**North Staffordshire & Stoke-on-Trent MECS**

***Minor Eye Conditions Service***

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

Following a lengthy process of negotiations and exchanges with commissioners, Staffordshire LOC is pleased to confirm that the current Acute Eye Service will shortly be re-commissioned as **North Staffordshire & Stoke-on-Trent MECS (Minor Eye Conditions Service)**, with launch scheduled for April 2017. Each accredited practice will have a contract with Staffordshire LOC’s contracting vehicle/limited company, Primary Eyecare [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 North Staffordshire & Stoke-on-Trent Clinical Commissioning Groups (CCGs). Please read it and ensure that you understand what is required of the contractor and each MECS practitioner.

**Why MECS?**

The MECS service (previously known as PEATS) was first commissioned by Stafford & Surrounds (SAS) and Cannock Chase (CC) CCGs in July 2015. It is closely aligned to the LOCSU Minor Eye Conditions Service (MECS) model pathway.

A survey of 8 GP surgeries in Stockport revealed that 20.5% of patients attend their GP directly for minor eye complaints. In most instances, the GP surgery will not have the necessary equipment, or may lack the specialist skills and knowledge, to manage the eye problem. As a result, the GP will have little option but to refer the patient to Eye Casualty or Ophthalmology Outpatients in most instances. This is unnecessary. Most common eye problems can be assessed and treated by local community optometrists. Typically, savings of around £43,000 per 1,000 MECS referrals are achieved.

An evaluation of Stafford and Cannock MECS by SAS and CC CCGs (January 2016) has found:

1. 65% of MECS patients can be managed solely by community optometrists
2. 13% of MECS patients can be managed by community optometrists working with GPs
3. Only 22% need referral to the HES
4. 100% of patients were very satisfied with the service

**MECS vs. Acute Eye Service**

The Acute Eye pathway service specification of April 2008 defines the GP practice protocol for referral into the scheme, and it is quite narrow in scope. The protocol specifies that patients with an eye problem should only be referred into the pathway by GPs or other referrers only if the onset of symptoms is within 72 hours of presentation, with a few limited exceptions. However, the remit of MECS is much broader than this.

**MECS enables the triaging of not only acute referrals, but non-acute referrals also**, by suitably trained and accredited optometrists located in convenient high street optical practices. Consequently, **GPs can choose to send referrals from non-accredited optometrists into the service for refinement**. In addition, **MECS enables the treatment of minor eye conditions** (e.g. conjunctivitis, blepharitis and dry eyes), and minor eye procedures (e.g. corneal foreign body removal, emergency contact lens removal and eyelash epilation).

Six years ago, there were talks of an Adnexal pathway to manage external eye problems (e.g. eyelid lumps and bumps) in the community. There is no need for this separate pathway - most of these adnexal conditions will now fall into the remit of MECS.

Another important way in which MECS differs from the Acute Eye pathway is that the CCGs will now be contracting for the service via SASPEC. SASPEC 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 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.

**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.

**North Staffordshire & Stoke-on-Trent MECS – key points:**

Accredited optometrists will utilise the web-based Metastorm IT platform. 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 Metastorm. It’s the only way you’ll get paid.

All contacts regarding MECS should be recorded in your practice records, 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 Royal Stoke Hospital’s Emergency Eye Clinic, 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.

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.

MECS referrals will be sent directly to your practice via GPs, and occasionally from non-accredited optometrists and DOs, plus self-referrals from patients. Once the patient has chosen their preferred practice, the referring clinician can either make contact with the practice to arrange for the patient to be seen, or can send the patient directly to that practice. 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 the Emergency Eye Clinic with appropriate urgency 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 in your practice records. **The 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 an accredited optometrist. This will spread demand and ensure consistent triage. Primary Eyecare (Shropshire & Staffordshire) Ltd has a tried and tested approach to ancillary triage which has already proved its success in Stafford & Cannock MECS.

**If the practice doesn’t have the availability, then it is that practice’s responsibility to find the patient an appointment from another practice in the service, within the appropriate time window** (i.e. as the patient is within a MECS service managed by SASPEC, and provided across a network of subcontractor practices). These timescales apply to working days, which are Monday to Saturday. **A list of participating practices can be found in Appendix 2**.

It is anticipated that a relatively small percentage of patients that undergo community assessments will require follow up (just 5% in Stafford & Cannock MECS). A follow up appointment will be offered, where clinically necessary, by the 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 and Performance Lead.

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 Emergency Eye Clinic (EEC) via fax, with appropriate urgency.

