NHS
Bromley
Clinical Commissioning Group

Service review of activity data, feedback and outcomes from the NHS Bromley CCG eye care pilot and recommendations for a future service specification

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1 Background (CCG sources)

In 2015, NHS Bromley CCG commissioned an eye needs assessment jointly with the Local Authority. This highlighted Bromley's ageing population and the growing burden of eye disease. Local hospital eye service (HES) capacity was already under strain. Primary care optometrists, represented by the Bexley, Bromley and Greenwich Local Optical Committee (BBGLOC) were willing to engage in new pathways utilising their skills and capacity, but there was no consensus on the best model to use. Users valued local services and had good experiences of enhanced community optometry services but wanted high quality services delivered by appropriately skilled professionals.

A Bromley eye care survey in 2017 further reinforced the need for service redesign in order to provide timely access to more primary eye care services closer to home, to try and alleviate the capacity issues in the local HES. Patients reported that they wanted to be treated faster and by the most appropriate health care professional for their needs.

Bromley GPs confirmed the findings of the patient survey in that Bromley's ophthalmology pathways could not cope, resulting in long waiting times from referral to diagnosis and treatment. A new model of care was required to meet the present and future demands of Bromley's population; with greater access to a range of eye care services. The key was to develop services which focussed on 'right patient, right place, right time, right clinician and the right tariff'. This would be achieved through streamlining and risk-stratifying the eye care pathways and maximising the appropriate use of providers at each part of the pathway.

Commissioners in South East London (SEL) CCGs were now having conversations about the need to tackle the increasing eye care demand from primary care referrals at scale. Previously, there had been historic issues around the support and harmonisation of Primary Care Trust Local Enhanced Services (LES). The situation started in SEL when Lambeth and Lewisham CCGs worked with each other under one specification for minor eye condition services (MECS).

It was recognised that individual service developments needed to align across SEL using the following underlying drivers:

- Enabling and ensuring clinical quality, effectiveness and safety;
- Promoting and supporting prevention and self-care where possible;
- Achieving of national and local performance targets;
- Working within available resources and financial obligations including the delivery of Quality, Innovation, Productivity & Prevention (QIPP) plans, and
- Progressive development of integrated care within the NHS, social care and third sector partners.

In 2016, Bromley CCG approved a business case to commission an integrated primary and secondary eye care model, but after a robust market engagement exercise, it was clear that a pilot project would better in order to test the system. The CCG followed recommendations to waiver procurement and to pilot a model for two years from April 2017 under a primary eye care contracting framework. Learning from such a pilot would inform a more robust contract specification and sharing that learning would enable transformation of SEL eye care pathways at

scale. Since April 2018. all six SEL CCGs have been working towards aligning their primary eye care specifications.

The objectives of the Bromley pilot were to allow faster access to primary eye care and reduce the number of inappropriate referrals to the HES, delivered via clinical triage and a single point of access (SPA). The NHS e-Referral (e-RS) service had introduced an "any to any" function for hospital booking from primary care providers other than GPs and a referral assessment service (RAS). NHS e-RS was launched in twelve optical practices as the first step for improving efficiencies and communication between eye care providers. Bromley CCG was an early adopter for the use of e-RS by optical practices and therefore, its implementation has been developmental and has already provided significant learning nationally. The pilot project milestones also included the initiation of a community clinic pilot with Kings College for the monitoring of stable patients with chronic eye disease. To date, this has not commenced. However, for this to be successful, there should first be:

i) Agreed inclusion criteria for any community pilot;
ii) Prior identification of suitable patients for discharge to community;
iii) An IT solution for communications, and transfer and recording of information;
iv) A fast track referral route back to HES when required;
v) Governance and failsafe arrangements, all supported by
vi) System agreement between SEL stakeholders on a consistent set of eye health and sight loss pathways (based on risk-stratification and workforce development in terms of accreditation/ qualification requirements along the pathways. e.g. as set out in NICE Glaucoma CG81[1]).

2 England context

The challenges affecting the wider NHS and care system are all applicable to eye health and sight loss; increasing need and demand for services from the demographic changes in the population and rising prevalence of chronic disease; the introduction of interventions for previously untreatable conditions; pressures on capacity, and the competing priorities for limited resources. NHS eye health services are characteristically high-volume activities.

Increasing demand and high volume

Primary care - General Ophthalmic Services (GOS) [2]

- NHS Sight Tests - 13 million NHS sight tests performed in 2016 -17, representing a 24% increase over 10 years.

Secondary care - Hospital Eye Services (HES) [3,4]

- Outpatients: 8.5 million attendances (8% of all outpatient attendances) in 2016 -17, representing a 40% increase over 10 years.

[NB. In 2006, the Scottish GOS was refocussed to contract **all** optometrists to provide follow-up appointments for repeat measures and minor eye conditions, and this was associated with the removal of direct walk-ins to ophthalmology emergency care, as a result there has only been a 13 per cent increase in ophthalmology outpatient attendances compared with a 34% increase in England for the same period].

- Admissions:
    - over 715,000 admissions (4.5% of all admissions) in 2014 -15, representing over 40% increase over 10 years.
    - Of these 54% are cataract operations (over 382,000) which have seen a 34% increase in activity over 10 years.

Along with increasing demand, costs are escalating but despite the importance of managing these issues, there has been a lack of a whole system approach for re-aligning provision and integrating the wide range of eye health service pathways which cover school and diabetic eye screening, GOS (NHS sight tests), primary eye care, community ophthalmology, hospital eye service, social care (low vision and rehabilitation), and services provided by the charity and voluntary sectors.

Service pressures

Lack of HES capacity is leading to longer waits for new appointments, but more importantly, patient safety issues for high-risk patients resulting from delays in their follow-up appointments, hospital-initiated cancellations and backlogs; these pose a risk of harm to patients (progression of eye disease severity). This was first highlighted in 2009 by a National Patient Safety Agency (NSPA) alert for avoidable sight loss due to delayed glaucoma follow-ups.[5] Since then, there have been Care Quality Commission alerts on HES capacity issues and delayed follow-up[6,7], parliamentary questions[,8,9,10], surveillance[11] and recently, a London Assembly health committee report highlighting the need for a strategic approach.[12]

Get It Right First Time (GIRFT), Failsafe optimisation, System and Assurance Framework for eye-health (SAFE) and the resultant impact on commissioning, planning and provision of eye health and care services.

The GIRFT ophthalmology project[13] is a national initiative designed to improve clinical quality and efficiency within the HES by reducing unwarranted variation. An England-wide report covering the assessment of 120 ophthalmology departments during 2017/18 is due to be published during the latter half of 2018. The National Elective Care Transformation Programme high impact intervention (HII) and failsafe prioritisation specification was launched in Q1 2018/19; with guidance and supporting materials developed with key national stakeholders.[14]

The HII specification includes three key actions to be undertaken by local Hospital Eye Services and CCGs/STP leaders:

- **Action 1** - Hospital Eye Services should develop failsafe prioritisation processes and policies to manage risk of harm to ophthalmology patients.
- **Action 2** - Hospital Eye Services should undertake a clinical risk and prioritisation audit of existing ophthalmology patients.
- **Action 3** - Each CCG/STP leaders should undertake an eye health capacity review to understand demand for eye services and to ensure that capacity matches demand with appropriate use of resources and risk stratification.

The failsafe specification Action 3 highlights the System and Assurance Framework for Eye-health (SAFE)[15] published by the Clinical Council for Eye Health Commissioning (CCEHC) as a basis for transformational change. This currently covers the main adult chronic (glaucoma and age-related macular degeneration (AMD)) and high-volume conditions (Cataract). SAFE provides the core constructs and technical tools to support the planning and provision of service systems that

take into account the full range and complexity of care pathways that (increasingly) involve multiple providers and settings to deliver services. Its implementation provides consistency in the approaches taken to improve access and availability of services, whilst managing rising need and demand.

The SAFE toolkit includes:

- SAFE Implementation of recent eye-related NICE Guidelines
- SAFE Quality Indicators for Commissioning
- Updated Vision UK Portfolio of Indicators for Eye-health and Care[16]
- CCEHC frameworks – Primary Eye Care, Community Ophthalmology and Low Vision, Habilitation and Rehabilitation. Full details can be found at: http://ccehc.org.uk

Action 3 requires CCG/STP leaders to determine the most appropriate local eye care model for delivery across primary care, community and secondary ophthalmology services, optimising skills and capacity within the system. This is necessary in order for ophthalmology pathways and referral processes to be standardised and understood locally, with patients directed to the right person, in the right place, first time. To do this effectively, there needs to be a systems approach to the commissioning and provision of integrated pathways, setting out clear responsibilities and establishing processes for governance and reporting on service implementation, quality (e.g.; serious incidents, appointment delays, patient experience) and outcomes data. SAFE recommends that in the absence of an identifiable STP structure for this, and whilst the wider system is evolving, an Eye-health Quality Board (EQB) or review group should be established linking to STP quality assurance processes. This could build on and receive input from existing local structures at CCG level for this purpose.

The SAFE cataract (Figure 1) and glaucoma (Figure 2) service systems are presented here schematically to reflect the key nodes required within each service, and the factors determining the type of care and setting in which it would be provided; by risk stratification of a patient's condition; and practitioner competencies.

CLINICAL COUNCIL
FOR EYE HEALTH COMMISSIONING

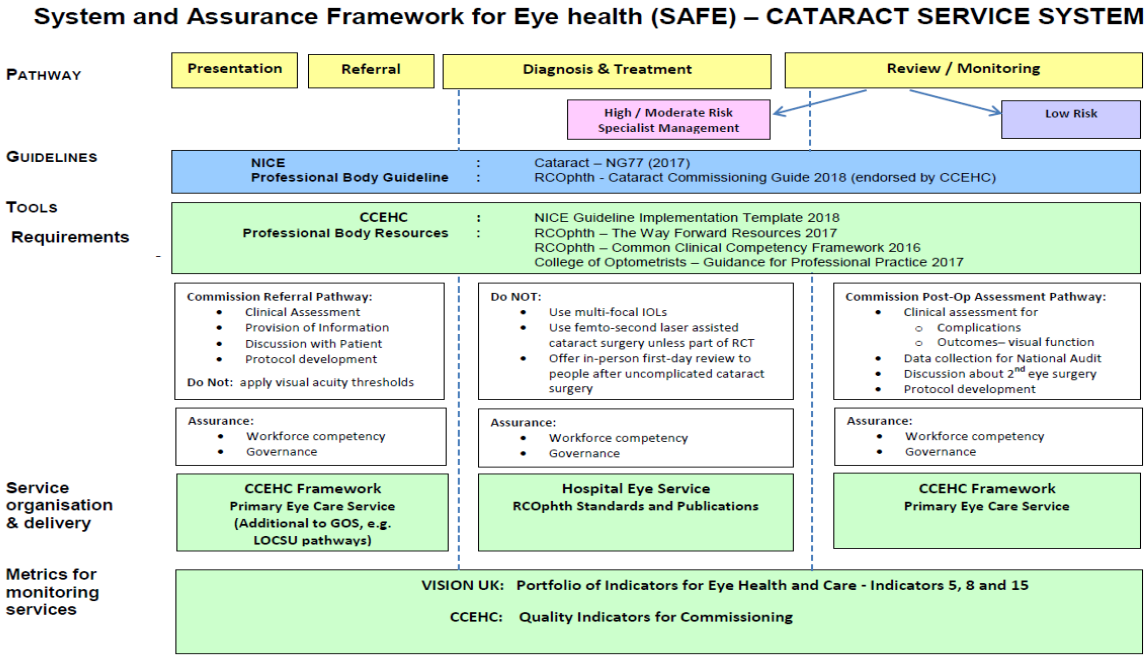


Figure 1 - SAFE Cataract system

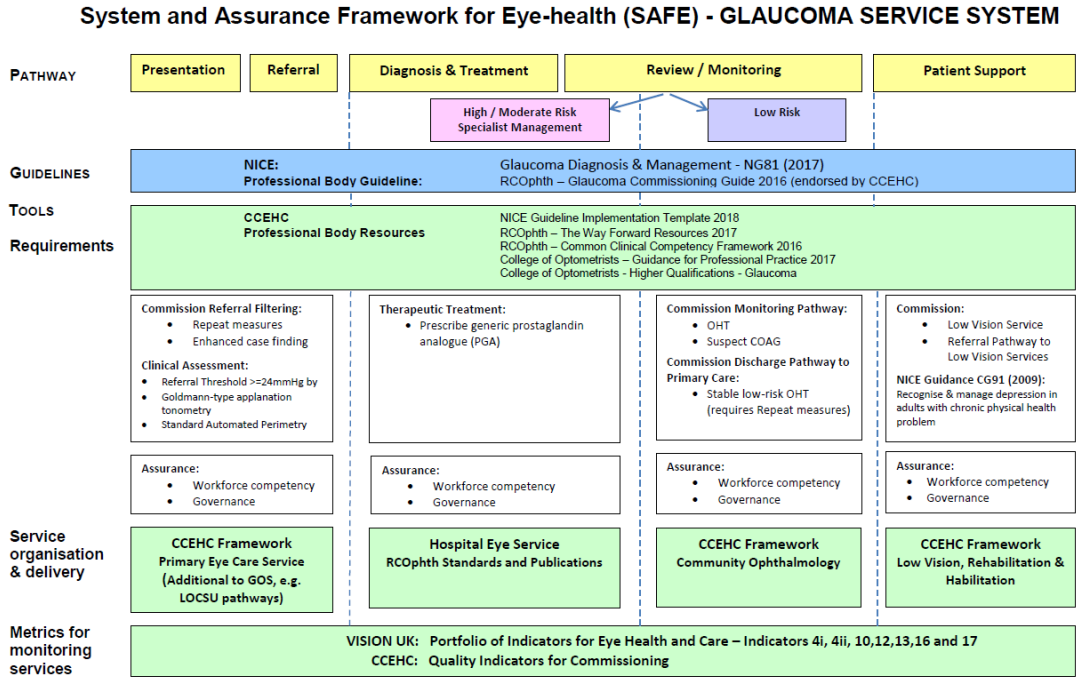


Figure 2 - SAFE Glaucoma system

3 Primary Eye Care Framework

The CCEHC Primary Eye Care (PEC) Framework[17] is a key component of SAFE and was used as the basis for the Bromley CCG pilot. The PEC framework is necessary due to the fragmentation of commissioning for first contact eye care. The NHS sight test provided under the General Ophthalmic Services (GOS) is a national delivery service contracted by NHS England. The GOS only funds a single NHS sight test appointment with a minimum recall interval, and it is the responsibility of CCGs to fund schemes to support the refinement of referrals via review and supplementary appointments. Implementation of a PEC framework additional to the NHS sight test supports better clinical decision-making and improves the quality of referral decisions. Research evidence suggests that optometrists involved in these services are three times less likely to make false-positive referrals.[18] Notably, schemes in SEL have provided national peer-reviewed evidence for repeat measures[17] and minor eye conditions.[19, 20, 21]

PEC services additional to NHS sight test include:

- Glaucoma repeat measures: repeating intraocular pressures (IOP) by Goldmann-type tonometry and repeating suspect visual field tests before referring suspect ocular hypertension / glaucoma referrals (NICE Glaucoma Guidance [CG81][1,22] and NICE Glaucoma Quality Standard 2.[23]
- Performing pre-cataract assessments, reducing unnecessary referrals:
  1. *Does the cataract affect the individual's sight and quality of life?*
  2. *Does the patient understand the risks and benefits and wishes to have surgery?*
- Managing minor eye conditions (MECS), improving links with GPs and HES.[19, 20, 21].

