NHS
North East London

SCHEDULE 2- THE SERVICES

A. Service Specifications

Service	Minor Eye Condition Service (MECs)- including other optometrist led services
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Provider	**North East London Primary Eye Care**
Provider Lead	Charles Greenwood
Period	March 2025 to February 2032
Date of Review	Annual review- March 2026

1. Service Overview

1.1 National / Local Context

There is a rising number of people living with eye health problems, and the growth in new treatments for conditions has increased the demand for Hospital Eye Services. Improving early access to services and preventing avoidable sight loss will benefit lives and will reduce the direct pressures on urgent hospital services and eye departments in North East London (NEL).

The aim of the Minor Eye Condition and other Optometrist led Services is to provide an alternative to GP primary care services and secondary care services - urgent care and ophthalmology services.

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

This will deliver the below benefits:

- To support general practice by providing faster access to routine diagnosis and treatment of minor eye conditions avoiding unnecessary GP appointments
- More access for patients - moving care to the high street, closer to home, making services easier for patients to access.
- To ensure that patients are seen by the appropriate clinician with the appropriate skills.
- To support secondary care urgent care services and routine outpatients by providing alternative options for patients for treatment of minor eye conditions and reducing hospital referral by refining suspect IOP readings by repeat measures and rechecking inconclusive visual fields and ensuring patients referred with cataract are willing to proceed to surgery.
- To ensure that there is sufficient capacity in secondary care to deal with “red flags” and more complex patients requiring specialist treatments and ongoing care.

1.2 Population Needs

The local population of North East London (NEL) ICB is across seven areas, known as places These are:

- Barking & Dagenham
- Havering

- Redbridge,
- Tower Hamlets
- Newham
- Waltham Forest
- City of London and Hackney

The current population for the seven boroughs is approximately 1,703,516 million with 299 General Practices, 179 optical practices, 382 Community Pharmacies, 137 Health Centres along with Clinics and Walk in Centres.

Barking & Dagenham, Havering and Redbridge are adjacent boroughs in outer North East London. The three boroughs have distinctive populations: Barking and Dagenham is a younger, ethnically diverse population, with 28% of people living in poverty; Havering has an older, largely white population, with 17% of people living in poverty; and Redbridge has an ethnically diverse, majority Asian, median income population with 25% of people living in poverty.

Tower Hamlets, Newham and Waltham Forest are adjacent boroughs in inner North East London, and are all diverse and deprived boroughs. Tower Hamlets is one of the most deprived boroughs in London with 39% of people living in poverty, and has an ethnically diverse population including one of the largest Bangladeshi communities in the country. Newham is a deprived borough with 37% of people living in poverty, and is ethnically diverse. Waltham Forest also has a very diverse population, and is deprived too with 28% of people living in poverty.
City and Hackney are adjacent districts in inner North East London comprising of the City of London Corporation and Hackney Borough Council. City and Hackney currently has a GP registered population of approximately 344,000 patients based in 8 Primary Care Networks and served by 39 practices. Hackney is the 19th most deprived local authority in England (of 326 local authorities) and the most deprived in North East London. In contrast, the City of London is ranked 280th and is within the 40% of least deprived local authorities in England and third least deprived in Greater London. However, there is considerable variation between its wards.

Current secondary care ophthalmology service provision for North East London ICB is mainly through three main NHS providers: Barts Health NHS Trust, Moorfields Eye Hospital, and Barking Havering and Redbridge University Hospital NHS Trust along with a number of Independent and out of area NHS providers.

2. Outcomes

2.1 NHS Outcomes Framework & Indicators

1	Preventing people from dying prematurely	
2	Enhancing quality of life for people with long term conditions	
3	Helping people recover from episodes of ill health or following injury	
4	Ensuring people have a positive experience of care	**X**
5	Treating and caring for people in safe environment and protecting them from avoidable harm	**X**

2.2 Local defined outcomes

- The new service will allow for existing services to be brought together into one service specification which will provide:
- Improved service quality and equity across North East London places
- Improved access to multiple locations across NEL
- Reduced variation in GP/Optometrist referral rates
- Improved productivity and efficiency
- Build a framework for adding in additional optometry led services

2.3 Aims and objectives of service

The aims and objectives of the service are to:

Aims

- Improve eye health and reduce inequalities by providing increased access to eye care in the community.
- Enable patients to be diagnosed and treated quickly and by the most appropriate clinical service.
- Ensure agreed patient care pathways are effective and followed by referrers and the service clinicians.
- Receive high levels of patient satisfaction.
- Reduce activity at A & E and Outpatient Services that can be dealt with in primary care.
- Support the delivery of a system approach to ophthalmology working with North East London and National Partners.
- The service will be patient-centred with a strong emphasis on patient education, self-management and prevention.

Objectives

- Ensure all places have equal access to MEC and related services in the community.
- Have a common MEC service and cost model across NEL.
- All places have access to Cataract pre-assessment.
- All places have access to (Glaucoma) repeat measures.
- Ensure pathways are clear to primary care and secondary care.
- Patient education is improved to self-manage minor eye conditions.
- Improve access times and locations across NEL (7 day a week access available in NEL).
- Improve the quality of secondary care referrals.

2.4 Service Outcomes

- All patients with minor eye conditions are able to be seen and if appropriate treated in the community quickly without recourse to GPs, A&E or outpatient services.
- False positives for raised pressures are reduced and patients are not unnecessarily referred.
- Cataracts – Patients are referred when they are ready to proceed with cataract operations and not referred unnecessarily and are referred with informed choice to an appropriate provider that can treat patients with more than one eye condition where necessary.
- All onward referrals to secondary care (where they have been assessed in MECs service) have a set of diagnostic investigations and results completed appropriately.
- All agreed care pathways are followed by Optometrists/GPs/referrers and education provided and targeted around the pathways where non-compliance is recorded.
- Patients feel empowered and more in control of their own eye conditions.
- The variation in routine referral activity for ophthalmology and linked services will remain low when benchmarked.

3. Scope of service

3.1 Service Model

The Minor Eye Condition Service (MECS) is community optometrist led and provides assessment, treatment and onward referral to specialist services where appropriate. The service will include other pathways:- glaucoma repeat measures and cataract pre-assessment for

patients showing signs of cataracts changes. Other services may be developed with the provider during the contract. These could include Low Vision Services and /post operative cataract pathways.
The service provider will ensure to provide these service pathways across multiple locations with sufficient capacity to meet demand.
Note: All site locations should offer Minor Eye Conditions, Repeat Measures and Cataract pre-assessment.
Other services may be commissioned, and these will be negotiated as they may not all require all sub-contractors to provide them in addition the above three.
The Minor Eye Condition Service operates in locations, usually, but not limited to High Street Optical practices, across the North East London footprint.
List of current locations - Appendix 2 – Locations should have good transport connections, be flexible to activity changes, and be open on weekdays with some weekend provision.
It is preferable that current MECS sites will continue so patients see continuity in service, however, that may not be possible, and providers should set out their plan to provide service locations across the geographic areas serving communities and PCNs to ensure all patients can access services close to where they live.
The service provider will have close working relationships with:

- Primary Care Networks and GP practices across the North East London footprint
- Single Point of Access Providers (There are currently two – one for Outer NEL boroughs and one for the Inner NEL boroughs.
- Secondary Care Providers:
  - Barts Health (Royal London, Newham, Whipps Cross)
  - Moorfields Eye Hospital including its outreach clinics
  - BHRUT (Queens and King Georges
- Local Pharmacies and/ or LPCs
- Local Optometry Committees (NEL)
- Local support services (Health advisers)
- Other secondary care providers

The commissioners will expect the service provider to with agreement on how and with what message, promote and advertise the service to the above stakeholders, working with other healthcare providers to ensure patients are seen in the right place, at the right time.
The service provider should ensure where applicable that patients are directed to access GPs, pharmacies and optometrists rather than use MEC services inappropriately.

