NHS
Bury
Clinical Commissioning Group

Meeting: Primary Care Commissioning Committee

Meeting Date	23 May 2018	**Action**	Approve
Item No.	12	**Confidential**	No
Title	Minor Eye Conditions Service (MECS) update		
Presented By	Margaret O'Dwyer, Director of Commissioning and Business Delivery		
Author	Catherine Tickle, Commissioning Programme Manager Daniel Cooke, Clinical Lead, Elective Care		
Clinical Lead	-		

Executive Summary

This paper provides Primary Care Commissioning Committee with further information on the Minor Eye Conditions Service (MECS) commissioned by the CCG, following an initial recommendation from the Finance Task and Finish Group, as part of the financial mitigation work, to consider ending the current contract (expired 1st May 2018).

The paper outlines the work undertaken by the CCG in an attempt to validate the data shared by the provider, which shows a reduction in outpatient activity between 2013/14 and 2016/17, which the provider is attributing to the MEC Service. Given the limitations of the SUS data, the CCG BI and Finance team have been unable to account for the reduction in outpatient activity, therefore it is prudent to assume there is a likelihood the service has made a contribution to the reduction.

The GM position is reflected in the paper and highlights the intended direction of travel across GM in building the primary eye care service framework proposal, as part of the GM Primary Care strategy and commissioning plans for a foundation level offer of eye health services in primary care optical practices across GM. This is supported via a positive Independent Cost Benefit Analysis (CBA) and the proposal is for GM Commissioners to commission this collaboratively.

Some high levels assumptions have therefore been made in the paper based on a clinical review of the MECS activity to estimate the impact of not continuing the service. Based on the data analysis the recommendation in the paper is to; continue to commission the service until the GM direction of travel is confirmed, in terms of the primary eye care service framework proposal. During this period it is proposed that Commissioners begin negotiations with the provider to explore opportunities to reduce the cost envelope for the current service (2018/19). It is also recommended that MECS is incorporated into the wider review of Ophthalmology services being undertaken by the CCG, to inform the future service model(s) and CCGs future commissioning intention.

It is believed that there is an opportunity to re-design the current service to realise some efficiencies and further enhance patient outcomes. The CCG is exploring opportunities to work collaboratively with key partners to undertake this work.

Recommendations
It is recommended that the Primary Care Commissioning Committee: o Continue to commission the service until the GM direction of travel is confirmed, in terms of the primary eye care service framework proposal. o Begin negotiations with the provider to explore opportunities to reduce the cost envelope for the current service (2018/19). o Incorporate the MEC service into the wider review of Ophthalmology services being undertaken by the CCG, to inform the future service model(s) and CCGs future commissioning intentions.

Links to CCG Strategic Objectives	
To empower patients so that they want to, and do, take responsibility for their own healthcare. This includes prevention, self-care and navigation of the system.	☐
To deliver system wide transformation in priority areas through innovation	☒
To develop Primary Care to become excellent and high performing commissioners	☐
To work with the Local Authority to establish a single commissioning organisation	☐
To maintain and further develop robust and effective working relationships with all stakeholders and partners to drive integrated commissioning.	☐
To deliver long term financial sustainability in partnership with all stakeholders through innovative investment which will benefit the whole Bury economy.	☒
To develop the Locality Care Organisation to a level of maturity such that it can consistently deliver high quality services in line with Commissioner's intentions.	☐
Supports NHS Bury CCG Governance arrangements	☐
Does this report seek to address any of the risks included on the Primary Care Commissioning Committee Assurance Framework? If yes, state which risk below:	

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☒	No	☐	N/A	☐
If you have ticked yes provide details here. Delete this text if you have ticked No or N/A						
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☒	No	☐	N/A	☐
Pausing the service may impact on patient experience as the CCG will no longer provide patients with a standalone MEC service to which they can self-refer. The patient will however still be able to access support via other primary care services (GP and local pharmacy). Working with the current provider to re-design the service as part of a wider review of ophthalmology may present some conflict of interest that will be managed internally as would						

any work with a provider.						
Are there any financial Implications?	Yes	☒	No	☐	N/A	☐
The finance impact of pausing the scheme cannot be accurately calculated due to a lack of available data so assumptions have been made.						
Has a Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☒	N/A	☐
Is a Equality, Privacy or Quality Impact Assessment required?	Yes	☒	No	☐	N/A	☐
Are there any associated risks?	Yes	☒	No	☐	N/A	☐
Are the risks on the CCG's risk register?	Yes	☐	No	☒	N/A	☐
Risks associated with the recommendation have been included in the paper and are dependent upon the decision of the Governing Body. The risks will be reviewed and added to the relevant risk register where appropriate.						

Governance and Reporting		
Meeting	**Date**	**Outcome**
Name of meeting		These boxes are for recording where the report has also been considered and what the outcome was. This will include internal meetings like SMT.
		If the report has not been discussed at any other meeting, these boxes can remain empty.

Finance Mitigations: Minor Eye Conditions Service (MECS) Review

1. Introduction

1.1. This paper provides Primary Care Commissioning Committee with further information on the Minor Eye Conditions Service (MECS) commissioned by the CCG, following an initial recommendation from the Finance Task and Finish Group, as part of the financial mitigation work, to consider ending the current contract (expired 1st May and working to an implied contract).