PEC services may also include:

- Assessments to support people with learning disabilities.[24]
- Post-cataract surgery follow-up care.[25]

In 2015, a Monitor productivity report[25] highlighted the use of primary care optometrists in delivering post-operative cataract follow-up care after uncomplicated surgery. Importantly, this facilitates the collection of essential post-operative refraction outcome data for the national ophthalmology database.[26] In addition to paper feedback options, there are now electronic data solutions available which allow optometrists to feed data directly into a hospital electronic patient record (Medisoft). Post-cataract surgery follow-up care should be considered as a future PEC development across SE London.

Use of the PEC framework and communication using e-RS supports greater efficiency of the clinical referral system. It also provides a common vision for an integrated care system from the service user's perspective which is described as *'my care is planned with people who work together to understand me and my carer(s), put me in control, co-ordinate and deliver services to achieve my best outcomes*'.

4 Scope of review

Both quantitative and qualitative approaches were used in assessing the effectiveness of the primary eye care service pilot; the scope of review was as follows, ensuring:

- Services are consistent and high quality as well as closer to home.
- Success criteria of patients being seen at the right time, place and right clinician (as per the case for change in the business case).
- Improvement in quality and reduction in variation of care.
- Development of sustainable specialist services local to patients, through a primary care/community-based service in high street optical practices.
- Improvement in access to primary eye care as specified in the service specification.
- Adherence to national waiting times for secondary care referral to treatment targets.
- Changes for how PECS is delivered to achieve the transformation required in accordance to national guidance.
- Improvement in communications between primary and secondary eye care.
- Effectiveness of e-Referral processes (GP, optometrist, triage), choice options and identify learning.
- Additional benefits to patients such as saving in time for their carer, communication and ease of accessing services.
- Additional benefits to General Practice and other providers, such as better use of referral appointments, better use of skills and competencies of the workforce and improved working relationships between providers.

Quantitative analysis:

- Activity and audit data from provider (October 2017 to March 2018 inclusive).
- SUS data (provided by CCC).
- Patient satisfaction surveys, feedback and incidents/ complaints (provided by NHS Bromley CCC).
- High-level review of the cost efficient of the new model (which may require input from the CCG financial team).

Qualitative analysis:

- High-level review of contractual requirements and benefits of using the Clinical Council for Eye Health Commissioning PEC framework as well as recommendation for future contracting methodology.
- Opportunities for community ophthalmology-type services and implications for workforce development.
- Benefits of the model through stakeholder feedback which will consist of interviews with 3 MECS practitioners and review outcomes.
- Interviews with 3 triagers and review protocols.
- Interviews with General Practice staff/clinicians (attendance at GP and cluster events).

Summary of review and recommendations:

- Consider revisions in the pilot service specification.
- Contribute to cluster meetings (4 cluster meetings total) to feedback about the review and seek GP comments on the draft report findings.
- Final report and presentation on the Bromley eye care pilot to the Clinical Executive Group, Governing Body and CCG membership groups.

Limitations of the review:

- Review after 1 year of a 2-year pilot.
- Only 6 months data.
- Service roll out still evolving.

5 Documentation review

The following Bromley Minor Eye Conditions Scheme (MECS) documents were reviewed and proposed amendments are noted below:

a) BMECS pathway diagram has been updated (Appendix B)

b) BMECS Standard Operating Procedure for practices (Appendix C).

- Clarity on typical presenting signs and symptoms for MECS and self-referrals.
- MECS appointments to incorporate glaucoma applanation tonometry (repeat measures) on first occasion as required and cataract refinement when indicated, not as an additional claim to MECS.
- Requirement for cataract assessments and repeat measures to be managed internally by optical practice as per contract especially where inappropriate or unrefined referrals are being made from non-accredited practitioners within the same optical practice.

c) Invite letter (Appendix D).

- Use of term MECS in letter. For future consideration: this links to g) and recommendation 1. This letter relates to MECS practitioners who are performing a range of refinement roles after the intervention of triage. Patients will have already been examined by another optometrist. As more services are added, the

offer to patients will extend beyond the scope of a traditional minor conditions service.

d) Booking a MECS appointment and practice sites opening times (Appendix E).

- Modify advice on drops - *Please note that as part of your examination, eye drops may be used to enable examination of the eyes. If drops are used, they will temporarily affect the ability to focus properly so you will not be able to drive for approximately 4 hours after your eye examination or until your vision has recovered. Your eyes may also, temporarily, become more sensitive to light so you may wish to wear sunglasses to relieve this. [This aligns with diabetic eye screening and HES advice to patients].*

e) NHS e-RS ophthalmology booking guidance (Appendix F).

- Clarity on expected wait times for an urgent (6 weeks) and routine (13 weeks) e-RS referrals.
- More detail on 2 weeks suspect wet AMD referral pathway and emergency referrals outside e-RS.

f) PEC triage guidance (Appendix G).

- Additional guidance for cataract, glaucoma, AMD, and floaters and flashes.

g) BMECS patient not booked (Appendix H).

- Consider shortening timescales to contact patient if MECS appointment if not made.

h) BECS – Service specification (Appendix I in separate file).

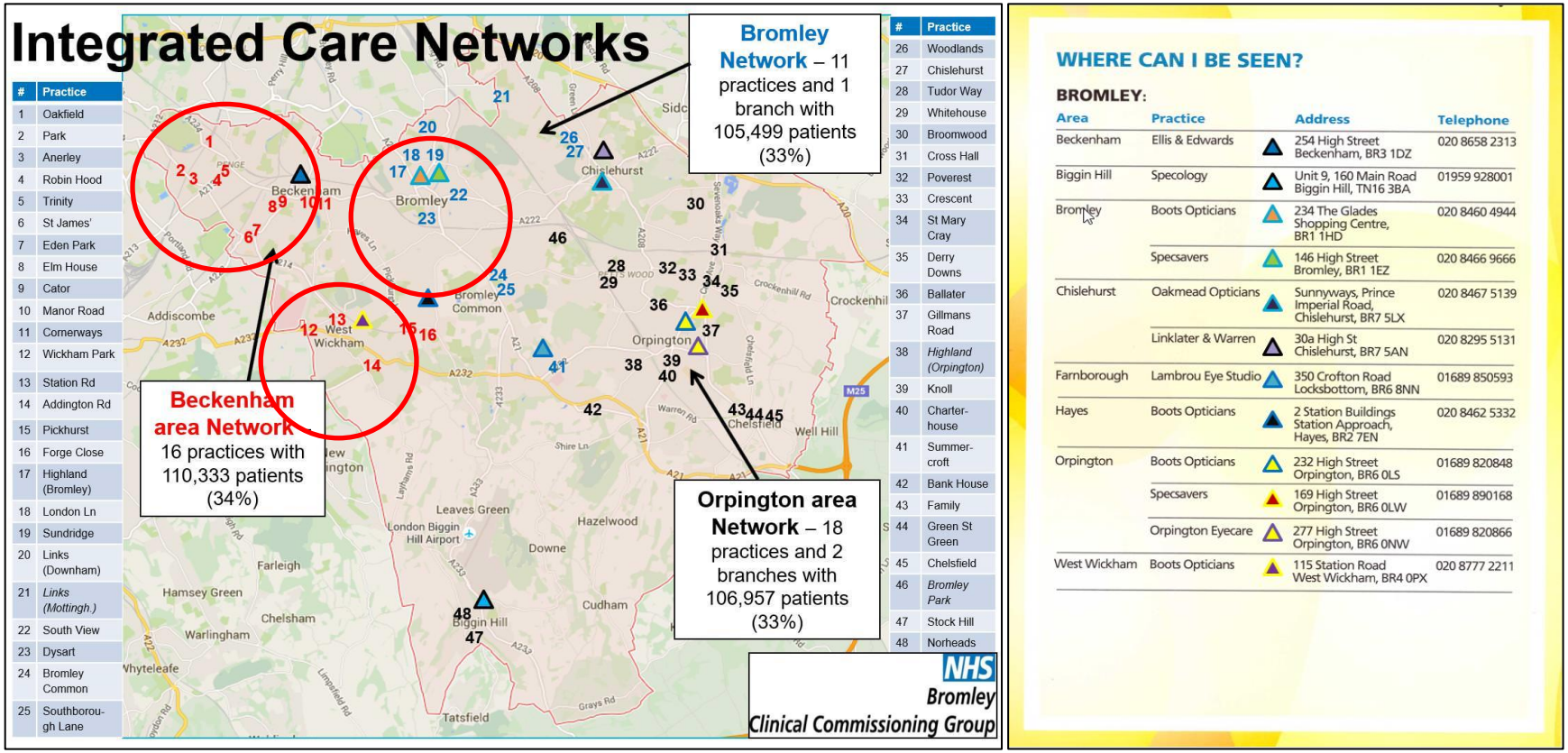
- Optometrists are contracted to provide a range of services which include MECS, cataract referral refinement and glaucoma repeat measures, and also use of a SPA triage via e-RS to identify those referrals suitable for further referral refinement. Across South East London, service developments have moved beyond the nationally agreed usage of the term MECS and there should be SEL agreement around a consistent set of pathways and terminology, and for the next steps in their development.
- Track changes and comments throughout document.

RECOMMENDATION 1: Clarity over terminology: consider using 'Bromley Eye Care Services' in a new procurement as the title of the **overall contract specification**. MECS would still be outward facing for GPs and the main entry point for patients. Future contracts need to cover a wider range of services, as there are opportunities for further services to be added as the workforce develops e.g. cataract post-operative care, OCT for refinement of suspect retinal conditions. Service models are already developing into lower levels of community ophthalmology, and there is significant scope for stable AMD and stable glaucoma monitoring; these would not be considered appropriate under a 'minor conditions' service (MECS).

Please note that RECOMMENDATIONS relate to a new procurement, and ACTIONS relate to the current pilot.

6 Activity review

MECS sites within Bromley integrated care networks



WHERE CAN I BE SEEN?

BROMLEY:

Area	Practice	Address	Telephone
Beckenham	Ellis & Edwards	254 High Street Beckenham, BR3 1DZ	020 8658 2313
Biggin Hill	Specology	Unit 9, 160 Main Road Biggin Hill, TN16 3BA	01959 928001
Bromley	Boots Opticians	234 The Glades Shopping Centre, BR1 1HD	020 8460 4944
	Specsavers	146 High Street Bromley, BR1 1EZ	020 8466 9666
Chislehurst	Oakmead Opticians	Sunnyways, Prince Imperial Road, Chislehurst, BR7 5LX	020 8467 5139
	Linklater & Warren	30a High St Chislehurst, BR7 5AN	020 8295 5131
Farnborough	Lambrou Eye Studio	350 Crofton Road Locksbottom, BR6 8NN	01689 850593
Hayes	Boots Opticians	2 Station Buildings Station Approach, Hayes, BR2 7EN	020 8462 5332
Orpington	Boots Opticians	232 High Street Orpington, BR6 0LS	01689 820848
	Specsavers	169 High Street Orpington, BR6 0LW	01689 890168
	Orpington Eyecare	277 High Street Orpington, BR6 0NW	01689 820866
West Wickham	Boots Opticians	115 Station Road West Wickham, BR4 0PX	020 8777 2211

Figure 3 - PEC sites within the 3 Bromley CCG GP networks

RECOMMENDATION 2: The coverage map (Figure 3) suggests that additional MECS sites should be considered: one in Bromley, one in West Wickham and two in the Beckenham area, in order to provide improved access for patients, referrals from GP practices and cover for holidays**.** Over time, more local optical practices should be able to offer MECS and repeat measures, but optometrists managing low-risk referrals from SPA need to develop a greater level of skills and experience.