* Sudden, persistent loss of vision <48 hours – urgent to EEC (<24 hours)
* Sudden, persistent loss of vision >48 hours – urgent to EEC (<72 hours)
* Sudden onset diplopia – urgent to EEC (<72 hours)
* Injuries: chemical, penetrating or post-operative infection – urgent to EEC (<24 hours)
* Severe ocular pain requiring immediate attention – urgent to EEC (<24 hours)
* Suspected retinal detachment – urgent to EEC (<24 hours)
* Suspected vascular abnormality

For the time-being, all urgent referrals to EEC must be via fax. **Please ensure that patient’s phone number is entered correctly on the report**. Your practice’s phone number should be included on the referral template also. Please give the patient a copy of the letter as well, together with the appointment time, and EEC address and phone number.

You must stress to the patient that once the EEC appointment has been booked, the patient will need to attend the allocated slot at that time. EEC 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 EEC 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 EEC <24 hours, try to make the referral straight away, rather than wait until the end of the day’s clinic.

**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 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:

* North Staffordshire Direct Access Cataract (DAC) pathway
* North Staffordshire & Stoke-on-Trent 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”**.

**Referrals**

**Routine referrals**

Routine referrals should be made to the GP via fax. In all consultations a report should be 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 EEC than MECS will bypass the reception triage. When this happens, the patient can be seen under MECS and then referred appropriately. Urgent referrals to EEC should be made by sending a fax. You may then wish to phone EEC to make sure that the fax has been received.

Don’t forget:

* **Please ensure that patient’s phone number is entered correctly on to the referral form**. Your practice’s phone number should be included on the form also. Don’t give the patient the referral form to take to EEC by hand, otherwise they will be sent to the back of the queue at A&E before they can be seen at EEC.
* You must stress to the patient that once the EEC appointment has been booked, the patient will need to attend the allocated slot at that time. EEC 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 EEC 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 EEC <24 hours, try to make the referral straight away, rather than wait until the end of the day’s clinic.

**Please refer to the MECS Guidance on Urgent Ophthalmological Referrals** when deciding whether an urgent referral to EEC needs to be seen <24 hours or <72 hours. The College of Optometrists’ Clinical Management Guidelines/CMGs are also helpful (see “Useful Resources” below).

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

SASPEC is a company that has been created as a contracting vehicle for MECS, GRRS, OHT & Stable Glaucoma Co-management, Post-op Cataract service, Paediatrics, and hopefully others to follow.

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 McCracken 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 NS & Stoke MECS Practices**

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| --- | --- | --- | --- | --- |
|   | Address 1 | Address 2 | Address 3 | Post code |
| B Newbold Ltd | 49 St Edwards Street | Leek | Staffs | ST13 5DN |
| Boots Opticians | 60-62 High Street | Newcastle | Staffs | ST5 1QL |
| Burgess Opticians | 97 Roundwell Street | Tunstall | Stoke on Trent | ST6 5AW |
| Royles Opticians | 77 The Strand | Longton | Stoke on Trent | ST3 2NS |
| Ernest Hanwell Ltd | 8 Tower Square | Tunstall | Stoke on Trent | ST6 5AA |
| Ernest Hanwell Ltd | 11 Glebe Street | Stoke | Stoke on Trent | ST4 1HP |
| Gillian Scarisbrick Optometrist | 266 Uttoxeter Road | Blythe Bridge | Stoke on Trent | ST11 9LY |
| Heath Optometric | 2 Garfield Avenue | Hanford | Stoke on Trent | ST4 8ES |
| Heath Optometric | 2 Garfield Avenue | Hanford | Stoke on Trent | ST4 8ES |
| James Herd | 59 High Street | Tunstall | Stoke on Trent | ST6 5TA |
| Lyn Thompson Opticians | 65 Liverpool Road | Kidsgrove | Stoke on Trent | ST7 1EA |
| Nusyte Opticians | 50 High Street | Cheadle | Staffs | ST10 1AF |
| SW Cotton Optometrist | 92 Liverpool Road | Kidsgrove | Stoke on Trent | ST7 4EH |
| SW Cotton Optometrist | 75 High Street | Biddulph | Stoke on Trent | ST8 6AA |
| Razvi Opticians Ltd | 57-59 Weston Road | Meir | Stoke on Trent | ST3 6AB |
| Specsavers Opticians | 9-11 Derby Street | Leek | Staffs | ST13 6HN |
| Specsavers Opticians | 36-38 Market Street | Longton | Stoke on Trent | ST3 1BS |
| Specsavers Opticians | Unit 9, Castle Walk | Newcastle | Staffs | ST5 1AN |
| Stevenson Jones | 6 Friar Street | Newcastle | Staffs | ST5 2DZ |
| The Specs Place | 46A Market Street | Longton | Stoke on Trent | ST3 1BS |