General Exclusions to Minor Eye Conditions and optometrist led services:

- Non-NEL ICB patients.
- Patients under the age of 5
- Patients that require an NHS eye test
- Patients that have eye conditions that are being regularly monitored by their optometrist (as part of GOS or other enhanced service) or hospital eye service
- Patients with sudden loss of vision in one or both eyes, considerable eye pain or trauma, chemical injury or burns or recent eye surgery – these patients should be directed to an A&E eye department for emergency treatment.

3.2 Access Criteria

The service will provide the services within the following timeframes:

Minor eye conditions

Patients will be offered an appointment within 1 working day for urgent referrals and 2 working days for routine referrals. It is anticipated that many patients will be able to be seen on the same day including routine appointments depending on the eye condition, to avoid patients attending hospitals to be seen for MECs. There must be arrangements for urgent referrals to be seen on a Saturday/Sunday and Bank Holidays at some locations in NEL. The provider will also offer some early morning or late evening appointments at some locations

Optometrist Led Schemes

Glaucoma Repeat Measures & Cataract Pre -assessment– appointments will be arranged within two weeks of either the original eye examination or being referred to the service by the Single Point of Access Triage or another optometrist/GP.

Note: *A referral being received will include 'at the point of the GOS eye test where a referral was indicated*.

3.3 Referral Sources

- Referral by a GP
- Any patients under the age of 5 are excluded to referring into the MECs service
- Referral by an optometrist (not a provider of MECs)
- Referral by a pharmacist or other healthcare professional who recommend attendance and treatment
- Self-referral to the service via local signposting (GP practice/Pharmacist/Health Adviser/A&E etc.)
- Conversion from a sight test, from which the optometrist may refer a patient to themselves for a minor eye conditions assessment or a referral refinement assessment, if the patient and their condition meet the service referral criteria, or if the practitioner would otherwise have referred the patient to secondary care, but believes that a MECS consultation would avoid this eventuality – However, these must be recorded and numbers will be monitored to ensure it does not become routine activity.
- Referral from clinical triage and Single Point of Access Providers
- Referral from 111

The provider may be required to work with A &E and Urgent Care services in particular ICB places to help manage local minor eye condition activity more effectively.

IMPORTANT

The service is available to all persons registered with a GP practice within the footprint of North East London, the full list of eligible practices within North East London area covered by this contract can be found here **https://nel-eyecare.com/directory/ .**

Note:

NEL ICB do not fund services for patients registered with other ICB GP practices, and will not pay providers for patients not registered with one of the identified practices, however, where there is evidence that a patient is not registered with any GP practice in England and they live within the boroughs geographical area they are eligible for a service and payment will be made . We expect providers to exercise a degree of due diligence in ensuring patients are eligible for the service

including contacting GP practices or NHS England (patient practitioner services) if there is uncertainty.

Both the non-registered patients and the clinical exception are expected to be uncommon and unexpected activity will be investigated.

3.4 Care Pathways

The clinical pathways will apply to all referrals:

- Minor Eye Conditions**:** Appendix 1
- Glaucoma Repeat Measures Internal: Appendix 2
- Glaucoma Repeat Measures External: Appendix 3
- Cataract Refinement: Appendix 4

3.5 Referral Criteria

Minor Eye Conditions: This service provides for the assessment and management of patients presenting with any of the following minor eye conditions, the list is not exhaustive and may include:

- Loss of vision including transient loss – [consider differential diagnosis (TIA, Temporal Arteritis)]
- Ocular pain or discomfort
- Systemic disease affecting the eye
- Differential diagnosis of red eye
- Foreign body and emergency contact lens removal (not by the fitting practitioner)
- Dry eye
- Epiphora (watery eye)
- Trichiasis (in growing eyelashes)
- Differential diagnosis of lumps and bumps in the vicinity of the eye
- Recent onset of diplopia – [consider stroke; binocular diplopia always significant]
- Flashes/floaters
- Retinal lesions
- Field defects
- Sudden onset of blurred vision (unless a sight test would be more appropriate)

Exclusions to MECs Referral

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

- Severe ocular pain requiring immediate attention
- Severe infection
- Suspected retinal detachment
- Retinal artery occlusion
- Chemical injuries
- Penetrating trauma
- Orbital cellulitis
- Temporal arteritis
- Ischaemic optic neuropathy
- Binocular double vision

Conditions excluded from the service:

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

- Long standing adult squints
- Long standing diplopia

This service does not replace those services included in General Ophthalmic Services (GOS) e.g. Sight Tests and cannot be used in place of GOS funded (or where a patient should self-fund) services.

Exception to Eligibility Criteria - where a patient presents with symptoms indicative of a retinal break (flashes/floaters).
These patient types can be considered at very high risk of permanent vision loss, should a retinal break be present, and are the only exception.
The guidance on seeing patients with flashes and floaters symptoms should be followed in these cases.
Any claims for patients outside of the eligibility criteria will be rejected.

Note: Where patients attend because of a minor eye condition issue but a requirement for a cataract or repeat measures refinement is clinically appropriate and provided, a fee for both elements can be claimed.

3.6 Appointments

3.6.1 Minor eye conditions

Reception services and administration of the referral process and appointment must be managed efficiently and appropriate to the patient need.
The provider will arrange to see the patient within the timeframes stated in 3.2 Access Criteria

- GP or other referral – The provider will contact the patient within 1 working day and arrange to see them as appropriate (subject to patient choice).
- Self-referral or where the patient has attended the premises with the GP referral the provider should arrange a time for the patient as appropriate or see the patient there and then if possible (subject to patient choice).

During this appointment the provider must assess, diagnose and treat as appropriate and determine then whether further diagnosis and treatment is required whether by the patients GP or specialist provider.

The optometrist is required to have a strong emphasis on patient education, self-management and prevention as it is core to the service to encourage and educate patients to manage many of the common conditions that do not need specialist input.

All patients with common conditions will be provided with a printed leaflet or a mobile phone link sent to their phone (according to their preference) while at the appointment for management of their symptoms.