Activity by GP practice

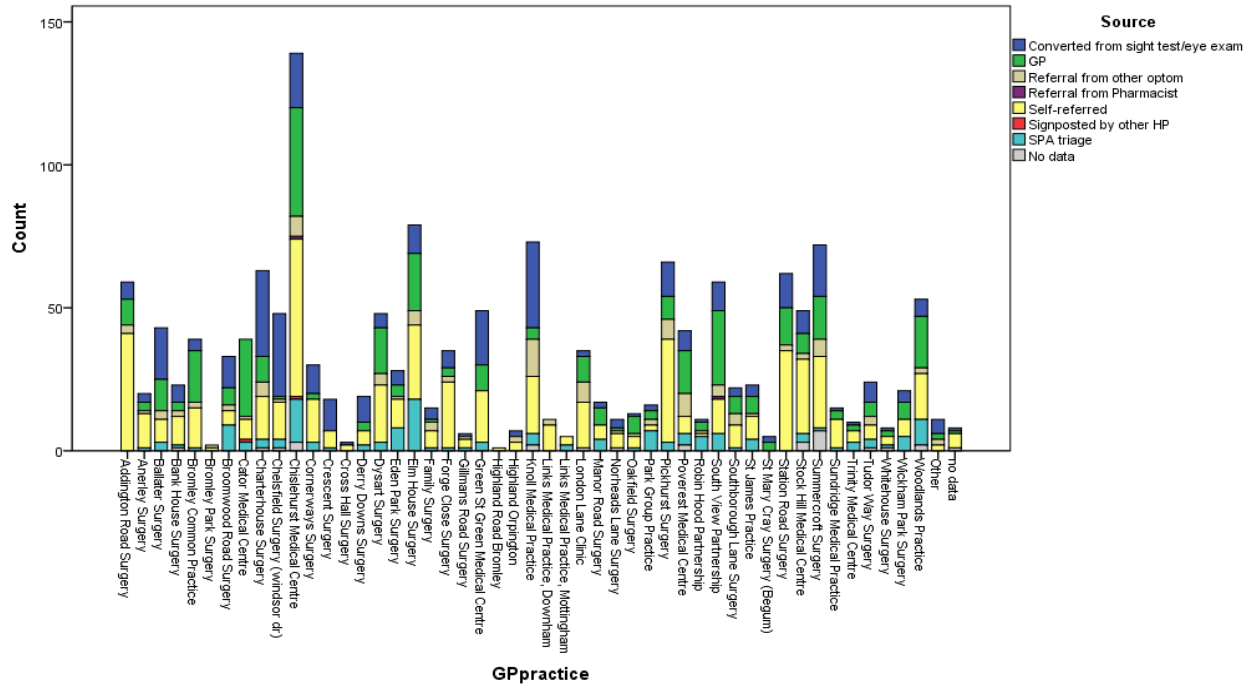


Figure 4 - Source of PEC activity (by GP practice)

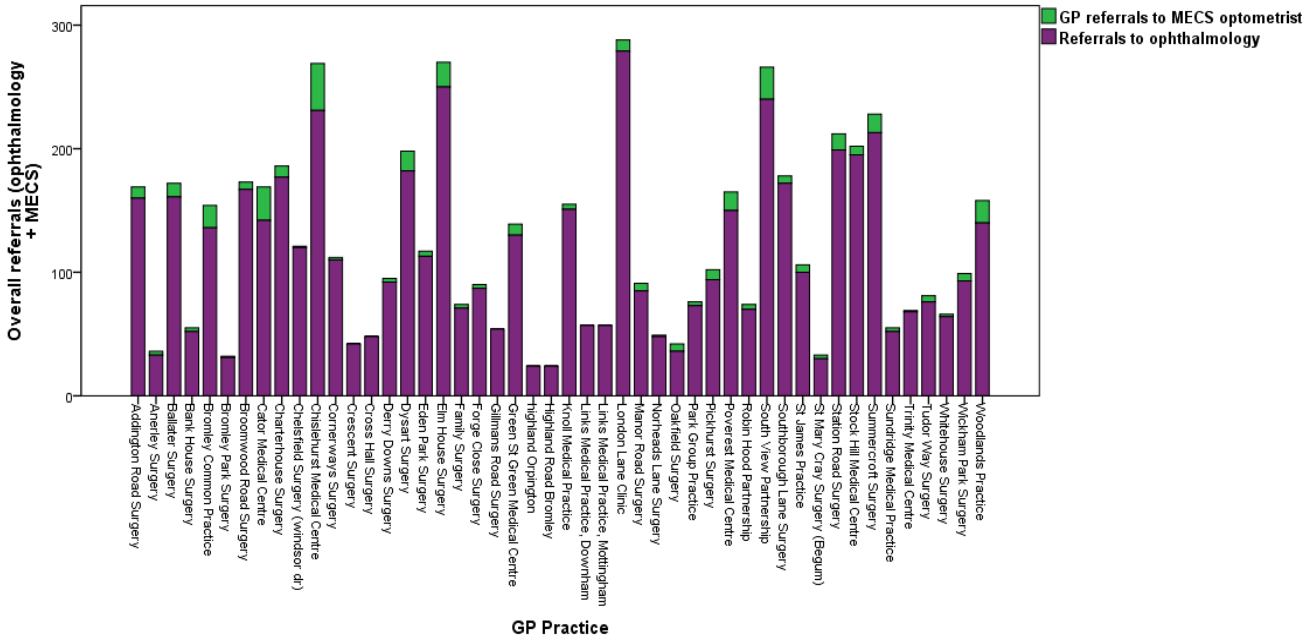


Figure 5 - Number of GP referrals to MECS optometrist compared with overall referrals to ophthalmology + MECS (by GP Practice)

Figures 4 highlights the variation in the number of referrals (green) to MECS from individual GP practices. Figure 5 suggests there is scope for greater use of MECS by GPs when this is compared to their practice ophthalmology referrals for the same period. There appears to be uncertainty by GPs around the MECS referral process and the forms to use. Old BBG PEARS forms are still in use and should be discarded. Figure 6 shows the variation in first ophthalmology referrals by GP practice (weighted per 1000 patients).

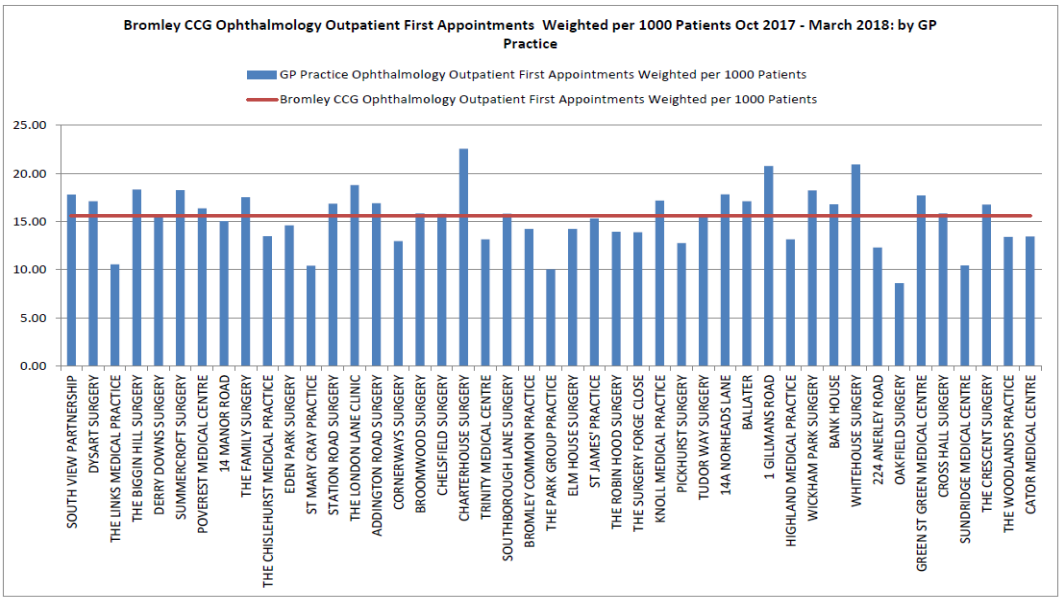


Figure 6 - 1st Ophthalmology outpatients appointments weighted per 1000 patients (by GP Practice)

ACTION 1: Further stakeholder engagement and communication with GP practices is required to promote the appropriate use of the MECS service.

Month	Full Capacity episodes (based on 2016/17)	Planned patient episodes referral (%)	Planned patient episodes (no)	Actual patient episodes	Variance
Apr-17	375	0%	0	0	0
May-17	375	0%	0	17	17
Jun-17	375	10%	38	23	-15
Jul-17	375	20%	75	75	0
Aug-17	375	30%	113	118	5
Sep-17	375	40%	150	124	-26
Oct-17	375	50%	188	196	8
Nov-17	375	60%	225	248	23
Dec-17	375	70%	263	200	-63
Jan-18	375	80%	300	296	-4
Feb-18	375	90%	338	293	-45
Mar-18	375	100%	375	370	-5

Table 1 - Patient activity

ACTION 2: Activity is to plan (Table 1, Appendix A), but there is a need to understand a degree of unwarranted variation of source of activity for two sites for 'conversion from sight test/ eye examination' (Figures 7 & 8). This is most likely a reporting issue but requires a review of comparative data and discussion with the provider sites to ensure appropriate recording of episodes. [The Standard Operating Procedure for MECS practices has been updated to highlight scenarios of presentations which would apply].

Source of activity

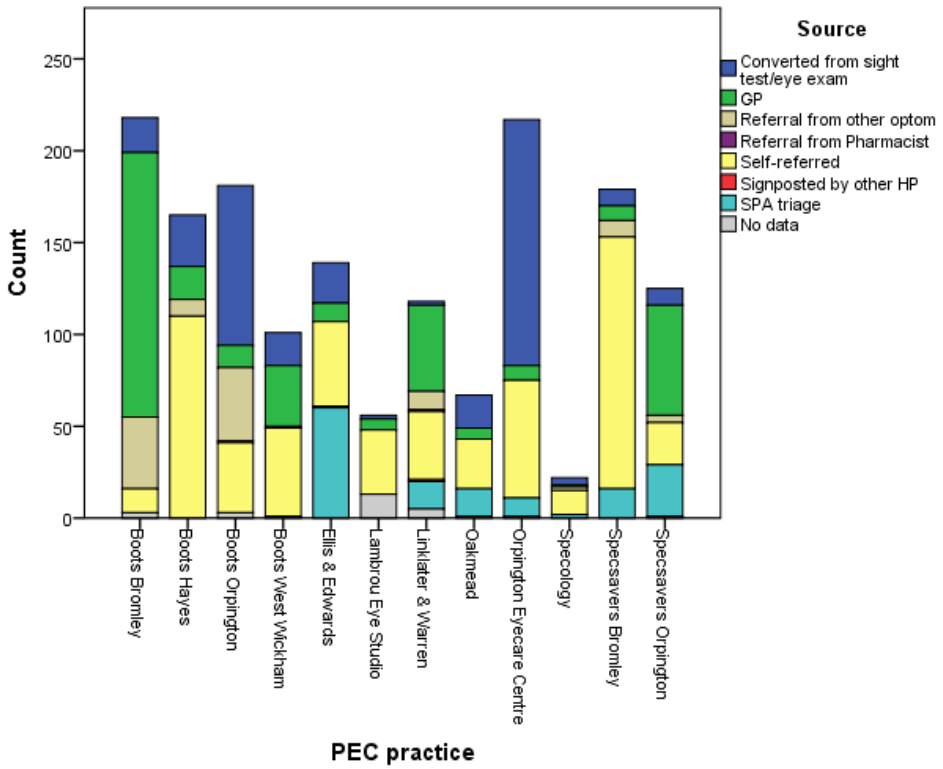


Figure 7 - Activity by MECS practices

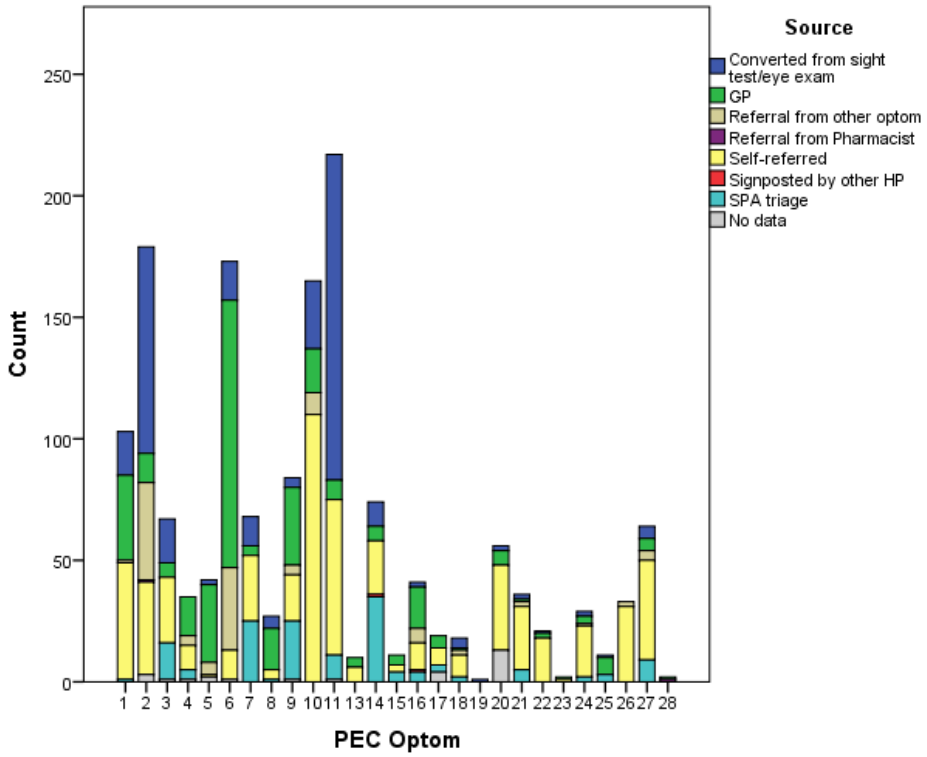


Figure 8 - Activity by MECS practitioner

Reason for activity

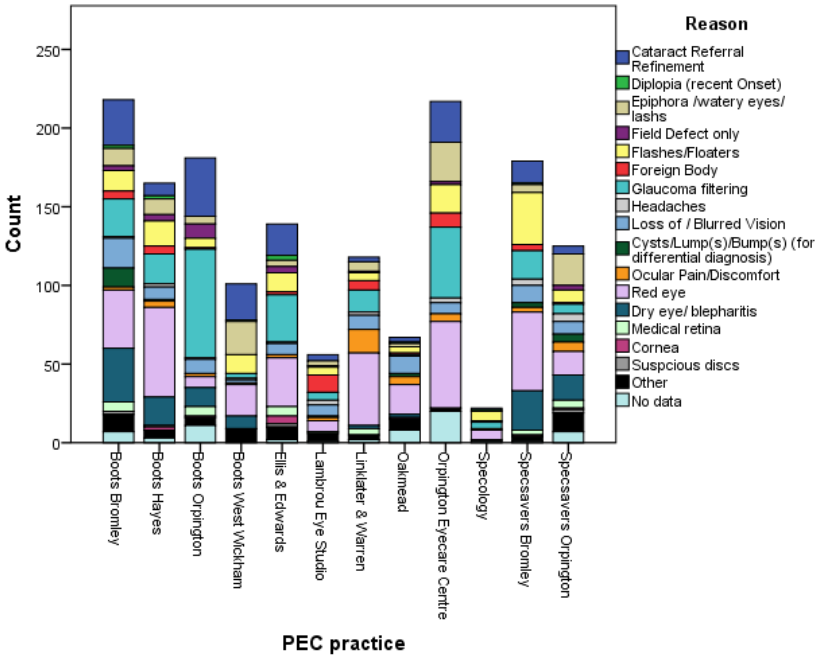


Figure 9 - Reasons for activity by MECS practice

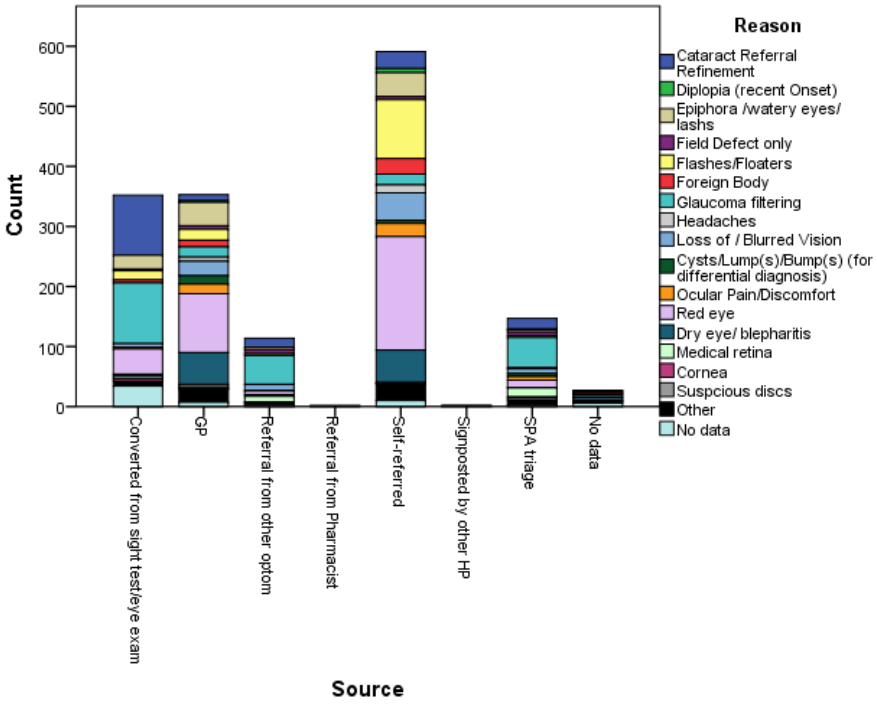


Figure 10 - Reasons for activity by source

The reason for PEC activity varies by MECS practice and by source (Figures 9 & 10). Several practices are highlighted where no or little glaucoma filtering is taking place. Glaucoma repeat measures is part of the service specification.

