometrists-formulary.html>

LOCSU Minor Eye Conditions (MECS) Pathway (previously PEARS): *An outline of the purpose of the service, criteria for inclusion, management and referral protocols, etc.*

[http://www.locsu.co.uk/uploads/community\_services\_pathways\_2015/locsu\_mecs\_pathway\_rev\_14\_03\_16,\_v3.pdf](http://www.locsu.co.uk/uploads/community_services_pathways_2015/locsu_mecs_pathway_rev_14_03_16%2C_v3.pdf)

**Appendix 1 – MECS URGENT / MECS ROUTINE**

**MECS Urgent (To be seen within 24 hours)**

* Moderate ocular pain / discomfort
* Recent onset transient vision loss / blurred vision <= 48 hours
* Red eyes: which cannot be managed by GP
* Corneal foreign bodies or abrasions
* Recent onset flashes and floaters

**MECS Routine (To be seen within 2 weeks)**

* Mild ocular pain / discomfort
* Recent onset transient vision loss / blurred vision >48 hours
* Watery eyes
* Dry eyes
* Eyelid lumps and bumps
* Ingrowing eyelashes

**Appendix 2 – List of Participating South Staffordshire MECS Practices**

**(Alison – please add list here. First section: Approved MECS Practices [as of May 2017]. Second section: Pending MECS Practices [as of May 2017].)**