Examples can be found at Eye conditions | Moorfields Eye Hospital NHS Foundation Trust

Patients who return for the same conditions that they could self-manage must be reviewed and service reporting should indicate the numbers of patients and what the underlying drivers for patients not being able to self-manage common conditions. The provider should consider implementing online patient self-management education training to mitigate this activity and/ or provide an alternative.

This initial assessment must include the identification of any red flags (indicators in the history or examination suggestive of serious underlying pathology) which should be managed as per local pathway. It should also include any diagnostics and/or procedures where appropriate to do so.

If a referral is not accepted by the provider, the provider will return the referral documentation to the referrer (GP/Other, etc.) with detailed reasons for rejection sufficient to minimise inappropriate referrals in the future and make recommendations (where appropriate) for ongoing management of this patient.

Rejection of referrals because of exclusions to the MECs service; that can be provided in another community service or via the single point of access (SPoA) to secondary care should be referred to the appropriate provider, (or of choice if applicable) with full details of any examination and diagnosis carried out.

3.6.2 Virtual/ Telemedicine appointment for MECs

These types of appointments are allowed when clinically appropriate and are not expected to be significant in numbers. Activity will be reported and closely monitored for quarterly review.

Patients should be offered virtual appointments where there are issues of mobility, medical issues effecting social contact and where patients are able to clearly communicate with the optometrist over visual and audio systems to enable appropriate outcomes.
The detailed protocol is to be agreed between the commissioning managers and the Provider with details of how the assessments will be conducted.

(Arrangements with other providers for direct referral will be arranged by commissioners where possible)

3.7 Onward referrals

Single Point of Access (SPoA): Optometry referral pathway

North East London ICS has started to implement single point of access points to manage onward referrals from optometrists and there are currently two services for Inner and Outer North East London.

However, Providers (Optometrists) who have provided the MECs pathway to patients must refer the patients to secondary care using e-Referral and offering a choice to patients

4. Glaucoma Repeat Measures

4.1 Background

A number of patients are referred for suspected Ocular Hypertension (OHT) and chronic open angle glaucoma and then found to have no glaucoma. False positive referrals can cause unnecessary anxiety to the patient, paperwork for the practitioner and are a waste of hospital resources. In order to reduce this occurrence, Contractors will repeat IOP measurements, using an applanation method (Goldmann or Perkins tonometer -up to two occasions), and/or repeat visual field tests on a separate occasion. This service will support optometrists to comply with NICE guidance (Clinical Guideline 85, November 2017 (www.nice.org.uk/guidance/ng81).
As described above, the number of patients referred for high pressures and then found to have none is high. The aim of this pathway is to reduce the number of inappropriate false positives being referred as suspected glaucoma and OHT referrals by reassessing (refining) the suspected glaucoma and OHT referrals sent referred by GPs and non-accredited Optometrists for ophthalmological assessment.

4.2 Glaucoma Repeat Measurement- IOP

NICE guidance states that patients with IOP, measured with Goldmann-type applanation tonometry that is consistently or recurrently 24mmHG or more, in the absence of any other signs or symptoms of glaucoma, should be referred for a differential diagnosis of OHT, COAG, or suspected COAG.

All patients with IOP > 31mmHg should be referred for suspect OHT or Glaucoma diagnosis without further repeat Goldmann measurement.

If the IOP measured at the patient's sight test/eye examination is 24mmHG or more optometrists should repeat this measurement using slit-lamp mounted Goldmann tonometry or handheld Perkins tonometry. (Slit lamp mounted Goldmann applanation tonometry is the preferred method of IOP measurement. However, Perkins tonometry is acceptable for the purposes of the repeat measurement Scheme.)

This can be done at the same appointment as the patient's eye examination. If the IOP is still only slightly raised, and discs and fields are normal, optometrists are encouraged to ask the patient to return on a second occasion for a further applanation measurement preferably later in the day, to determine whether this IOP is a repeatable measurement. Only if the IOP is consistently or recurrently above 24 mmHg (with normal discs and fields), and meets the criteria set out below, should the patient be referred for a diagnosis of OHT as per the NICE guidance.

Where the initial IOPs are measured with a non-contact tonometer, they should be the average of 4 readings per eye. (College of Optometrists professional guidance)

4.3 Glaucoma Repeat Measurement- Visual Fields

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

- the discs and angles are normal and the IOPs are <24mmHg

and

- the visual fields are 'suspicious' or 'defect' using the Humphrey, Henson, Dicon or equivalent visual field screener, or
- there is a significant defect on the FDT (without a known cause)

and

- the optometrist feels that a further visual field test is necessary in support of their referral

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

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

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

4.4 Patients referred from Non – Participating Practices

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

At the appointment the patient will have the following assessments:

- Goldmann or Perkins applanation tonometry

- Standard automated perimetry
- Anterior chamber angle assessment using the Van Herrick method or OCT
- Dilated slit lamp indirect biomicroscopy

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

4.5 Eligible patients

Patients eligible for this service are:

1. Patients that have been assessed under an GOS or private eye examination and found to fall into the IOP categories for repeat measures or repeat visual fields criteria. (See appendix 1b)
2. Patients who have been routinely referred (by GP or other appropriate clinician/SPoA) for glaucoma assessment:

• AND who have high intra-ocular pressures that have not been measured using a Goldmann or Perkins applanation tonometer and/or suspicious visual field
• AND who have no other significant clinical signs of glaucoma

The service clinician (Optometrist) will then decide on all the clinical information as to the patient outcome.

Patient destinations

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

Patients should be provided with a clear explanation (letter or leaflet) on why they are being discharged or referred to a specialist clinic.

Other considerations

There could be occasions where a practitioner participating in the referral refinement scheme has asked a patient to return for repeat pressures or fields, and the patient fails to attend for these measurements. In the first instance, the practitioner would be expected to contact the patient to make a further appointment. However, if the patient still fails to attend, the practitioner should consider his/ her duty to make a routine referral of the patient to their GP. This guidance does not remove a practitioner's individual clinical responsibility. Each patient should be dealt with on a case-by-case basis.

If there is any doubt, refer for further investigation.

5. Cataract

5.1 Cataract Refinement

The service is for patients identified with a cataract following a sight test and would like to be considered for surgery as indicated within NICE NG 77.

Providers are expected to carry out cataract refinement for their own patients post GOS or privately funded examination when patients are determined to have visual acuity of 6/9 or worse. It is important to recognise that cataract is a reversible condition and patients should be counselled appropriately that it is not an urgent condition and surgery will correct the condition irrespective of how soon they have the surgery.

All Optometrists who undertake an eye examination (NHS/Private funding) should follow NICE Guideline NG77 when they are referring for cataract surgery and should have undertaken a discussion with the person (and their family members or carers, as appropriate) that includes:

- how the cataract affects the person's vision and quality of life
- whether 1 or both eyes are affected

- what cataract surgery involves, including possible risks and benefits
- how the person's quality of life may be affected if they choose not to have cataract surgery
- whether the person wants to have cataract surgery

Referrals: Patients may be referred by the Single Point of Access, their own GP or by an optometrist within North East London.