GPs are referring to MECS for mostly red eye and dry eye/blepharitis. The main reasons for conversion from a sight test appear to be for cataract refinement and glaucoma repeat measures. This is slightly confusing, cataract assessment and glaucoma repeat measures are more

accurately reported as ‘additions to the sight test’, as a sight test is completed and not stopped at any point. Appropriately, red eye, and floaters and flashes are the main reasons for self-referrals.

ACTION 3: Implementation of glaucoma repeat measures (filtering) within MECS practices should be followed up as part of the contract.

Outcomes for MECS/Cataract/ Repeat measures appointments

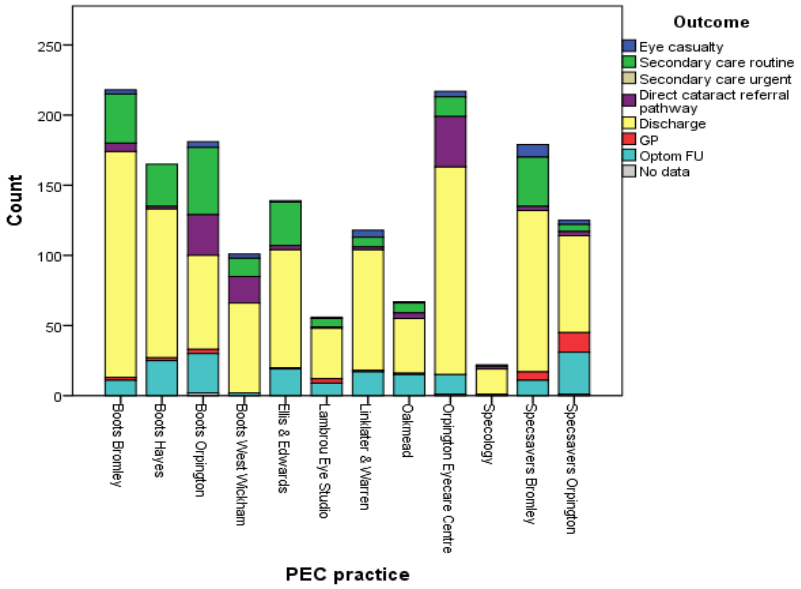


Figure11 - Outcomes by MECS practice

There is a high discharge rate across all practices, and across all activity sources (Figures 11 & 12) and modest usage of MECS follow-up appointments (light blue).

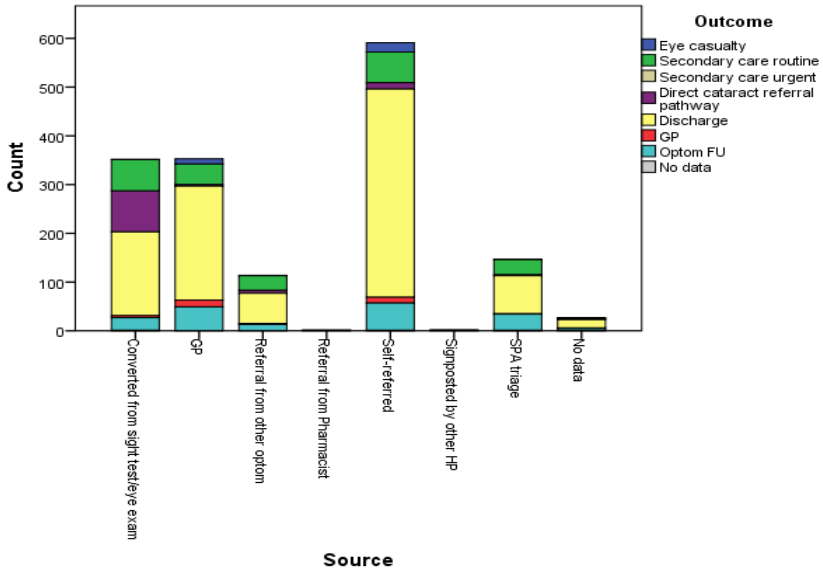


Figure 12 - Outcomes by source of referral

Glaucoma filtering is the main activity from the SPA. More glaucoma filtering activity in terms of ‘enhanced case finding’ (which involves dilation) should be possible from SPA triage during the second year of the pilot, as approximately 60% of local optical practices are currently outside the pilot and additionally 15% of referrals may be received from optical practices outside Bromley CCG boundaries. Reports of unreadable letter scans on e-RS needs to be investigated and steps taken to improve.

ACTION 4: Need to maximise the capture of unrefined referrals via the SPA triage (sourced from GP referrals, and referrals sent to GP by non-MECS accredited (or locum) optometrists for onward referral to HES (both within and outside the CCG boundary). This includes any unrefined referrals from MECS practices (e.g. where glaucoma filtering has not been undertaken). Consider plan to improve readability and completeness of referral correspondence (includes visual fields) on e-RS.

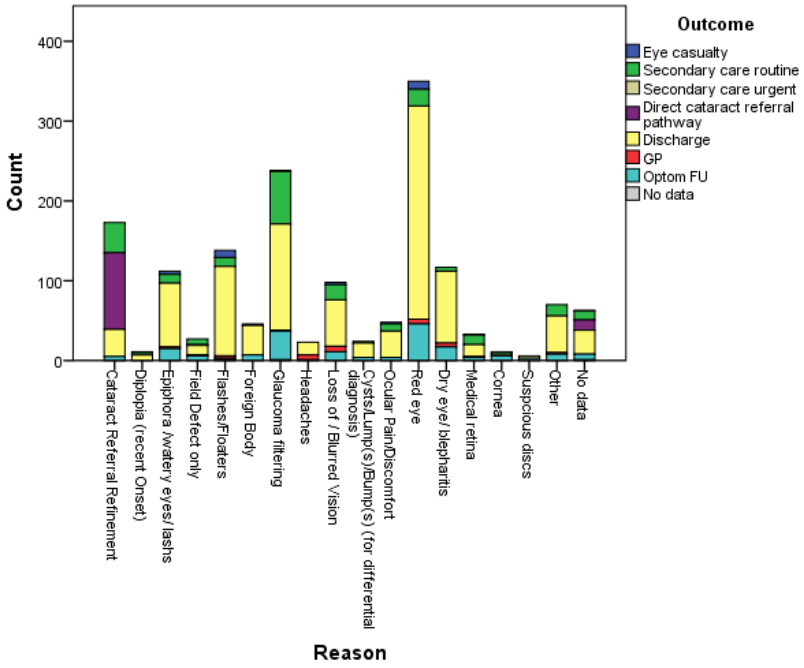


Figure 13 - Outcomes for PECS/ MECS appointment by reason

Outcomes of non-referral/ discharge occurred in 20% of cataract refinement assessment, 67% of glaucoma filtering assessments, and MECS is supporting clinical decision-making resulting in non-referral for the following presentations: red eye 92%, dry eye/ blepharitis 97%, floaters and flashes 91%, and removing foreign bodies 85% (Figure 13).

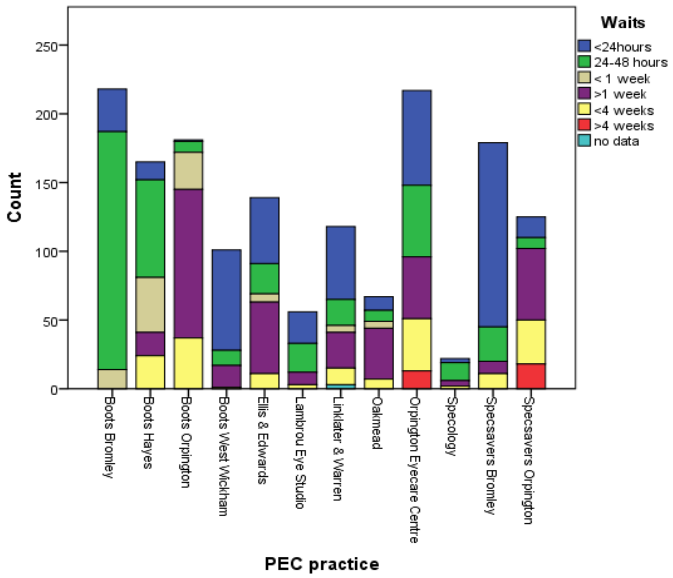


Figure 14 - Waits for appointment by PECS/MECS practice

Waits varied by optical practice; these differ based on source of referral e.g. appointments as a result of triage will take longer to arrange than GP to MECS referrals (Figure 14). A few practices had waits >4 weeks but this may be due to patient choice. Ideally, waits >4 weeks should be minimised.

ACTION 5: Attempt to minimise waits >4 weeks to ensure any 'referrals on' to the HES can be seen within the required 18-week target.

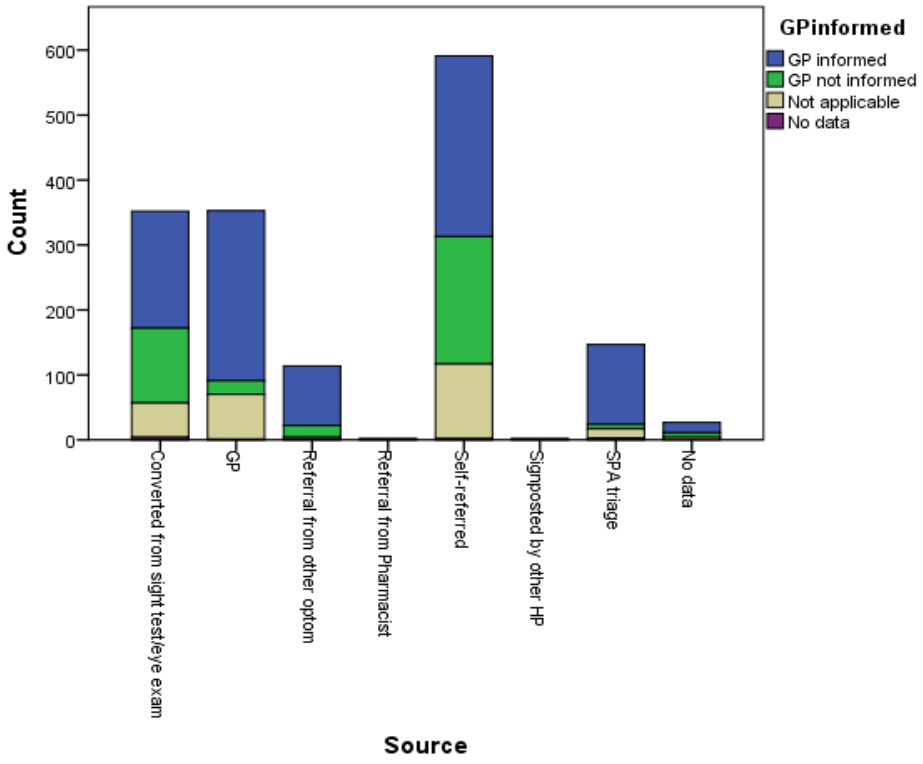


Figure 15 - GP informed of MECS appointment

A MECS outcome letter to the referring GP was reported as 'not applicable' in a number of cases (Figure 15). This may be a recording issue, or it could be that the GP receptionist had directed the patient to MECS. To be clear, all MECS episodes following GP referral require an outcome letter whether their patient has been referred by a GP or the review is as a result of triage. There needs to be similar requirement to send a copy of the MECS outcome to the referring optometrist. This is essential feedback and needs to happen to complete the optometrist referral improvement loop. This point was also made by the MECS optometrists *(see MECS optometrists feedback).* There is no requirement to inform the GP in self-referral cases and conversion from a sight test where no reason requiring referral is found.

ACTION 6: All referrers to MECS to receive an outcome letter from MECS optometrist. Also, GPs **AND** optometrist referrers to receive an outcome letter from the MECS optometrist for any patient seen as a result of SPA triage.

7 Feedback

Visits and conversations took place during April 2018 with 4 MECS optometrists, 3 SPA triagers and attendance at a Bromley GP CPD event on urgent eye referrals (23rd April 2018). There was good support for MECS from all stakeholders, and a willingness to develop and expand the service. However, rather than feedback and ideas for the future, possibly because this was a new service, much of the conversations were around clarity over what to do in certain circumstances. Undertaking a pilot therefore was the correct decision with the continuing need for wider and improved communication across all groups.

The following points and queries were identified; answers and considerations are provided in italics.