1.2. The scheme was considered alongside a number of other services at both Clinical Cabinet and Primary Care Commissioning Committee in April and a decision reached to do further work to understand the implications of ending the scheme following data from the provider that suggested the scheme was deflecting activity from secondary care, in the form of first and follow up appointments. It was agreed that further analysis of the data was required to fully understand the risk to the CCG should the service be withdrawn.

1.3. This paper provides the Primary Care Commissioning Committee with an overview of the work undertaken to review the secondary care data and a recommendation for consideration and approval.

2. Background

2.1 The MEC Service commenced in Bury on the 1st May 2014 and is provided by Primary Eyecare North Ltd.

2.2 Primary Eyecare North Ltd is the lead for the network of 13 optical practices across the area delivering the MEC service.

2.3 The service costs for 2017/18 is £226,586 including £10k for prescribing. The contract is cost per care at £59.50 per patient.

2.4 The current contract with Primary Eyecare North Ltd ended on 1st May 2018. The service is currently working under an implied contract. The CCG would be required to provide 3 months' notice if a decision was reached to end the service.

2.5 The service was commissioned by Bury CCG with the aim of reducing attendances at General Practice and referrals to secondary care providers for minor eye conditions and deliver a more local efficient service for patients.

2.6 MECS utilises the skills of optometrists to manage, assess and prioritise eye patients who can be managed in primary care. The service aims to provide more choice for patients and to move care closer to home.

3. GM Context

The Greater Manchester Local Eye Health Network (LEHN) have been building the primary eye care service framework proposal as part of the GM Primary Care strategy and commissioning plans for a foundation level offer of eye health services in primary care optical practices across GM. They have engaged with all CCG's, including Bury CCG in this process directly and through the primary care strategic oversight group.

The LEHN received a final CBA analysis on the 16th May 2018 and a proposal from them be taken to JCB in June/July 2018 based on the findings of the CBA.
In addition the optometry advisory group and the LEHN will be working with the providers to review the MECS pathway.

4. MEC Service Impact - Data Analysis

4.1 Since the scheme commenced in May 2014 the activity going into the MECS has increased year on year as shown below:

- 14/15 1649 (partial Q1)
- 15/16 2606
- 16/17 3367
- 17/18 3633

4.2 The two highest sources of referral into the scheme in 2016/17 were self-referral, which accounted for over 49.78% of referrals in 2916/17 and referrals from General Practice, which fall into 2 categories - patients referred *having seen* a GP (14.55%) and patients referred via GP staff *having not seen* a GP (17.76%).

4.3 During the mitigations work the provider of the MEC Service has shared with the CCG data showing a reduction in Ophthalmology first and follow up appointments (appendix 1) between 2013/14 and 2016/17 as shown in table 1 below:

Table 1: Bury Ophthalmology First and Follow Up Appointments 2013/14 Compared to 2016/17

	First & Follow-up Appts	2013/14	2016/17	Variance
Bury	First appts	7316	6100	-16.60%
	Follow-up appts	16060	14946	-6.90%

4.4 The provider has also shared referral source data for three categories of referrer, which shows a reduction in activity into secondary care during the same time period as outlined in table 2 below:

Table 2: Source of Referral into Ophthalmology for 2013/14 Compared to 2016/17

	Referral Source to Ophthalmology	2013/14	2016/17	Variance
	A&E	1065	641	-39.80%
	GP	10030	7360	-26.60%
Bury	Self Referral	816	699	-14.30%

4.5 It should be noted that as the provider has identified a reduction in secondary care data, during the period of time the MECS has been operational, the working assumption is that it is likely MECS has contributed to this reduction. However, the provider has been unable to evidence that the reduction in activity is directly as a result of the MECS managing conditions that had previously gone into secondary care.

4.6 The provider has also shared data with the CCG for Ophthalmology first and follow ups comparing Bury CCG against Oldham CCG and Bolton CCG, both of whom do

not have a MEC service, to further highlight the reduction in activity in Bury attributed to the MECS. Both the aforementioned CCGs have seen growth in outpatient activity during this period.

4.7 Based on the above data (full analysis in appendix 1) the provider has made an assumption that the reduction in activity is as a direct result of the MEC service. Based on this information and conversations with Ophthalmology colleagues at PAHT (who consider MECS to be the primary causal factor in the reduction of activity), this assumption is supported by the CCG in the absence of more concrete evidence.

4.8 The Bury CCG BI Team has validated the reduction in secondary care data and work has been undertaken by BI and Finance to try to account for the reduction. It has however, not been possible to drill into the SUS data to the level required to be able to obtain a breakdown of the first and follow up appointments and the conditions for which patients are being seen, as this data is not available.

4.9 In trying to further understand the reduction in outpatient activity BI and Finance at the CCG mapped outpatient appointments in Ophthalmology to a previous elective appointment in Ophthalmology. This was done for the duration of the MEC service and did not highlight anything significant; as a result it has not been possible to attribute the reduction in outpatient activity to MECS. This analysis was expanded to compare the whole of the activity in Ophthalmology during the same time period to try and look for any trends that would explain the reduction and nothing significant was found.