The service is for patients identified with a cataract following a sight test and would like to be considered for surgery as indicated within NICE NG 77.

5.1.1 Evidence Based Interventions (EBI) Criteria

There is a strict referral criterion in North East London under the Evidence Based Intervention Policy – see policy as follows:

Cataract Surgery (Policy Extract)

Patients should be referred when both of the following criteria are met:

1. Patient has a best corrected visual acuity of 6/9 or worse in either the first or second eye

AND

2. Patient has impairment in lifestyle such as substantial effect on activities of daily living, leisure activities, and risk of falls

OR

When the patient has any of the following ocular comorbidities:

- Glaucoma

Conditions where cataract may hinder disease management or monitoring, including diabetic and other retinopathies including retinal vein occlusion, and age-related macular degeneration; neuro-ophthalmological conditions (e.g. visual field changes); or getting an adequate view of fundus during diabetic retinopathy screening

- Occuloplastics disorders where fellow eye requires closure as part of eyelid reconstruction
- Corneal disease where early cataract removal would reduce the chance of losing corneal clarity (e.g. Fuch's corneal dystrophy or after keratoplasty)
- Corneal or conjunctival disease where delays might increase the risk of complications (e.g. cicatrising conjunctivitis)
- Severe anisometropia in patients who wear glasses
- Posterior subcapsular cataracts

However, in the above circumstances you should ideally refer to the provider that is managing their ocular comorbidity rather than an alternative provider due to the complexity of the care that may be required and the opportunity to reduce the number of patients appointments and interventions.

Where patients have a best corrected visual acuity better than 6/9, surgery should still be considered where there is a clear clinical indication or symptoms affecting lifestyle. For NHS treatment to be provided, there needs to be mutual agreement between the provider and the responsible (i.e. Paying) commissioner about the rationale for cataract surgery prior to undertaking the procedure).

5.1.2 Exclusion - If the patient is already under the care of an ophthalmologist they are excluded from this scheme and must be referred via the relevant SPoA (or GP if no SPoA is in place) for consideration of Cataract/PCO surgery to their current ophthalmology provider so cataract surgery can be considered alongside their other condition to minimise patient attendances and provide holistic care.

5.2 Service Line

The patient attends for the full cataract assessment to elicit relevant ocular, medical and social information which will assist secondary care facilities to ensure patients receive the most appropriate treatment and care. This will include:

- Pupil dilation and examination by indirect ophthalmoscopy in order to establish whether there are any co-existing ocular disorders as well as cataract.
- The use of a shared decision-making aid and provision and discussion of a Cataract patient information booklet which includes the patient feedback questionnaire and patient health questionnaire, and any outstanding issues dealt with.
- Communicating the relative risks and benefits of cataract extraction.
- Ascertaining the patient's willingness for surgery.
- Ensure and document on the referral how they meet the EBI criteria.
- Offer informed choice of NHS funded cataract surgery providers that meet the patients requirements.

It is important to cover clearly with the patient the following areas:
1. Cataracts are a reversible condition and does not lead to permanent blindness
2. Cataract procedures will require adjustment procedures in future years and patients should be aware that they may have to return at regular intervals to undertake these

These discussions should clearly be referenced in the patient records.

5.2.1 Outcomes

Clinical guidelines and a patient self-assessment questionnaire will support the clinician (optometrist) to differentiate between:

- Cataract patients who are not currently appropriate for referral for NHS treatment as they do not meet the NEL EBI clinical criteria
- The patient chooses not to be considered for cataract surgery as they don't feel that they need the surgery (they can always represent at a later date)
- Cataract patients who are suitable for direct referral to the cataract surgery provder. In this case, the supporting information provided with the referral will allow the hospital to determine whether the patient is likely to be suitable for a direct access clinic or a traditional clinic due to their more complex health needs.

It will be the provider's responsibility to establish the patient's eligibility.
They should therefore only assess and refer patients under this service who are NOT already under the care of an NHS Trust ophthalmologist for another active ocular condition.

Note: A letter to the consultant explaining the patient's current visual difficulties is required for patients under the care of an NHS Trust consultant ophthalmologist for another active ocular condition.

5.2.2 Patients not requiring NHS referral

Some cataract patients will not require a referral to the hospital for NHS treatment. These will be those that:

- having been counselled on the risks and benefits of cataract extraction, choose not to proceed with surgery.
- have been assessed under the service but have chosen to be referred for private treatment rather than NHS surgery – these should be referred directly to a named consultant.

In these cases the GP should be informed. The appropriate tariff for the work up can still be claimed.

5.2.3 Returning Patients

If the provider has carried out the full examination and the patient initially decided they did not want to have surgery, but then returns at a later date requesting a referral for surgery the following will apply:

- If a patient returns within six months and there are no other symptoms, there is no need to reexamine. The referral form can be re-submitted, as long as the consent box is ticked. No additional fee can be claimed.
- If the patient returns within six months with symptoms of worsening vision, and the practitioner feels further investigations are required, the patient can be re-examined and if this is due to the cataracts, another fee under the scheme can be claimed. If the patient returns after six months, the patient can be re-examined.

5.2.4 Onward Referral

If the patient is willing to undergo surgery and the clinician considers that they are suitable, then a discussion over the choice of hospitals should occur.

Provider Choice

Under this service the provider is responsible for offering the patient **informed** choice of providers to provide their cataract surgery:

- Patients who are already under the care of secondary care should be referred to that provider unless they do not offer cataract surgery. Patients with co eye morbidities will often benefit of having procedures taking into account their other conditions as this will lead to better care and outcomes and less appointments for the patient.

Patients who only require cataract surgery should be counselled on their needs from a provider which may include:

- **Location:** many patients have limited access to transport and may benefit from services close to where they live and where there are good public transport links
- **Waiting Times:** there is no clinical urgency for cataract surgery and patients should understand that, however, patients should receive their surgery within 18 weeks from referral as that is a national standard.
  Patients may have to wait longer if they choose a specific clinician or provider.
- **Clinical support:** providers should all be able to offer full access for patients with protected characteristics such as disabilities, race, gender, sexual orientation, religious belief etc as well as other issues such as not speaking English.

If you are referring to independent providers for NHS treatment then they should be providing surgery under an NHS contract and the surgeons should be registered on the GMC specialist register.

Unless the surgery provider is unsuitable to provide the service then patients should be offered their choice and the provider of this service should not be influencing them inappropriately. Refer to point 19: Applicable Service Standards.

Service providers cannot receive any incentives for referring patients to specific providers – see professional standards. This includes being paid for cataract aftercare unless agreed with NEL ICB.

Once hospital choice has been made, and patient consent obtained, the referral form and incorporated patient decision-making tool will be emailed within 1 working day to the Single Point

of Access (SPoA) stating the chosen hospital. The patient should also be informed that the hospital will contact the patient in due course.