Triage

- Visual fields plots are missing from many suspect glaucoma referrals when the letter reports abnormal fields. Triage optometrists reported that some referrals on e-RS do not have the optometrist referral letter and/ or visual field plots attached, but instead there is a short summary in the GP referral letter. GPs reported that the resulting optometrist referral letter scans are often unreadable. Consequently, essential information does not reach the ophthalmologist. ***Answer:*** *Approach Local Optical Committee (LOC) to communicate a request to all local optometrists to include suspect visual field plots with their referral when they make reference to a visual defect. CCG to communicate with GPs that they forward all readable optometrist referral correspondence including visual field plots with the referral. Investigate instances of poor quality scans (links to action 4).*
- Insufficient information in the referral letter, should this stop or reject the referral?
  Answer: *If there is a general indication that the patient should be seen by the HES rather than MECS refinement, reduced referral quality should not slow the patient referral. This should be reported to the SPA office, so that feedback can be given to the referring practice/practitioner. Where there are obvious omissions, or the scan is unreadable, so that a triage decision cannot be made, then reference back to the referring practitioner is necessary.*
- What is the appropriateness of SPA triage guidance for patients who are referred on e-RS with recent floaters and flashes. Current triage guidance for those patients with onset within 4 weeks of referral date is 'refer HES URGENT', and onset over 4 weeks 'refer into MECS'. These patients may already have been dilated and examined by an optometrist, but this may not be the case if referred by the GP.
  Answer: *Management of floaters and flashes should be in line with the NICE clinical knowledge summary on management of suspected retinal detachment whatever the presentation or referral route. If no visual acuity change or field loss, and no practitioner has yet examined the patient's retinae, they should be reviewed within 24hrs for dilated SL-BIO examination by the MECS optometrist; if there are symptoms reported of changes in visual acuity or visual field loss, then the patient needs to be referred direct to emergency eye casualty/ rapid access same day (Appendix G).*
- Identification of outlier referral practices, lots of referrals for asymmetric disc cupping. Should MECS optoms be dilating for suspect OHT/glaucoma case finding?
  Answer: *Repeating measures by the initial optometrist is quite different to another practitioner seeing the patient after referral by the first practitioner. The level of assessment should be higher at 'enhanced case finding' level, which would include dilated disc assessment (assuming patient consent and assessment of angle), visual fields and*

Goldmann-type tonometry. This is in line with NICE glaucoma CG81 enhanced case finding practice.

- Unwarranted variation in referral quality from several referral outlier practices and practitioners identified by the triage. ***Answer:*** *Feedback should be made direct to the SPA so they can contact the practice and practitioner to inform future referrals.*
- Cataract referrals appear to be generally good, some optometrists questioned the need for diversion for cataract assessment as patient expectations have been set. ***Answer:*** *Cataract referral guidance and treatment thresholds should be aligned using the London choosing wisely cataract protocol (available soon). Cataract pre-assessment should be part of the referral decision-making process, it is less effective following SPA triage.*

MECS Optometrists:

- GPs like the service and patients are pleased with MECS.
- It was reported that some GP reception staff are not giving out forms or information letters to patients, just advising them to go and see MECS optometrist. *[Relates to Action 1. communication with GP reception staff is needed as some of these patients could be seen under the GOS].*
- Patients expect to be seen immediately without an appointment. *[Relates to Action 1 on communication].*
- Optometrist letter is not always attached to GP referral on e-RS.
- Some GPs do call MECS practice in advance to provide more clinical information.
- Does MECS really need to see patients who have had a chalazion present for 3 months and not resolving? Patients are attending expecting these to be removed by the MECS optometrist.
  Answer: *Consider advice for Chalazion (un-resolving) and present for over 10 weeks to be referred to HES for incision and curettage.*
- Important for feedback to referring optometrist, as well as GP.
- What constitutes a headache symptom being referred into MECS?
  Answer: *This needs to be ocular headache and when an NHS sight test cannot be provided. Therefore, such circumstances should only arise very occasionally.*
- Can we have clear guidance on eye conditions suitable for MECS? And when should a patient be booked in for an NHS sight test (GOS)?
  Answer: *Updated guidance (Appendix C).*
- Use of e-RS has been a steep learning curve. Can we have better e-RS instructions as not always easy to track down or view referral letter? ***Consideration for PECS Provider.***
- When do we use glaucoma repeat measures?
  Answer: *Repeat GAT IOPs when NCT 24-approx 29mmHg.*
- There is never any correspondence to optometrist on referral outcome from Kings College, while Maidstone Hospital do reply back to the optometrist.
  Consideration for CCG and local Ophthalmology*: HES to increase feedback to referring optometrist on referral outcome for continuity of care and improving future referral appropriateness.*
- Reports that patients are waiting 5 months for Yag laser by the HES (April for Sept 2018).
- Need for peer review of referrals within MECS practices/ adherence to practice guidelines.
- Outliers – highlighted impact of locums who refer on the day rather than internally.
- More guidance for MECS optometrists on Choice booking options.
- GPs need to include more patient history for MECS, e.g. antibiotics used and other medication.
  Consideration for CCG*.*

Booking and IT issues:

- Poor appointment slot availability PRUH and QMS.
- Referral administration, limitations of laptop with multiple optometry clinics.
- No straightforward way to generate letter on e-RS, requires keyboard with smart-card slot.
- Working with multiple systems, the laptop is not integrated with practice systems and instances of not linking with printer, time taken to complete is longer and often after patient has gone, choice is offered prior to going on system so useful to have referral templates on laptop as easier to compose referral letters, and email letter to GPs and give patients a copy.
- Laptop screen is too small.
  IT considerations for CCG and PECS provider.

GP event

- General support for MECS.
- Not sure which forms to use, or where they can be accessed on the GP systems.
- Not sure of opening times at QMS rapid access clinic *(8.30am-4.00pm daily).*
- GPs want more information. *Links to Action 1.*

GP Cluster meetings

- GPs have noticed a reduction in the number of optometrist referrals.
- It was suggested that more optometrists needed to get involved in the schemes.
- Comment by one GP, 'GPs need to continue to manage straightforward cases e.g. conjunctivitis as they do have some knowledge of common external eye conditions', but this is limited by the lack of necessary equipment for further investigation.
- Sometimes, there is poor readability of the optometrist letter when received and this was a common theme. GPs cannot read them and therefore it is pointless to attach scan to records.
- 'It would be much better if everyone was on the same electronic system'.
- Direct referral for all ophthalmology was supported by GPs, one GP said they felt like a 'secretary' in the process. ***Consideration for CCG:*** *This could be supported with hub access to the local care record via EMIS community and information sharing agreements with GP practices and HES.*
- Concern was expressed when the optometrist referral letter states urgency 2-4 weeks, e.g. in cases of blurred disc margins GPs cannot do this on e-RS, so they refer direct to rapid access clinic. ***Consideration for CCG:*** *These types of referrals have increased with a recent high-profile case. There should be discussions with Kings and agreement on a 2-week pathway on e-RS, and advice to optometrists and GPs on referral criteria with appropriateness of referral timescales.*

HES

- Agreement for alignment of whole system SEL pathways.
- Boundaries, failsafe and step-down responsibilities need to be clear.
- HES have a responsibility to see all patients referred to them, it is the responsibility for primary care to improve quality of referrals.

General observations on community ophthalmology:

- CCEHC's Community Ophthalmology framework[27] describes a greater role for a multi-disciplinary team of practitioners working above primary care in community ophthalmology and in collaboration with HES. This could be HES or community led.
- The development of community ophthalmology should be a priority area, but this will require innovation and joint working between key stakeholders and services in SEL.
- Step down to primary and community care will only occur when there is confidence on the part of the HES that patients will be appropriately managed with clinical communication flowing both ways.
- Engagement needs to continue across SEL between patients, clinicians and commissioners.

RECOMMENDATION 3: Quarterly meetings involving commissioners and providers to focus on the development of community ophthalmology service model involving primary and HES providers. Communication and closer liaison between primary eye care lead and HES lead. This could involve direct contact as required and separate one-to-one meetings to improve local issues.

RECOMMENDATION 4: Community ophthalmology model will require further development around failsafe (tracking of patients and outcomes), and workforce planning and training (e.g. informed by risk stratification of pathways) to provide assurance. The SPA could be used as a step-down route to provide such failsafe.

8 System activity analysis

It has been difficult to make a full assessment based on only six-months of data, but analyses confirm that primary eye care referral activity is being managed more appropriately. Eighteen-week support was used locally during 2017/18 and will impact on waiting time performance (Figure 16). Data shows that Bromley GP ophthalmology referrals (including optometry referrals) have been lower in 2017/18 confirming GP cluster observations (Figure 17). While ophthalmology activity data might be accurate, there are obvious errors in reporting at subspecialty and procedure level (highlighted yellow Table 2). This is a national issue, but improved quality of these data would enable commissioners and providers to have more confidence in monitoring and planning services. However, improved quality of data and procedure reporting might identify the need for more funding. ***Consideration for CCG Contract Board.***

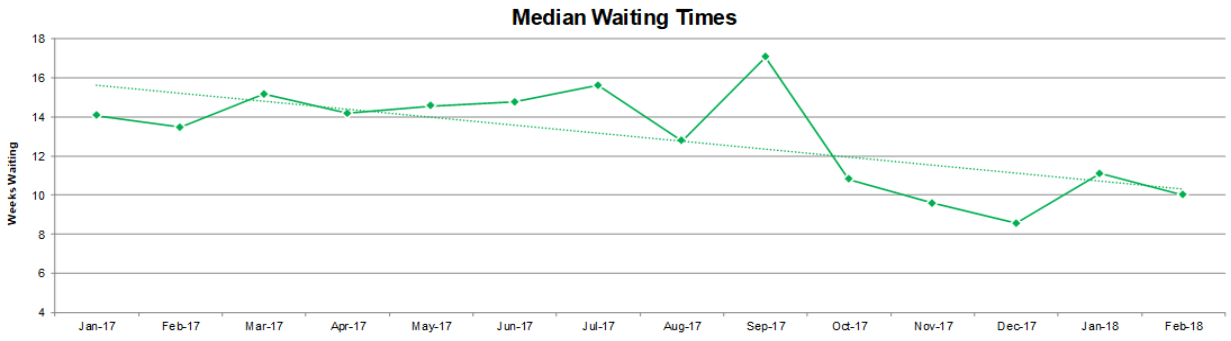
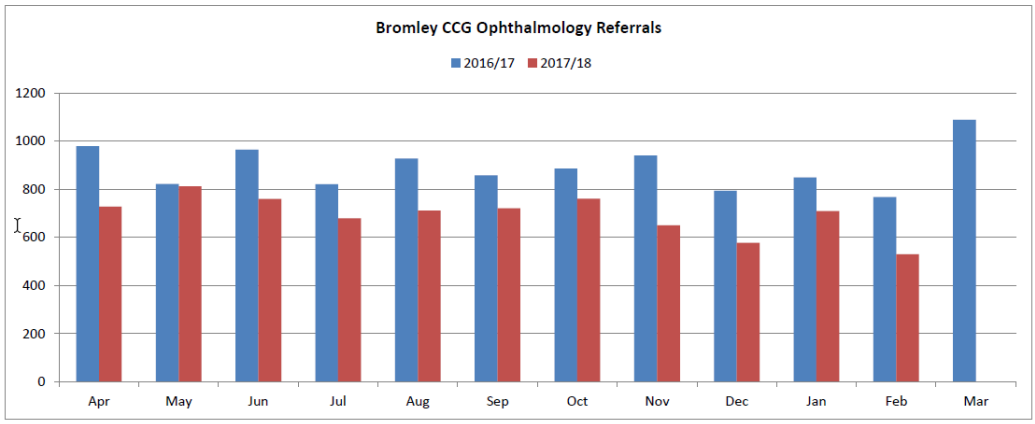


Figure 16 - Kings ophthalmology waiting times

[Kings College Hospital NHS foundation Trust NHS Bromley CCG Ophthalmology non-admitted]



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD
2016/17	979	822	965	821	928	858	886	940	794	849	768	1089	10699
2017/18	728	813	760	680	711	721	761	650	578	710	530		7642

Figure 17 – Bromley GP Ophthalmology referrals

All Bromley CCG Ophthalmology Outpatient Procedures by HRG Label			
HRG Label	**2016/2017**	**2017/2018 YTD (Feb)**	**2017/2018 FOT**
Vitreous Retinal Procedures - category 1	11059	0	0
Retinal Tomography, 19 years and over	0	8903	9712
Intermediate Vitreous Retinal Procedures, 19 years and over, with CC Score 0-1	0	1655	1805
Vitreous Retinal Procedures - category 2	965	0	0
Minor Vitreous Retinal Procedures, 19 years and over	0	816	890
Lens Capsulotomy	450	0	0
Minor, Cataract or Lens Procedures	0	388	423
Major Vitreous Retinal Procedures, 19 years and over, with CC Score 0-1	0	271	296
Oculoplastics category 1: 19 years and over	201	0	0
Glaucoma - category 1	140	0	0
Minor, Glaucoma or Iris Procedures	0	136	148
Minor Oculoplastics Procedures, 19 years and over	0	146	159
Intermediate, Glaucoma or Iris Procedures, with CC Score 0	0	88	96
Digital Retinal Photography, 19 years and over	0	75	82
Minor, Orbit or Lacrimal Procedures, 19 years and over	0	73	80
Intermediate Oculoplastics Procedures, 19 years and over, with CC Score 0-1	0	64	70
Orbits / lacrimal category 1: 19 years and over	52	0	0
Minor Ocular Motility Procedures, 19 years and over	0	41	45
Cornea / Sclera - category 1	32	0	0
Minor Skin Procedures, 13 years and over	0	22	24
Intermediate Skin Procedures category 2 without CC	21	0	0
Major Oculoplastics Procedures, 19 years + with CC Score 0-1	0	16	17
Intermediate, Orbit or Lacrimal Procedures, 19 years and over, with CC Score 0	0	7	8
Minor, Cornea or Sclera Procedures	0	3	3
Oculoplastics category 1: 18 years and under	3	0	0
Electrocardiogram Monitoring or Stress Testing	0	2	2
Minimal Nose Procedures, 19 years and over	0	4	4
Major, Glaucoma or Iris Procedures, with CC Score 0-1	0	2	2
Minor Vitreous Retinal Procedures, between 4 and 18 years	0	1	1
Intermediate Skin Procedures, 13 years and over	0	1	1
Grand Total	**12923**	**12714**	**13870**

Table 2 - Ophthalmology outpatient procedures

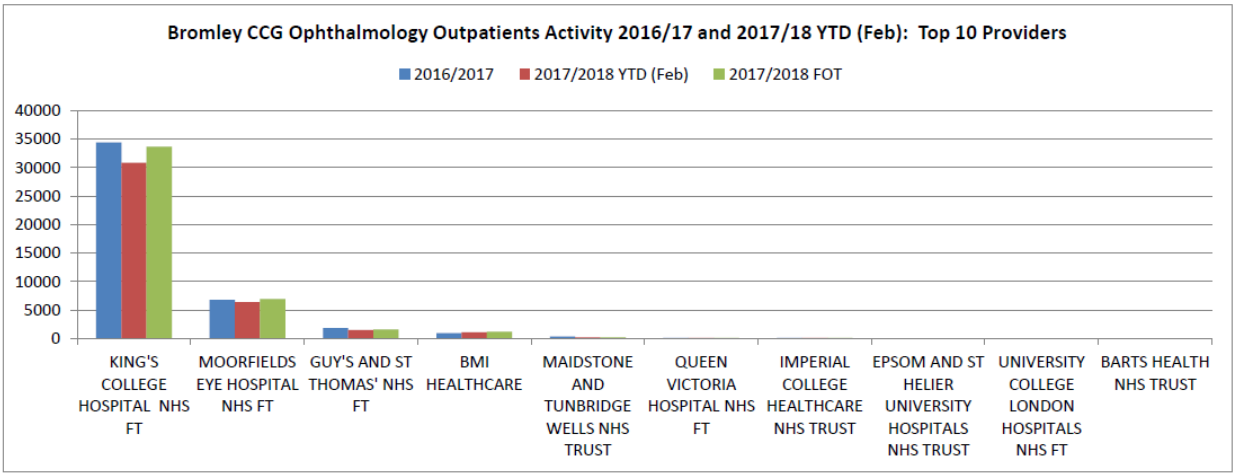


Figure 18 - Ophthalmology outpatients activity

Ophthalmology Outpatients Activity by Top 10 Providers	2016/2017	2017/2018 YTD (Feb)	2017/2018 FOT
KING'S COLLEGE HOSPITAL NHS FT	34420	30862	33668
MOORFIELDS EYE HOSPITAL NHS FT	6829	6399	6981
GUY'S AND ST THOMAS' NHS FT	1887	1486	1621
BMI HEALTHCARE	954	1103	1203
MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	350	227	248
QUEEN VICTORIA HOSPITAL NHS FT	132	116	127
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	112	108	118
EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST	66	56	61
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FT	38	45	49
BARTS HEALTH NHS TRUST	42	44	48

Table 3 - Ophthalmology outpatients activity by provider

Ophthalmology outpatient appointment activity (2016/17 and 2017/18 is broadly the same across all providers, with a small rise for BMI healthcare Figures 18,19,20, Table 4). Ophthalmology activity includes both new and follow-up appointments.

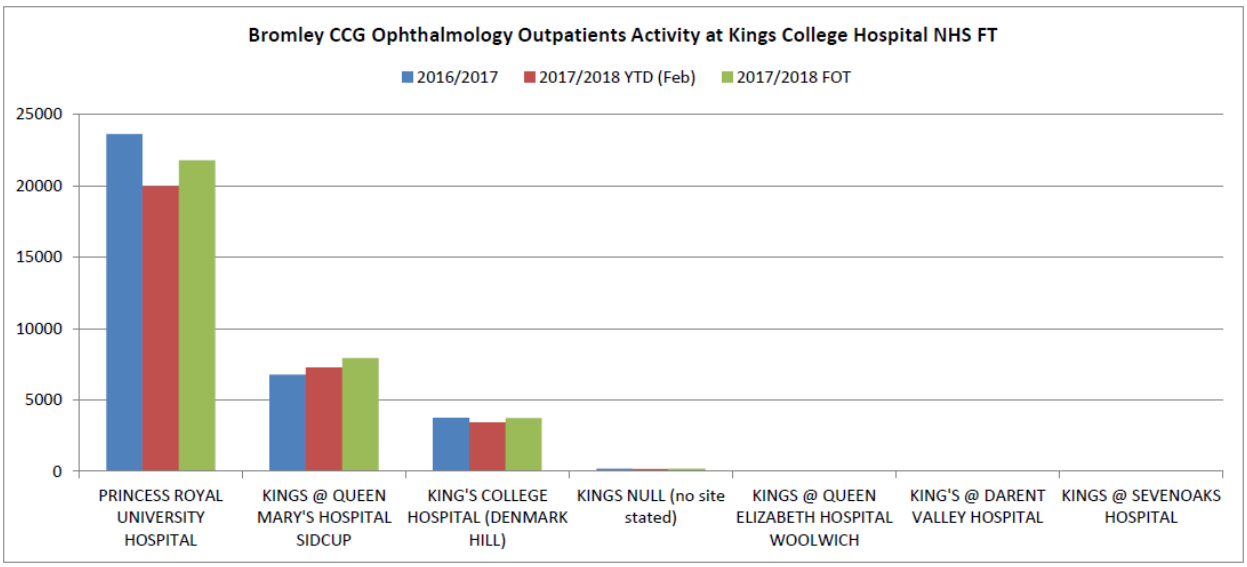


Figure 19 – Kings ophthalmology activity

Ophthalmology Outpatient Activity at KCH 2016/17 and 2017/18 YTD (Feb)			
KING'S COLLEGE HOSPITAL SITES	2016/2017	2017/2018 YTD (Feb)	2017/2018 FOT
PRINCESS ROYAL UNIVERSITY HOSPITAL	23606	19943	21756
KINGS @ QUEEN MARY'S HOSPITAL SIDCUP	6772	7278	7940
KING'S COLLEGE HOSPITAL (DENMARK HILL)	3757	3433	3745
KINGS NULL (no site stated)	191	182	199
KINGS @ QUEEN ELIZABETH HOSPITAL WOOLWICH	42	26	28
KING'S @ DARENT VALLEY HOSPITAL	11	0	0
KINGS @ SEVENOAKS HOSPITAL	41	0	0
Grand Total	**34420**	**30862**	**33668**

Table 4 - Kings ophthalmology activity

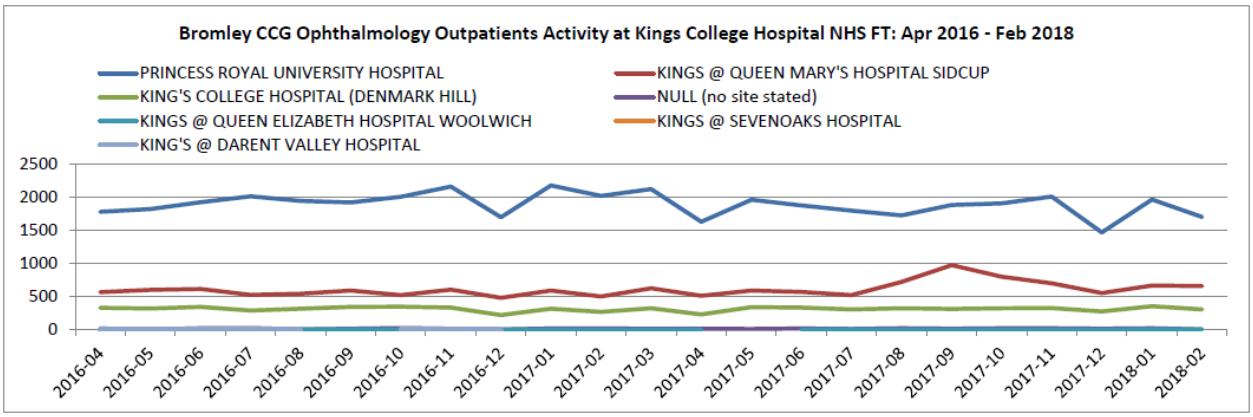


Figure 20 – Kings ophthalmology activity 2016 -2018

Ophthalmology Outpatient Activity by Attendance Type and Top Ten Provider 2016/17					
Provider	First	Follow-up	Procedure	Grand Total	1st: FUP Ratio
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	9157	15886	9377	34420	1:1.7
KINGS @ PRINCESS ROYAL UNIVERSITY HOSPITAL	4377	11599	7630	23606	1:2.6
KINGS @ QUEEN MARY'S HOSPITAL SIDCUP	4166	1892	714	6772	2.20:1
KING'S COLLEGE HOSPITAL (DENMARK HILL)	513	2230	1014	3757	1:4.3
KINGS NULL (no site stated)	53	135	3	191	1:2.5
KINGS @ QUEEN ELIZABETH HOSPITAL WOOLWICH	17	9	16	42	1.89:1
KINGS @ SEVENOAKS HOSPITAL	26	15	0	41	1.73:1
KINGS @ DARENT VALLEY HOSPITAL	5	6	0	11	1:1.2
MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST	1043	3209	2577	6829	1:3.1
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	364	855	668	1887	1:2.3
BMI HEALTHCARE	311	577	66	954	1:1.9
MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	152	161	37	350	1:1.1
QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST	8	111	13	132	1:13.9
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	8	34	70	112	1:4.3
EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS	6	31	29	66	1:5.2
BARTS HEALTH NHS TRUST	7	23	12	42	1:3.3
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FT	7	27	4	38	1:3.9

Table 5 - Ophthalmology outpatients activity 2016/17

Data from 2016/17 (Table 5) to 2017/18 (Table 6) is suggesting that first ophthalmology outpatient appointment activity is very slightly down, but this is not significant. Reductions in referrals from primary care need to continue. This will not reduce overall HES activity but is essential to free up HES capacity in order to avoid harm from potential follow-up appointments delays. HES may need to employ use of virtual clinics to manage their increasing workload.

No serious incidents or complaints were received for the PEC/MECS pilot up to the end of the this audit period.

Ophthalmology Outpatient Activity by Attendance Type and Top Ten Provider 2017/18 YTD (Feb)					
Provider	First	Follow-up	Procedure	Grand Total	1st: FUP Ratio
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	7864	13614	9384	30862	1:1.7
KINGS @ PRINCESS ROYAL UNIVERSITY HOSPITAL	2884	9702	7357	19943	1:3.4
KINGS @ QUEEN MARY'S HOSPITAL SIDCUP	4401	1899	978	7278	2.32:1
KING'S COLLEGE HOSPITAL (DENMARK HILL)	523	1864	1046	3433	1:3.6
KINGS NULL (no site stated)	39	143	0	182	1:3.7
KINGS @ QUEEN ELIZABETH HOSPITAL WOOLWICH	17	6	3	26	2.83:1
KINGS @ SEVENOAKS HOSPITAL	0	0	0	0	0
KINGS @ DARENT VALLEY HOSPITAL	0	0	0	0	0
MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST	1106	2802	2491	6399	1:2.5
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	280	652	554	1486	1:2.3
BMI HEALTHCARE	403	615	85	1103	1:1.5
MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	81	111	35	227	1:1.4
QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST	8	95	13	116	1:11.9
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	7	48	53	108	1:6.9
EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS	6	30	20	56	1:5.0
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FT	4	41	0	45	1:10.3
BARTS HEALTH NHS TRUST	7	23	14	44	1:3.3
Ophthalmology Outpatient Activity by Attendance Type and Top Ten Provider 2017/18 FOT					
Provider	First	Follow-up	Procedure	Grand Total	1st: FUP Ratio
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	8579	14852	10237	33668	1:1.7
KINGS @ PRINCESS ROYAL UNIVERSITY HOSPITAL	3146	10584	8026	21756	1:3.4
KINGS @ QUEEN MARY'S HOSPITAL SIDCUP	4801	2072	1067	7940	2.32:1
KING'S COLLEGE HOSPITAL (DENMARK HILL)	571	2033	1141	3745	1:3.6
KINGS NULL (no site stated)	43	156	0	199	1:3.7
KINGS @ QUEEN ELIZABETH HOSPITAL WOOLWICH	19	7	3	28	2.83:1
KINGS @ SEVENOAKS HOSPITAL	0	0	0	0	0
KINGS @ DARENT VALLEY HOSPITAL	0	0	0	0	0
MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST	1207	3057	2717	6981	1:2.5
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	305	711	604	1621	1:2.3
BMI HEALTHCARE	440	671	93	1203	1:1.5
MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	88	121	38	248	1:1.4
QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST	9	104	14	127	1:11.9
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	8	52	58	118	1:6.9
EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS	7	33	22	61	1:5.0
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FT	4	45	0	49	1:10.3
BARTS HEALTH NHS TRUST	8	25	15	48	1:3.3

Table 6 - Ophthalmology outpatients activity 2017/18

All Bromley CCG Ophthalmology Outpatient Activity by Source of Referral			
Source of Referral	2016/2017	2017/2018 YTD (Feb)	2017/2018 FOT
Referral from a general medical practitioner	26180	23531	25670
Referral from a consultant, other than in an accident and emergency department	6953	6282	6853
Self-referral	3838	3428	3740
Referral from an accident and emergency department (including minor injuries units and walk in centres)	2809	2608	2845
Other - not initiated by the consultant responsible for the consultant out-patient episode	3048	2595	2831
Other - initiated by the consultant responsible for the consultant out-patient episode	1189	1220	1331
Following an accident and emergency attendance (including minor injuries units and walk in centres)	455	380	415
Referral from an optometrist	393	385	420
Referral from a national screening programme	139	166	181
Referral from an allied health professional	20	24	26
Following an emergency admission	31	45	49
Referral from a general dental practitioner	8	6	7
Referral from an orthoptist	12	7	8
Following a domiciliary consultation	14	8	9
NULL	2	2	2
Referral from a community dental service	0		0
Referral from a prosthetist	0	1	1
Referral from a specialist nurse (secondary care)	1	1	1
Grand Total	**45092**	**40689**	**44388**

Table 7 - Ophthalmology activity by source

Table 7 reporting is misleading as optometrist referrals are a primary source for at least 75-80% of referral activity by GPs.

9 Summary of actions for remainder of pilot

Based on a review of data, documentation and feedback, the following actions should be implemented for the duration of the eye care pilot:

ACTION 1: Further stakeholder engagement and communication with GP practices is required to promote the appropriate use of the MECS service.

ACTION 2: Activity appears to be to plan (Table 1, Appendix A), but there is a need to understand unwarranted variation of source of activity for two sites for conversion from sight test/ eye examination (Figures 5 & 6). This may be a reporting issue but requires the sharing of comparative data and discussion with the provider sites to ensure correct recording of episodes. [The Standard Operating Procedure for MECS practices has been updated to highlight scenarios of presentations which would apply].

ACTION 3: Implementation of glaucoma repeat measures (filtering) within MECS practices should be followed up as part of the contract.

ACTION 4: Need to maximise the capture of unrefined referrals via the SPA triage (sourced from GP referrals, and referrals sent to GP by non-MECS accredited (or locum) optometrists for onward referral to HES (both within and outside the CCG boundary). This includes any unrefined referrals from MECS practices (e.g. where glaucoma filtering has not been undertaken). Need to ensure completeness and readability of referral correspondence (includes visual fields) on e-RS.