A copy of the referral form should be sent to the patient's GP and a printed copy of the referral form should be given to the patient (either physical or via email as per patients wish).
The SPoA will confirm receipt if a referral is made and the optometrist may need to follow up with SPoA if the patient is not contacted within 4 weeks to arrange their appointment and ensure the referral is being processed.

5.2.5 **Domiciliary patients:** this service can be offered to patients who are eligible for home eye tests. Arrangements will be subject to providers who are commissioned to provide home sight tests by NHS England.

6. General for all service elements

6.1.1 Follow up appointments

It is not anticipated that follow up will be part of the Minor Eye Condition service as the rates in similar services are less than one in twenty- *Lambeth and Lewisham Presentation 2015*.
Follow ups should be provided for essential treatment or monitoring within the relevant guidance and patients should be discharged back to their GP as soon as it is clinically appropriate. Where a follow up is clinically appropriate the provider should make the necessary arrangements with the patient. Levels of follow-up will be audited to ensure quality and patient outcomes are being achieved.

Note: The tariff takes into account the provision of follow ups in the MECs pathway.

6.1.2 Discharge from service (including onward referral to secondary care)

Patients must be discharged from the service when the desired clinical outcomes have been reached and/or it is deemed that the patient can now be passed back to the care of their GP or they are being referred to another provider (secondary care etc).
Upon discharge patients are to be provided with written advice on managing their condition as appropriate specific to their individual needs. Self-Management is an important part of patient care and patients should receive advice and directions on how to self-manage aspects of their condition.

The provider is responsible for producing relevant leaflets and on line resources, however, there is already many already available and these can be utilised as appropriate unless there is a NEL specific guidance for patients.

Within 5 working days of discharge from the service the provider will supply an electronic discharge summary to the patients GP and other referrer if applicable. Discharge summary will include:

- Details of any medication (number of days supplied or prescribed, indication for medication, length of treatment required)
- Details of clinical outcomes/Onward referral details if appropriate (which provider etc)
- Any additional recommendations, including monitoring and the conditions for re-referral to the same or another service

6.1.3 Did Not Attend (DNA)

It is in the providers' interest to ensure they have mechanisms in place to minimise the number of patients who fail to attend pre-arranged appointments.

Patients who DNA an assessment or follow up must be offered one further appointment. If they DNA again they can be discharged from the service at the providers discretion. The patient and the GP/referrer if applicable must be sent a copy of the discharge letter.

6.1.4 Continual Service Improvement Plan

There are key expectations of providers around continuous improvement, with the focus that providers will engage their patients and review their services periodically to sustain efficient, effective and high-quality services.

Service Improvement

- Providers are expected to review service provision in the light of recent research to ensure that they are providing the most effective package of care.
- The provider must also demonstrate how they have already developed and improved their services through innovation.
- The provider is required to participate in and support research undertaken across all of the areas covered by this service.
- The provider will work with the commissioner in implementing nationally driven service improvements ensuring adjustments are made to meet patient needs.
- The provider will work with the ICB on service improvements including developments with referral refinement and enhanced follow-up care in the community.

6.1.5 Patient Engagement

- The Provider will record and monitor levels of patient experience with the service and identify themes, trends and areas for improvement.
- The Provider will supply the results of surveys in full along with action plans for service improvement based on the outcome of patient surveys to the Commissioner.
- Patient surveys will include questions around access, communication, quality and overall experience.
- The Provider will comply with the NHS duty to involve users and stakeholders, and to undertake patient involvement under sections 10 and 12 of the Standard NHS Contract, and subsequent involvement legislation.
- The Provider will ensure that arrangements are made to secure the involvement of service users in the planning and development of services and in any proposals for changes in the way services are provided and/or in decisions that affect the operation of services.

6.1.6 Population Equity

The Service will be sensitive to individual patient needs, including gender, age, culture, and religious beliefs. Specifically, the provider will offer a preferred gender of professional where appropriate e.g. for religious or cultural reasons.

6.2 Access

6.2.1 Provider requirements around access:

- All provider subcontractors should hold a GOS contract to ensure that the practice is listed on the NHS 111 DOS and provide appropriate documentation for referrals.
- The provider will locate services in a minimum of 5 agreed sites per place but we expect the current venue numbers in the places to continue and to aim for a minimum of 2 sites per 100,000 of the place population.
- Consider new location in the Leyton/Leytonstone area E11 for Waltham Forest Place.

Current numbers of locations in Place – see appendix 1 for location addresses:

North East London Places	Place Population (census 2021)	MEC Sites
Newham	355266	7
Tower Hamlets	331969	6
Redbridge	305658	8
City and Hackney	291879	5
Waltham Forest	276940	5
Havering	260651	9
Barking & Dagenham	214107	5
	2036470	45

- Venues should be strategically placed and consider the local geography where possible eg. distances.
- The venue (s) must be suitable and easily accessible to patients with good public transport links.
- Providers should aim for a service to be available even at weekends although Sunday services may not be available in every place but there should be some availability across NEL.
- The service shall offer appointments at a suitable time and in easily accessible buildings for patients including provision for people with disabilities. In addition, the provider should seek to offer appointments outside normal hours (normal hours - 9am – 5pm) and potential providers should make this an integral part of their offer to NEL Integrated Care System.
- Special consideration may need to be paid to the provision of the service to accommodate race, language, physical and learning disability requirements and for those in employment as far as reasonable practicality allows.
- Providers should look to have at least one location within easy reach to local A & E/Urgent care centres to ensure that patients with minor eye conditions can be redirected to a MEC service.
- A risk and suitability assessment of the venue must be undertaken and sent to the commissioner.
- The ICB has no estate of its own as the health estate is managed by either by the Trusts, NHS Property Company, or individual GP practices and Optometrists. These organisations should be contacted directly to arrange their use.

6.2.2 Premises Requirements

The providers must ensure that the premises used are safe and suitable for the delivery of this service. The service must be provided in a geographically convenient, easily accessible location which:

- Complies with health and safety legislation (CQC registration is not currently required for optometry services)
- Has disability access
- Has appropriate waiting and treatment area
- Is appropriately furnished and equipped with necessary equipment
- Is of the highest level of cleanliness and hygiene (Complies to Infection Control legislation)
- Is easily accessible via public transport.

A site visit may be required to assess new provider premises.

6.3 Clinical Equipment

The service provider will be responsible for all equipment including consumables, maintenance and quality assurance costs associated with service equipment used in the delivery of this service. This will include insuring against theft and damage. It is expected the provider will have maintenance and service schedules/logs for each piece of equipment. The provider will be responsible for all appropriate decontamination of clinical equipment.

The provider will provide the following equipment:

- Slit lamp
- Contact tonometer (Perkins or Goldman)
- Visual field equipment with the ability to control threshold and produce a printed field plot
- Ophthalmoscope
- Amsler charts
- Epilation equipment
- Diagnostic drugs (mydriatics, stains, local anaesthetics etc.)
- Volk-type lens
- Equipment to remove foreign bodies Means of indirect ophthalmoscopy to allow a suitable field of view (Volk/headset indirect ophthalmoscope)
- Slit lamp
- Applanation Tonometer
- Distance test chart (Snellen/LogMAR)
- Near test type
- Equipment for epilation
- Threshold fields equipment to produce a printed report
- Amsler Charts
- Equipment for FB removal
- Appropriate ophthalmic drugs
    - Mydriatic
    - Anaesthetic
    - Staining agents

6.4 Language

The Provider will be able to access NEL primary care commissioned language lines. These need to be booked in advance and the provider will need to contact the appropriate language services to arrange access for different NEL places. The provider will not deter patients who cannot speak English and will make every appropriate effort to book an interpreter including sign language interpreters as required to be available to all patients eligible for the services.

7. Medicines Optimisation and Prescribing

Prescribing must be in line with local medicines formulary and relevant Medicines Optimisation Guidelines . Where Prescription Only Medicines (POM) are required the minimum quantities/pack size for 14 days must be supplied or prescribed unless the full course of treatment is less or a smaller quantity is deemed clinically appropriate.

Currently there is no requirement for the service to prescribe POM medications – this may change during the contract with agreement with both parties.

7.1.1 Supply of over the counter medicines

The provider should stock a range of treatments or have arrangements in place with a local pharmacy that will treat minor eye conditions specified in section 3.5. The medicines stocked and prescribed should adhere to the recommendations of the North East London formulary. GSL or P medicines should be supplied by the provider as part of the service charges.

Products that can be Stocked by optometrists as part of the core service may include:

Drug Name	Status	Additional notes
Hypromellose eye 0.3% strength only	P	
Carbomer 980 0.2% eye Drops 10g	P	
Carmellose 0.5% eye drops	P	
VitaPOS eye drops	P	
Sodium cromoglycate 2% eye drops, 10ml	P	Only 10ml bottle as 13.5ml is a POM
Alomide Allergy™ eye drops	P	Prescribe only as Alomide Allergy™ as this is a P. For allergic conjunctivitis only in adults and children over 4 years after sodium cromoglycate 2% eye drops has been tried.
Chloramphenicol eye drops 0.5% 10ml	P	For an urgent situation only Script to be dispensed within 24hours
Chloramphenicol eye ointment 1% 4g	P	For an urgent situation only Script to be dispensed within 24hours

Note: The Providers and subcontractors must not use the service as an opportunity to sell to patients' other medications or devices as part of this service provision. There may be occasions when alternative products may be provided but these transactions with the patient should be limited to products that are evidence based, clinically appropriate and support optimal patient outcomes. It must be made clear to the patient that they are not part of NHS service criteria but are optional and they should also be made aware of alternative sources for the products. The Provider will ensure the supply of all medicines by subcontractors will be subject to audit and review

It is important that patients do not see the NHS funded service as a commercial activity and the provider is expected to ensure that all subcontractors comply to that aim.

7.1.2 Safety

Medicines shall be managed safely and effectively. Provider(s) shall:

- Ensure that medicines are procured, stored, supplied, handled, administered and disposed of in a safe and secure manner in accordance with current legislation, licensing requirements and best practice.
- Ensure adherence to national requirements, including the Medicines Act and Misuse of Drugs Regulations, regarding the management, storage, handling, prescribing, supply, recording and disposal of drugs including controlled drugs.
- Develop and implement policies that can be evidenced regarding medicines optimisation and prescribing.
- Implement national/local safety alert and guideline recommendations. Inform the commissioner of how these have been implemented when requested.

- Comply with the recommendations and requirements of the NHS England - London Region Controlled Drugs Accountable Officer. england.londoncdaccountableoffice@nhs.net
- Access to up-to-date pharmaceutical advice, information and support.
- Ensure recording and reporting of significant events and near misses via Learn from patient safety events- Learn from patient safety events (learn-from-patient-safety-events.nhs.uk) .

7.1.3 Medicines Storage, Handling and Administration

The Provider shall ensure:

- Safe systems for storage and handling of medicines, including controlled drugs and systems for prescribing, medicines procurement, receiving, storage, expiry checking, supply, administration, and disposal.
- Medicines stocked and prescribed will comply with the NHS North East London formulary.

7.1.4 Prescribing

The Provider(s) shall:

- Ensure prescribing is safe, clinically effective and cost efficient.
- Ensure all medicines are supplied in appropriate quantities for the condition being treated and comply with all relevant legislation regarding packaging, labelling and the use of Patient Information Leaflets (PILs).
- Ensure patients that require medication to be personally administered will have these administered to them as part of the core service.
- Ensure that clinical support, updates and supervision are in place to ensure medical and non-medical prescribing meets all legal requirements.
- Ensure that non-medical prescribers treat and prescribe appropriately within their individual scope of practice and competence in accordance with professional ethics and practice.

8. Administration & Governance

8.1 Management and Administrative Arrangements

It is a requirement for the provider to initially attend monthly meetings with the commissioners, the frequency reducing subject to reaching the agreed service delivery outcomes. These meetings must discuss service issues, action plans and agree areas for development. An annual contract review will be held and will determine amendments, cancellation and any other contractual issues in accordance with standard NHS contract terms.

8.1.1 Complaints

The provider must:

- Have a formal complaints policy and procedures through which patients can raise issues with the service.
- Endeavour to resolve any complaints directly with the patient, and only escalate to the commissioner if the complaint cannot be resolved directly.
- Adhere to local commissioner policies and procedures regarding complaints, including the need to inform the commissioner of all complaints.
- Respond to complaints in line with the NHS complaints procedure and the relevant statutory regulatory body.

8.1.2 Marketing

The provider may undertake communication activity and limited marketing campaigns in order to promote the NHS funded service with the commissioner's approval. The contents should stress an alternative to attending their GP or Urgent care services and not encourage patients to attend optometrists for everyday issues that resolve independently.

The ICB has the right to approve content of such materials and will provide guidance on the approval criteria. Materials may include posters, information sheets or electronic media on accessing the service.

As a minimum the commissioners require a patient leaflet with information to access the service – this should be available in both hard copy and electronic formats so they can be published on NHS North East London ICB and other patient information websites.

The leaflet is to be used to advertise the service offered by the provider as well to inform patients of the sites where the service is available to all patients across the NEL footprint.

Marketing should not be linked to private services where patients are expected to pay for additional services outside a GOS contract.

8.2 Safeguarding Children and Vulnerable Adults

Providers must adhere to the terms of the NHS contract and the local policies stated within.