ACTION 5: Attempt to minimise waits >4 weeks to ensure any 'referrals on' to the HES can be seen within the required 18 weeks target.

ACTION 6: All referrers to MECS to receive an outcome letter from MECS optometrist. Also, GPs **AND** optometrist referrers to receive an outcome letter from the MECS optometrist for any patient seen as a result of SPA triage.

General observations on referral quality and feedback loop:

- Good communication including referral feedback and information sharing are important in any integrated clinical pathway.
- Good quality referral information enables signposting of the patient into the appropriate community clinic or ophthalmology sub-speciality clinic at the first attempt. This reduces the number of appointments for the patient, improving the efficiency of the pathways.
- As more optometrists are now the primary referrer on e-RS, HES feedback or discharge summary letter should be to the referring optometrist and copied to the GP ***Action for CCG Contract board*** *– seek HES replies to referring optometrist, consider contractual requirement, trusts to add all SEL optical practices, and their addresses and contact details to their systems.*
- There should be more opportunities to bring together all practitioners involved in eye care for periodic Continuous Professional Development (CPD) sessions e.g. feedback on referrals, the type of information is most useful in a referral letter, current pathways and treatments for eye conditions and referral timescales for acute eye conditions.
- The SPA should make direct links with the SEL Diabetic eye screening programme (DESP). Greater communication between providers could reduce optometrist referrals for non-sight-threatening retinopathy for patients already under screening.
- SEL DESP to encourage patients to take eye screening result letter to NHS sight test.
- Pilot use of e-RS for advice and guidance.

10 Recommendations for April 2019 onwards

Recommendations and considerations for a future procurement/ contract specification:

RECOMMENDATION 1: Clarity over terminology: consider using 'Bromley Eye Care Services' in a new procurement as the title of the **overall contract specification**. MECS would still be outward facing for GPs and the main entry point for patients. Future contracts need to be flexible to include a wider range of services, as there are opportunities for further services to be added as the workforce develops e.g. cataract post-operative care, OCT for refinement of suspect retinal conditions. Service models are already developing into lower levels of community ophthalmology, and there is significant scope for stable AMD and stable glaucoma monitoring; these would not be considered appropriate under a 'minor condition' service (MECS).

RECOMMENDATION 2: The coverage map (Figure 3) suggests that additional PEC sites should be considered: one in Bromley, one in West Wickham and two in the Beckenham area, in order to provide improved access for patients, referrals from GP practices and cover for holidays**.** Over time, more local optical practices should be able to offer MECS and repeat measures, but optometrists managing low-risk referrals from SPA need to develop a greater level of skills and experience.

RECOMMENDATION 3: Quarterly meetings involving commissioners and providers to focus on the development of community ophthalmology service model involving primary and HES providers. Communication and closer liaison between primary eye care lead and HES lead. This could involve direct contact as required and separate one-to-one meetings to improve local issues.

RECOMMENDATION 4: Community ophthalmology model will require further development around failsafe (tracking of patients and outcomes) and workforce planning and training (e.g. informed by risk stratification of pathways) to provide assurance. The SPA could be used as a step-down route to provide such failsafe.

CONSIDERATION 1: Failsafe Action 3 on Demand and Capacity review should highlight issues requiring SAFE system changes, any contract to include review dates for changes to service specification.

CONSIDERATION 2: Alignment and agreement of SEL whole system wide pathways (priority) e.g. risk stratification of Glaucoma pathway, as per NICE guidance and Cataract post-assessment/ NOD data as recommended in Monitor productivity report 2015. Wherever possible, there should be alignment of PEC service specifications and related exclusion criteria.

CONSIDERATION 3: SEL governance arrangements should include procedures for prospective evaluation of the design and delivery of whole eye care pathways (across primary, secondary and social care) which demonstrate: more appropriate and effective patient management, patient safety, clinical audit, competence of the workforce, and high levels of patient experience.

CONSIDERATION 4: Include Healthy Living Opticians within next PEC specification where optical practices are able to offer, or direct to: Smoking Cessation Services. Alcohol Screening, NHS Health Checks including glucose testing and cholesterol, Weight Management. Health Living Opticians is a strategy that started in the borough of Dudley which has gained national attention. http://dudleyhlo.co.uk/wp-content/uploads/2015/10/Dudley-HLO-Prospectus-FINAL.pdf

and promote South London Innovation Network - VISIBLE recommendations to link vison and falls services. *https://healthinnovationnetwork.com/visible/*

11 Conclusions

1. The Bromley CCG eye care pilot is mid-way through its contract period and has already made an impact on improving referral quality and reducing inappropriate referrals.

2. This report highlights the benefits of the PEC service model with SPA function and provides actions for the current pilot and recommendations for full procurement at a future date.

3. More engagement and communication are necessary to promote the MECS service to GPs, to optometrists (outside the PEC service) and to patients. These are similar findings to Cottier (2015).[30]

4. Contract monitoring should continue to inform any future procurement decisions.

5. This area of service redesign is still evolving. Future developments are possible and desirable. Any future contract should be flexible with regular annual reviews to allow for the development and roll out of further eye care initiatives.

6. Action 3 of HII requires CCGs/STP leaders to undertake an eye health capacity review in 2018 in order to understand the demand for eye services; the outcomes of this exercise should inform a wider eye health strategy for SEL.

7. It is too early to generate financial assumptions based on six-months data in year 1, but the report's findings are extremely encouraging. Assuring local HES capacity must remain a priority, improving flows within the whole pathway by 1) reducing unnecessary referrals and 2) allowing step-down for the management of patients with stable long-term eye conditions.

8. HES to provide feedback and communication with primary eye care by sending the outcome letter to the referring optometrist/ optical practice. A reply to the primary referrer is necessary for continuity of care (ophthalmologist to confirm patient consent at the end of the ophthalmology appointment). HES to report examples of unwarranted referral variation by source to the CCG. All optical practices should be encouraged to use NHS.mail and this would facilitate the receiving of referral outcome letters. HES would require a database containing information of all SEL optical practices.

9. Step-down or community ophthalmology pathways require system agreement by all relevant stakeholders. Actions 1 and 2 from the failsafe audit should assess follow-up patients according to risk. Some of the low-risk patients may be suitable for discharge, while other low-risk stable patients may be more suitable for community monitoring by a multi-professional team.

10. Data from the two-year pilot should be used as the basis for a research paper highlighting the integrated approach of the PEC framework, and the use of MECS in the wider context of triage and managing unwarranted variation.

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13 Glossary

The following definitions are taken from the CCEHC SAFE documents.

Service System

A service system includes the range of pathways of care delivering services that may involve multiple providers and settings, to address the health needs of a defined patient population or condition.

General Ophthalmic Service (GOS)

The GOS is commissioned by NHS England. This contracts primary care opticians' practices to provide NHS sight tests for preventative and corrective eye care for children, people aged 60 and over, adults on low incomes and those suffering from, or predisposed to, eye conditions and diseases.

Primary Eye Care Framework

This service is commissioned by CCGs. It includes supplementary services that are necessary **prior to referral** for specialist ophthalmic opinion (usually within the Hospital Eye Service), thereby improving the quality of referrals. A primary eye care service will typically include the ability to:

- conduct supplementary checks to confirm abnormal test results (detected by a NHS eye test / eye examination) e.g. repeat measures as outlined in NICE Glaucoma Guideline NG 81.
- further refine the decision to refer e.g. where risks and benefits are discussed with the patient prior to referral for cataract surgery
- address the needs of a patient presenting with an acute eye condition (first contact)
- manage a range of low-risk primary eye conditions

Community Ophthalmology Framework

This service is commissioned by CCGs. It involves the assessment and management of patients whose eye conditions are at low-risk of deterioration who are **either referred by primary care for further assessment or discharged from secondary care for monitoring**, in order to release capacity and improve patient flows within the system. It has some or all of the following characteristics:

- the ability to make definitive diagnoses to manage and treat the majority of cases referred into it
- be effective as a monitoring service for patients at risk of their condition deteriorating asymptomatically
- provides an access point for patients with recurrent symptomatic disease.

Hospital Eye Service

This service is commissioned by CCGs. It provides specialist ophthalmic services for acute and chronic care for diagnosis, intervention and management; and emergency and urgent eye care.

Appendix A – Service activity data

BMECS 2017-18

Triaged to service or booked to

Total number of patient episodes incl. 1st appointments awaiting

Number of patients seen in each pathway

Number of follow-ups by pathway

Number of onward referrals after being seen in BMECS

Number of patients seen within 4 weeks – KPI 90%

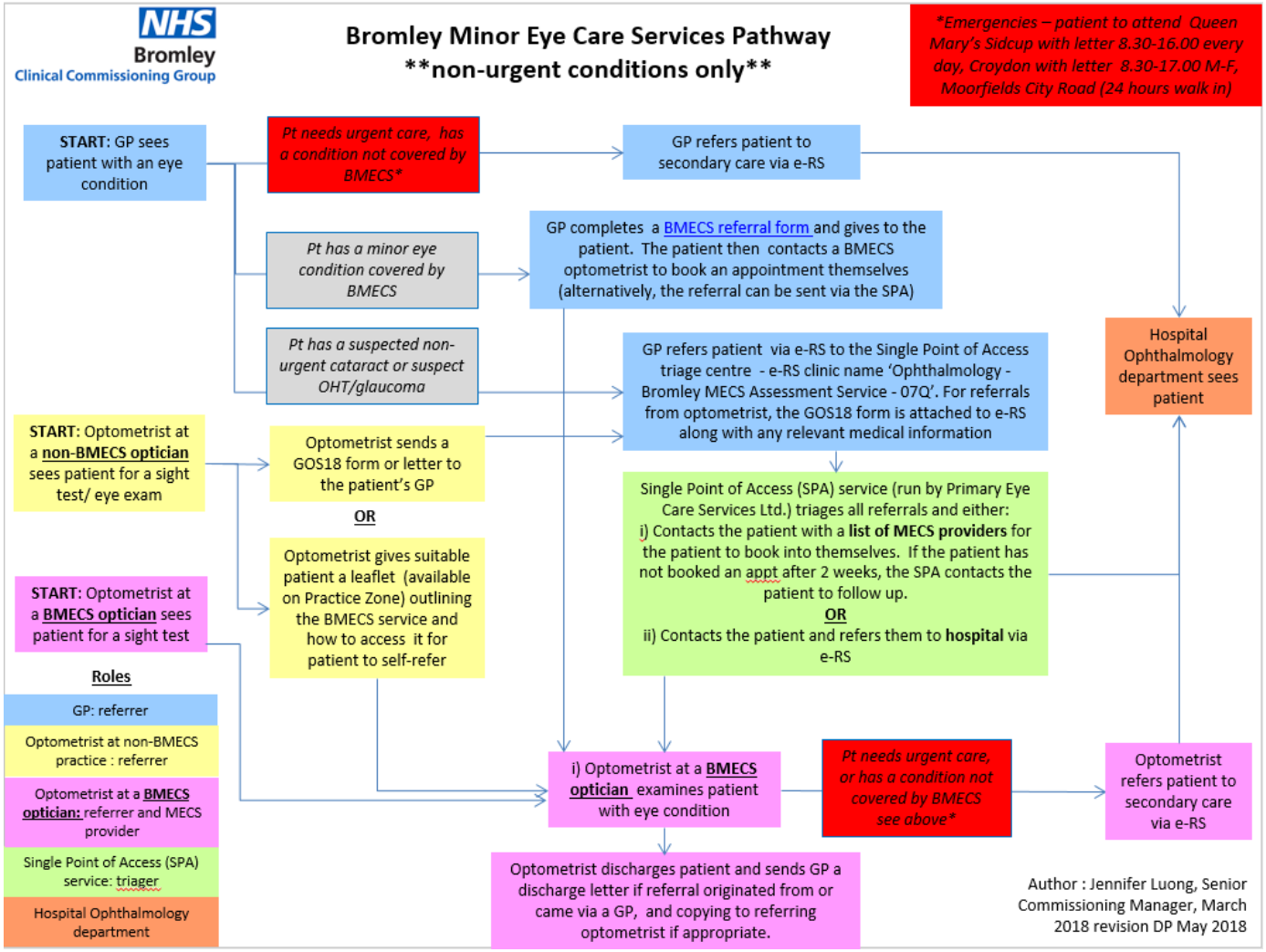
Number of DNAs

Number of discharge summaries sent to GP within 5 working days

Month	SPA	Referred to:		Total px episodes	Px seen				Follow-ups (booked)								Onward referrals						<4 weeks		DNA		Discharge summaries	
		Sec Care	BMEC		MECS (1st+fu)	MECS 1st	Glauc	Cat	MECS	%	Glauc	%	Cat	%	Total fu (KPI <30%)	%	MECS	%	Glauc	%	Cat	%	Activity	%	Activity	%	Activity	%
April																												
May				17																								
June				23																								
July				75																								
Aug				118																								
Sept	221	163	58	124	108	101	7	13	15	15%	1	14%	0	0%	16	13%	24	22%	0	0%	8	62%			0	0%	43 / 70	61%
Oct	301	240	61	196	155	138	21	20	18	13%	2	10%	0	0%	20	10%	26	17%	7	33%	19	95%	186	95%	0	0%	59 / 64	92%
Nov	343	226	117	248	184	170	29	35	17	10%	1	3%	0	0%	18	7%	28	15%	11	38%	32	91%	236	95%	0	0%	66 / 68	97%
Dec	236	179	57	200	163	149	23	14	17	11%	2	9%	0	0%	19	10%	28	17%	2	9%	12	86%	194	97%	0	0%	70 / 70	100%
Jan	293	230	63	296	240	223	32	24	41	18%	9	28%	0	0%	50	17%	37	15%	6	19%	20	83%	290	98%	0	0%	67 / 75	89%
Feb	235	181	54	293	245	223	28	20	21	9%	2	7%	0	0%	23	8%	38	16%	7	25%	20	100%	285	97%	0	0%	60 / 70	86%
Mar	240	189	51	370	287	269	50	33	44	16%	6	12%	0	0%	50	14%	44	15%	13	26%	28	85%	336	91%	0	0%	97 / 104	93%

Appendix B – GP/ Optometrist Pathway

Updated May 2018



Appendix C Standard Operating Procedure for MECS practices

Patients self-referring or directed by GP to MECS

Patients may self-refer, typically for the eye conditions below, or be directed by a GP or other health care professional. They should be booked with appropriate timescales based on presenting symptoms.