8.3 Governance

The provider will demonstrate that there are clear organisation governance systems and structures, with clear lines of accountability and responsibility. The provider will ensure clinical and corporate governance processes are in place to include:

- Clinical governance lead
- Incident reporting
- Infection control
- Serious Incidents (SIs) reporting and investigation
- Quality assurance
- Clear policies to manage risk and procedures to identify and remedy poor professional performance
- Evidence of peer and patient review and action taken

Specifically, robust arrangements must be in place to:

- Always follow clinical effectiveness requirements and NICE guidance
- Co-ordinate the patient pathway
- Identify, assess and manage risk
- Manage patient information and notes (confidential, electronic system)
- Manage diagnostic results
- Manage complaints and ensure that learning occurs
- Manage incidents and ensure that learning occurs
- Manage SI's in accordance with NHS London guidance and ensure that lessons learnt are implemented
- Ensure patient confidentiality at all times

The Providers must have Clinical Governance processes in place as per the latest National Guidance. These will include but not be confined to;

- Ongoing training and education
- NICE guidance
- Development and maintenance of Clinical records

- Continuing rolling programme to develop Evidence Based Clinical Guidelines
- Health and safety policy
- Infection Control Policy
- Maintenance and proper storage of equipment in use
- Half-yearly clinical audit to be undertaken against agreed standards
- Complaints procedure
- Critical incident reporting
- Standards around delivery of care and waiting times
- Risk management
- Research and development
- Clinical audit
- Clinical effectiveness

The provider will adhere to appropriate North East London policies.

8.4 Information Technology and Information Governance

Providers must ensure that they are familiar with and comply with the NHS minimum information technology standards, and ensure (and be able to demonstrate) that they have the necessary systems and processes in place to comply with HSCIC Requirements, Electronic Government Interoperability Framework and the Information Governance Statement of Compliance (IGSoC).

The Provider must ensure that the storage of medical records and information which is relevant to treatment and on-going care is passed between all parties in accordance with the Caldicott Principles, General Data Protection Regulation (GDPR) and The Data Protection Act 2018.

Providers must have an electronic patient administration and reporting system, meet IGSoC requirements and must be able to provide all necessary returns, including the Community Data Set, to the commissioner in the required format.

Providers will have or work towards interoperability with North East London ICB IT system developments (such as the Integrated Digital Care Record) and GP IT systems, ability to send the discharge summary electronically and send copies of the assessment to the consultant who is overseeing the service and ability to record key information such as the registered GP which can be audited or sent to commissioners, as appropriate.

The Provider will use e-RS and NHS mail for communication of patient identifiable information.

8.5 Audits

The provider must notify the commissioner of the result of any audit undertaken by a professional regulating body, or any other NHS commissioner (NHS England).

The provider must allow the commissioner, or any individual or organisation acting on the behalf of the commissioner to inspect the quality of service through observation of service delivery, audit of patient records and data, audit of business processes and records relating to the service contract and audit of staff records, as required.

The provider should undertake an annual or ad hoc clinical audit as requested by the commissioner.

8.6 Workforce

The service provider must describe and demonstrate that they are qualified to provide this service, and how they will assure commissioners of their competency to practice both at the time of contract letting, and throughout the contract life.

As per the NHS contract terms and conditions, providers must regularly and systematically review their professional practice in line with the professional standards as set out by their regulating body and be able to demonstrate how they assure this through regular review and/or appraisals. A report of any review or appraisal that takes place, including recommendations and any requirements for retraining, must be available to the commissioners upon request.

The provider must encourage and allow for their staff to undertake Continued Professional Development consistent with the requirements of their professional regulator.

The provider must ensure that the following levels of supervision are provided to the clinical staff team:

- Management supervision
- Clinical supervision
- Safeguarding supervision

The provider must include the following roles (these do not need to be undertaken by different people):

- Clinical Lead Optometrist(s) responsible for ensuring a high quality of clinical practice by all practitioners within the service, including necessary supervision of more inexperienced or junior staff and that all staff, including subcontractors, meet the requirements as set out in the service specification and the NHS Terms & Conditions
- Service Manager responsible for operational management of the service and ensuring key performance indicators are adhered to by the service.
- Caldicott guardian responsible for ensuring compliance with all information governance requirements.

9 Applicable Service Standards

9.1 Applicable National Standards

The service requirements have been designed with consideration to the relevant Royal College of Ophthalmologists – Applicable Guidelines: Clinical Management Guidelines - College of Optometrists (college-optometrists.org)
Relevant NICE guidance – Glaucoma
Royal College of Ophthalmologists – Applicable Guidelines
College of Optometrists – Applicable guidance including MECs
Home - College of Optometrists (college-optometrists.org)
Clinical Management Guidelines - College of Optometrists (college-optometrists.org)

9.1.1 Professional Standards

Health professionals delivering services must be registered with the regulatory body appropriate to their profession and must adhere to the professional standards and codes of practice set out by that: Home |GeneralOpticalCouncil . All health professionals must have regular appraisals and evidence of continuing professional development (CPD) accreditation, where appropriate.

Note: Service providers cannot receive any incentives for referring patients to specific providers

9.1.2 Applicable Local Standards

- The provider and all clinical staff employed or engaged by the provider in respect of the provision of the services, will satisfy accreditation criteria and unless clinical staff are qualified ophthalmologists where different criteria may apply, we expect the service to

be delivered by optometrists who will need to be accredited for the elements of the service.

- The Provider is responsible for all aspects of clinical governance through an effective system of quality and risk management in line with the requirements of Standards for Better Health.
- The provider shall nominate a senior manager or clinician who shall have responsibility for ensuring the effective operation of clinical governance.
- The Provider must provide an up-to-date document outlining clinical governance arrangements to the ICB prior to service commencement. This will include details of any sub-contract arrangements associated with the service.
- The provider will provide the ICB with evidence that all practitioners providing the service meet the accreditation requirements appropriate to their role.
- The provider is responsible for ensuring all clinical staff have the necessary qualifications and continuing professional development required to maintain their qualification.
- This service is not intended to replace current primary and secondary care services or increase demand where need is not indicated. The success of the service will be evidenced by reduced usage of secondary care services and patient outcomes increasingly being met in the community rather than from secondary care for common minor eye conditions. It is important for the provider to support this premise in order to support the ongoing commissioning of the service.

9.2 Registration and Skills

To become accredited to provide minor eye condition services, optometrists must be registered with the General Optical Council (GOC) Home | GeneralOpticalCouncil and be able to identify a range of ocular abnormalities and must demonstrate proficiency in the use of the previously mentioned equipment.

9.3 Training

Participating optometrists must complete the WOPEC MECS Part 1 and Part 2, before providing minor eye condition services. Part 1 must be completed before Part 2.
In addition, each optometrist taking part in the refinement schemes must complete further accreditation in glaucoma – repeat measures and cataract refinement. Accreditation can be gained by successful completion of:

- WOPEC/LOCSU glaucoma distance learning module (part 1)
- WOPEC/LOCSU cataract module.

Equivalent accreditation may be agreed by the commissioners. An optometrist who has a relevant higher qualification and recent experience may be exempt from the MECS Distance Learning and/or the Practical Skills Assessment at the discretion of the commissioner Clinical Lead who may seek further specialist advice.

9.4 Induction

Clinicians new to MECS will be required to undergo relevant induction sessions agreed by the ICB and delivered by the provider, primarily to cover the administrative procedures and protocols involved in providing the services. The training session will cover:

- An introduction to the service
- Administration of the service including protocols, processes and paperwork
- There should be adequate training to administration staff that interact with patients so they can easily identify patients that are attending for MECs services or from those who are looking for sight tests.

9.5 Supervision Arrangements

Health professionals delivering services must be registered with the regulatory body appropriate to their profession and must adhere to the professional standards and codes of practice set out by that body (e.g., Royal College of Ophthalmologists, The College of Optometrists, and Health Professions Council). All health professionals should have regular appraisals and evidence of continuing professional development (CPD) accreditation, where appropriate. The commissioners would recommend that optometrists providing this service will require the following or similar supervision arrangements annually:

- 2 attendances at a peer review session- One of these must include an annual peer workshop, provide by the Company, which includes cased based discussions relevant to the MECs & glaucoma service

9.6 Key Performance Indicators

	MEASURE AND THRESHOLD	**REPORTING MECHANISM**
KPI 1	Proportion of MECS attendances seen within access requirements (95%) • Urgent 24 hours or one working day • Routine 48 hours or two working days	Monthly KPI report
KPI 2	All Repeat measure and refinement completed within 2 weeks (14 days)	Monthly KPI report
KPI 3	95% of patients satisfied with service Sampling should be 5% of MECs activity each quarter	Quality reporting-quarterly
KPI 4	Exception reporting – each venue/location is meeting a minimum of 90% of MECs access requirements	Monthly KPI report
KPI 5	Self Management – 25% of MEC patients discharged are provided with condition self-management instructions and directions for help and support	Quality reporting-quarterly
KPI 6	Referrals by MECs to routine secondary care services should not exceed 10% of MECs new activity	Monthly KPI report
KPI 7	Delivery of GP education on pathways to each place (15 -20 mins)	Once per year per place
KPI 8	Annual educational clinical peer review sessions- 100% of MECs clinicians attend at least 2 case-based discussion events per year.	Annual Contract Review meeting
KPI9	Professional Development- PEC events will involve collaboration with local ophthalmology consultants wherever possible. 75% of MECs clinicians should attend atleast 1-2 events per year. Other training and education events provided by NEL providers can be jointly accredited with commissioners to contribute to the ongoing optometrist certification and professional development. The provider should advise any events that are being included for commissioner agreement.	Annual Report
KP10	Discharge Notes to GPs and other AHP referrers should be sent within 5 days electronically 90% Achievement	Monthly report

9.7 Reporting Requirements

Activity in line with the NHS contract must be complied with to include dates, times, outcomes of referrals and appointments including follow up activity. It should include the following as minimum:

- Source of referral
- Number of MECs attendance (Face to Face & Virtual)
- Number of cataract % referred for surgery

- Number of repeat measures % of false positives (glaucoma repeat measures)
- Number of patients referred to A&E for urgent treatment
- Number of patients referred onto routine secondary care
- Number of patients discharged
- Number of patients referred to GP
- Waiting times (Patients seen beyond 1 working day (urgent) 2 working days (routine)
- Number of patients who have completed the agreed patient satisfaction survey
- Number of patients that have been overall satisfied with the service they received
- Number of prescriptions dispensed/ claimed
- Number of complaints (written & oral)
- Number of serious incidents

The KPI reporting template will be provided by the commissioner for the provider to Complete and return on a monthly basis.

This report on activity, detail behind the KPIs and patient outcomes will be forwarded by the provider to the commissioning manager an agreed day of the month following the month in which the patients received the service, on the template provided by the commissioner for that purpose.

Quarterly and annual reports will be submitted in the first month following the quarter/year passed and in line with contract monitoring meetings so they can be discussed and actions agreed.

Detailed activity containing PID may be specifically requested for audit purposes. Details of this and IG arrangements will be notified and agreed when requested.

Clinical Governance issues and complaints will be reported by the provider to the commissioning manager by exception, in accordance with the contract.

Other relevant information required from time to time by the commissioner will be provided by the provider in a timely manner.

A monthly report will be agreed that will comprise of all the necessary activity data to support the KPI reporting including monthly cumulative backing data for invoicing.

A standard KPI overview report will be submitted using the appropriate data highlights.

Annual and Exception Reporting:
The provider should monitor waiting times as per standards above and report on an exception basis. If waiting times standards are not being met, this should be raised with the commissioner and an action plan developed to address this issue- this may include more formal reporting requirements.

The provider should share a report annually detailing performance against waiting times; feedback from referring clinicians; uptake of service by non-MECS optometry practices; rate of referral to MECS/primary care and other potential service developments.

9.8 Management and Administrative Arrangements

It is a requirement for the provider to initially attend monthly meetings with the commissioners, the frequency reducing subject to reaching the agreed service delivery outcomes. These meetings must discuss service issues, action plans and agree areas for development.
An annual contract review will be held and will determine amendments, cancellation and any other contractual issues in accordance with standard NHS contract terms.

9.9 Data Protection

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

The Provider must provide an up-to-date document outlining clinical governance arrangements to the NHS North East London ICB prior to service commencement. This will include details of any subcontract arrangements associated with the service.

The provider will provide the NHS North East London ICB with evidence that all practitioners providing the service meet the accreditation requirements appropriate to their role.

10 Activity & Costs

10.1 Estimated Activity

The expected annual activity levels are estimated based on the activity of the MECS services in 2023/24 (where MECS services were in place) and additional activity which will result from the expansion of a NEL wide refinement service.

Service	**Activity 2024/25**
MECs Pathway (Face to Face)	14,295
MECs Pathway (Virtual)	1,588
Glaucoma Repeat Measures- Full Assessment	143
Glaucoma Repeat Measures- IOP only	286
Glaucoma Repeat Measures- Fields only	71
Glaucoma Repeat Measures- IOP & Fields	71
Cataract Refinement- External	1,430
Cataract Refinement- Internal	715
Total	18,600

10.2 Cost: MECs, Glaucoma Repeat Measures, Cataract Refinement

Service	**Tariff**
MECs Pathway (Face to Face), New attendance inclu FU and OTC meds	£63.50
MECs Virtual Pathway (Non Face to Face), New attendance incl FU and OTC meds	£15.00
Cataract Refinement External	£46.00
Cataract Refinement Internal	£30.00
Glaucoma Repeat Measures (Full assessment e.g. new referral)	£54.00
Glaucoma Repeat Measures- refinement IOP only	£28.00

Glaucoma Repeat Measures- refinement Fields only	£32.00
Glaucoma Repeat Measures- refinement IOP and Fields	£44.00

Note:
The tariffs constitute full payment for the service and the provider in return will be responsible for all costs (excluding the direct oversight cost) of providing the service as per the specification.

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

11 Care Pathway-

Minor Eye Conditions**:** Appendix 1
Glaucoma Repeat Measures Internal: Appendix 2
Glaucoma Repeat Measures External: Appendix 3
Cataract Refinement: Appendix 4

Insert pathways