Patients converted from sight test to MECS

If it becomes clear during a NHS sight test that a patient is presenting with conditions such as:

- Red eye
- Sticky, yellow or watery discharge
- Pain or discomfort in eyes
- Recent onset or sudden increase of flashes of light and/or floaters

and it is more appropriate for the patient to be seen in the MECS pathway, then the NHS sight test should be abandoned and a MECS assessment completed. The NHS sight test if still needed can be re-booked for another occasion. If the MECS examination finds the need for the measurement of IOP by GAT on first occasion or cataract refinement, these should be done within and as part of the MECS appointment and not as a separate claim.

Addition to the sight test

If the patient need to be assessed for cataract referral or needs glaucoma repeat measures, then this is to be carried out as an addition to the sight test. Repeat measures may require the patient to return on another occasion.

Important: if a patient is seen by a non-accredited practitioner (e.g. newly qualified or locum) in a MECS Practice but is deemed suitable for one of the pathways, then they should be referred within the practice for the MECS, cataract, or glaucoma repeat measures assessment to take place as per contract.

Patients referred from triage

Patients who have been referred to hospital will be triaged by an optometrist at the Single Point of Access (SPA). If the patient is deemed suitable to be seen in the MECS service, then they will be sent a letter (overleaf) offering a choice of providers. The patient will then phone their choice of provider to make an appointment. You can check that the patient has come from this source by asking for their UBRN number.

To access the original referral, those who have smartcards and have received training, will be able to retrieve from the e-referrals system. Those who are not at this stage will need to request the information from the SPA. This should be requested by email to broccg.bbgspa@nhs.net with as much notice as possible. The request should include the patient's name, date of birth, and UBRN as well as the date and time of appointment. The original referral information will be emailed back along with the triager's comments.

Onward referrals

Those with smartcards that have received training will be able to refer direct on e-RS. Those who are not should email any onward referrals to broccg.bbgspa@nhs.net who will process this on your behalf. Please note in your email which clinic the patient should be referred to.

Urgent referrals

Any urgent referrals that are not same day (i.e. possible wet AMD) should be emailed directly to the PRUH or QMS using an nhs.net email address

The email needs to be marked **** URGENT OPHTHALMOLOGY REFERRAL AGREEMENT TO REFER OUTSIDE E-RS **** NAME – DOB

For PRUH: kch-tr.br-referrals@nhs.net

For QMS (Queen Mary Sidcup): Kch-tr.urgenteyesqms-referrals@nhs.net

Queries

Please direct any queries for broccg.bbgspa@nhs.net or call 020 3876 4931

Appendix D Patient invite letter

<<date4>>

Dear <<Title>> <<Surname>>

UBRN Number: <<UBRN>>
Password: <<password>>

We have recently received a referral letter for you from your GP/optometrist. We are pleased to let you know that your condition has been deemed suitable for the specialist clinics run by the Bromley Minor Eye Conditions Service.

The Bromley Minor Eye Conditions Service provides patients experiencing certain eye conditions with appropriate treatment closer to home. The service is provided by local optometrists with the specialist knowledge and skills to carry out this work at a locally approved optical practice.

All you need to do is call one of the approved opticians practices listed overleaf and book yourself an appointment. You will require your UBRN number and password as detailed above.

It is imperative when contacting the opticians to make an appointment that you state that you have been referred by your GP/optometrist and you are to be seen under the Bromley Minor Eye Conditions Service.

Yours sincerely

Bromley Eye Care Services
Tel: 020 3876 4931

Appendix E Booking a MECS appointment

Booking of Bromley Minor Eye Conditions Service (BMECS) appointment

Please contact one of the local optometrists listed below, who will offer you an appointment. Inform the optometrist's receptionist that this is a request for a BMECS appointment and be sure to take this referral form with you when you attend.

Please note that as part of your examination, eye drops may be used to enable examination of the eyes. If drops are used, they will temporarily affect the ability to focus properly so you will not be able to drive for approximately 4 hours after your eye examination or until your vision has recovered. Your eyes may also, temporarily, become more sensitive to light so you may wish to wear sunglasses to relieve this.

Hayes Optical - Boots Opticians 2 Station Buildings, Station Approach, **Hayes**, Kent BR2 7EN Tel No: 020 8462 5332 *BMECS service availability: Monday to Saturday: 9pm to 5pm*	**Boots Opticians** 40 The Glades, **Bromley**, BR1 2QG Tel No: 020 8460 4944 *BMECS service availability: Monday to Friday: 9am - 5.30pm*
Boots Opticians 232 High Street, **Orpington**, Kent BR6 0LS Tel No: 01689 820848 *BMECS service availability: Tuesday, Wednesday, Thursday & Saturday: 8.30am–5pm*	**Boots Opticians** 115 Station Road, **West Wickham**, Kent BR4 0PX. Tel No: 020 8777 2211 *BMECS service availability: Monday, Tuesday, Wednesday, Thursday & Saturday: 9am-12pm & 2pm–5pm, Friday: 9am–12pm & 3pm–5pm*
Linklater & Warren Opticians 30A High Street, Chislehurst, **Bromley**, Kent BR7 5AN Tel: 020 8295 5131 *BMECS service availability: Monday-Friday: 9am - 5.30pm, Saturday: 9am -2pm*	**Oakmead Opticians** Sunnyways, Prince Imperial Rd, **Chislehurst** BR7 5LX Tel: 020 8467 5139 *BMECS service availability: Mon 8am-7.30pm, Tue 8am-7pm, Wed 8.30am-8pm, Thurs 10am-8pm, Fri 8am-5.30pm, Sat 9am -1pm*
Ellis & Edwards Opticians 254 High Street, **Beckenham**, Kent BR3 1DZ Tel: 020 8658 2313 *BMECS service availability: Monday, Thursday and Friday 9am to 4pm.*	**Specology** 160 Main Road, Biggin Hill, Kent, TN16 3BA Tel: 01959 9280 *BMECS service availability: 9am to 5pm Tuesday to Friday; 10am to 4pm Saturday (closed Monday and Sunday)*
Specsavers 169 High St, **Orpington**, Kent BR6 0LW Tel: 01689 890168 *BMECS service availability: Monday, Tuesday, Wednesday, Friday and Saturday: 9.30am-5pm*	

Appendix F NHS e-RS ophthalmology booking guidance

Ophthalmic clinics

There are 13 possible clinic types within the HES that Ophthalmic patients can be referred into. If there is more than one appropriate clinic i.e. patient has Cataract and Glaucoma please direct into the one you are most concerned about.

List of possible clinics:

Oculoplastic/Orbits/Lacrimal	Cornea	Cataract
Laser (YAG)	Vitreoretinal	Diabetic Medical Retina
Other Medical Retina	Glaucoma	Low Vision
Orthoptics	Squint/Ocular Motility	External eye disease
Oncology (established diagnosis)		

****Please note DO NOT USE "not otherwise specified". There is also no option to book into neuro-ophthalmology. Please choose most suitable so that patient is seen in the HES.**

e-Referrals can have one of 2 possible outcomes:

Urgent (6 weeks)	Routine (13 weeks)

There is no option for "soon". Once a hospital receives a referral it may bring that referral forward after carrying out its own triage.

Those referrals which require to be prioritised as more urgent referrals (ie those to be seen within 2 weeks e.g. suspect wet AMD) are emailed direct to either PRUH or QMS.

[For same day emergency referrals, patients need to be directed with a letter to the most appropriate site – QMS rapid access clinic with letter or a walk-in hospital eye casualty].

The email needs to be marked **** URGENT OPHTHALMOLOGY REFERRAL AGREEMENT TO REFER OUTSIDE E-RS **** NAME – DOB

For PRUH: kch-tr.br-referrals@nhs.net

For QMS (Queen Mary Sidcup): Kch-tr.urgenteyesqms-referrals@nhs.net

Issues with booking into e-RS

Some clinics are not what we think they are…

If you see referrals for the following, please can you book into these clinics:

Clinic type on e-RS	Conditions covered
Cornea	Anything corneal related
Oculoplastics	Entropion, ectropion, ptosis, lid lesions i.e cysts etc and bells palsy
External eye disease	Corneal, external eye disease, conjunctival conditions (does not cover cysts, lumps and bumps and lacrimal/lid misposition)

Appendix G Triage guidance

Condition	Referral Criteria
Cataracts	VA of 6/12 or worse in either eye OR Symptomatic AND Ideally, patient has indicated they want to have surgery
Glaucoma	NICE IOP referral criteria on IOP alone is 24mmHg or above by Goldmann-type tonometry as per NICE guidelines Nov 2017) NCT between 24 and 29mmHg, and no other signs, refer to MECS optom for enhanced case finding using Goldmann tonometry. Refer on if average IOP by any other method is over 29mmHg. Other referral criteria: Repeatable field defect by suprathreshold visual fields– refer on, Refer to MECS optom is visual field defect is only found on FDT and NCT IOP is between 24 and 29mmHg inc. Disc asymmetry and signs of glaucoma disc change is not just about CD ratio but barring of blood vessels, ISNT not met. Disc haem - refer Narrow angles – refer on for gonioscopy
Dry AMD	Presence of oedema, haemorrhages Symptoms of metamorphopsia Sudden reduction in vision
Naevi	All suspicious lesions to be referred (additional referral guidance required – after further discussion with Kings/ G&T) Descriptions of large and elevated, location in relation to the Optic Disc
Flashes and Floaters	If referral is from GP/ Optom and there has been no dilated fundal examination using SL-BIO, refer to MECS 24hrs, If onset is within 4 weeks of referral date and patient has already had dilated assessment and has been referred– refer URGENT If onset over 4 weeks (any source) refer into MECS (< & > 4 weeks requires further discussion with Kings/ G&T)
Keratoconus	Refer into HES
Styes and Cysts	Refer into MECS – only to be referred when treatment has not worked.
Blepharitis and Dry Eye	Refer into MECS only if recent onset – to be referred to HES if longstanding (e.g. over 3 months) when compresses and/or other treatments have not worked.
Orthoptics	This is with team of orthoptists only – this is not a consultant led service – if patient requires further investigation into squint, diplopia etc please book into Squint/Ocular Motility clinic
Blurred disc margins	Very urgent referrals (requires further discussion with Kings/ G&T)

With any referral please use your clinical judgement to decide upon most appropriate course of action for patient.

Evidence for the Action[30]

Immediate referral to ophthalmology - Evidence for change

Management: How should I manage a person with suspected retinal detachment?

The urgency of specialist assessment depends on whether there are changes in visual acuity, visual field loss, or signs seen on fundoscopy.

- ***If the person is experiencing new-onset flashes and/or floaters, refer them immediately to an ophthalmologist to be seen on the same day*** *if there are signs of sight-threatening disease, such as:*
  - *Visual field loss (such as a dark curtain or shadow), or distorted or blurred vision.*
  - *Fundoscopic signs of retinal detachment or vitreous haemorrhage.*
- ***If the person is experiencing new-onset flashes and/or floaters, refer them urgently to a practitioner competent in the use of slit lamp examination and indirect ophthalmoscopy, to be seen within 24 hours*** *if there is:*
  - *No visual field loss.*
  - *No change in visual acuity.*
  - *No fundoscopic signs of retinal detachment or vitreous haemorrhage.*
- ***Considering offering the person a patient information leaflet*** *about retinal detachment and the early warning signs of possible future retinal tear or detachment, such as that published by the Royal College of Ophthalmologists and the Royal National Institute of Blind People Understanding retinal detachment.*

Immediate referral to ophthalmology

- *The recommendation to refer a person immediately to ophthalmology if they present with signs of sight-threatening disease is based on expert opinion in the College of Optometrists Guidance for professional practice [The College of Optometrists, 2014], the Local Optical Committee Support Unit Flashes and Floaters Management Guidelines [LOCSU, 2013], and expert opinion in a number of review articles [Gariano and Kim, 2004; D'Amico, 2008; Kang and Luff, 2008].*
  - *Signs of a visual field defect but preserved visual acuity suggests that the macula is not yet detached, and early intervention with timely surgery may prevent macular detachment and improve visual outcomes [Gariano and Kim, 2004].*
  - *If the person presents with vision loss, this suggests retinal detachment or vitreous haemorrhage is present, and signs of retinal break or detachment are likely, so the person should be assessed urgently by ophthalmology [LOCSU, 2013].*

Urgent assessment by a practitioner competent in the use of slit lamp examination and indirect ophthalmoscopy

- *The recommendation to refer a person urgently to a competent practitioner within 24 hours if they present with only floaters and/or flashes and no other signs or symptoms is based on expert opinion in the Royal College of Ophthalmologists guidance Management of acute retinal detachment [Royal College of Ophthalmologists, 2010], in the Local Optical Committee Support Unit Flashes and Floaters Management Guidelines [LOCSU, 2013], and in a British Medical Journal review article Management of retinal detachment: a guide for non-ophthalmologists [Kang and Luff, 2008].*
    - *Retinal breaks and tears may initially present with symptoms of flashes and/or floaters, and early detection and treatment may prevent subsequent retinal detachment. Retinal detachment cannot be excluded using direct ophthalmoscopy in primary care, as this gives a narrow field of view. Specialist slit lamp examination is needed to look for pigment cells within the vitreous and vitreous haemorrhage, and indirect ophthalmoscopy is needed to examine the peripheral retina fully to determine whether posterior vitreous detachment, retinal breaks, or retinal detachment are present [Kang and Luff, 2008; Royal College of Ophthalmologists, 2010].*
    - *Competent practitioners can check for retinal breaks, tears, or detachment without the need for initial ophthalmology assessment if the person presents with non-sight-threatening symptoms and signs.*

Offering patient information

- *The recommendation to consider offering the person a patient information leaflet about retinal detachment and its early warning signs is based on expert opinion in the College of Optometrists Guidance for professional practice [The College of Optometrists, 2014], the Local Optical Committee Support Unit Flashes and Floaters Management Guidelines [LOCSU, 2013], and is based on what CKS considers to be good medical practice.*

Appendix H Patients not booked SOP

Similar arrangements should be agreed across all 6 CCGs.

Bromley

MECS appointments

- After 4 weeks, patient to be called up to 3 times
- If patient has been seen or no longer requires appointment they will be either allocated to the practice they were seen at on e-RS or cancelled on e-RS
- If patient still wishes to be seen, they will be given UBRN etc if needed
- If patient cannot be contacted by phone, letter stating that they will be considered not to require their appointment unless they contact the SPA within 2 weeks
- If still no contact, patient removed from e-RS and GP advised

Hospital choice given

- Patient receives to automated reminders from e-RS
- After 3 months, patient removed from e-RS and GP written informed

Appendix I Service specification (separate file)