4.10 In the absence of this more granular data, the CCG is unable to confirm the reduction in the outpatient activity is primarily due to the MEC service, but an assumption has been made that the service is positively contributing to these reductions.

4.11 In addition to the activity data provided in the quarterly and annual reports from the provider, it should also be noted that patient satisfaction is high with 99.32% of patients either extremely likely or likely to recommend the service to family of friends (2017/18).

4.12 Clinical and Commissioner opinion is that should the service be stopped a significant proportion of the activity managed by MECS would go to back to primary care, either to be managed by a General Practitioner, or some patients may seek advice and treatment from pharmacists.

4.13 Having reviewed, with pharmacist expertise, the list of conditions treated, it is believed that more patients could seek support from a pharmacist going forward. The CCG may wish to consider the role of the pharmacist in managing minor eye complaints regardless of the decision taken by the Primary Care Commissioning Committee in relation to the future of this service.

4.14 In an attempt to try and quantify the impact on secondary care should the service not be continued, the Clinical Lead for Elective Care has undertaken a clinical review of the conditions managed by the MECS schemes, as outlined in the annual performance report (2016/17). The Clinician has made the following assumptions as to how the patients presenting with these conditions would be managed in the absence of a MEC Service.

- It is estimated that approx. 65% (1642) of the activity managed by the MEC

service in 2016/17 could be managed solely by primary care (GP and Pharmacy). It should be recognized many of these may have needed referral to secondary care for further treatment beyond scope of GP's either due to lack of skills equipment.

- A further 20% (511) may return to primary care, but GPs would not be the most appropriate practitioner to manage these patients based on skill levels and equipment, therefore it is estimated that most of these patients may be referred into secondary care.

- It is estimated the remaining 15% (374) would need to be referred to secondary care, regardless of whether they were seen by MECS in the first instance. It should be noted this estimated onward referral rate from MECS is higher than is reported by the MEC service in 2016/17 (10.37%).

4.15 Primary Care Commissioning Committee is asked to note that the analysis undertaken is purely an *estimate* and is based on clinical opinion, in the absence of having seen the patients.

4.16 It should be noted that in the 2016/17 performance report when asked where patients would have gone in the absence of a MEC service 66.26% (1976) advised they would visit their GP, 5.06% (151) pharmacy and 15.59% (465) A&E.

4.17 Utilising the 2017/18 MECS data and applying the same clinical assumptions, this would equate to 66% (2381) of the activity returning to primary care over a 12 month period and 22% (793) returning to primary care, of which most will be referred to secondary care. 12% of the activity is likely to go straight from primary care to secondary care as it would currently.

4.18 Using the most recent dataset for MECS (2017/18) and applying the same clinical assumptions, it is estimated that if the activity categorized in the clinical review as being most likely to return to primary care, with the potential for onwards referral to secondary care (793 (22%)), all get referred on, this would in financial terms equate to approximately c. £190k. The current cost of the MECs scheme is £226,586 (2017/18), inclusive of prescribing.

5 Associated Risks

5.1 There is a risk that the MEC service may have generated a demand that would not have existed had the service not been established. The activity going into MECS is increasing year on year, along with the associated spend and prescribing costs. A large proportion of the referrals are self-referrals. There is a risk that through continuation of the scheme with the current pathways the CCG may continue to see the increase in activity.

It should be noted that the CCG has explored with the provider opportunities to re-design the pathways and there is a willingness to work with the CCG. There is recognition that the current service model may not be the most effective and may not be targeting the most appropriate cohorts of patients, where self-care could play a greater role. The CCG is also concerned that the current service model may not be providing the best value for money.

To mitigate against this risk it is recommended the CCG explores opportunities to negotiate a reduction in the current cost envelope (2018/19) with the provider and the in collaboration with the provider the CCG undertakes a review of the current pathways and the potential for re-design, to include the pharmaceutical budget.

5.1 There is a risk that in the absence of more granular data on the reductions in first and follow up appointments, the CCG does not have the sufficient information to accurately quantify the impact the service is making, therefore an assumption has been made that the service is likely to be contributing to the reduction in activity.

To mitigate against this risk it is recommended that the CCG continues with the current service, exploring with the provider opportunities to reduce the cost envelope in year, and the MECS forms part of a wider review of Ophthalmology Services.

5.2 The provider is working with Greater Manchester (GM) as part of the devolution agenda. There is a risk that if the CCG ends the service and GM recommended a minor eye conditions service the CCG may need to re-establish the model. This risk can be mitigated by working with the current provider to re-design the pathways as part of the wider CCG review to take account of the GM direction of travel.

5.3 Should the recommendation to continue the service in the short term not be supported, it should be noted that a 3 months formal notice period would be required.

As the CCG is working to an implied contract the sub-contracting arrangements in place with local optical practices and the message communicated to practices to date, and in the future, would also need to be considered to reduce the risk of confusion amongst opticians and patients.

To mitigate against this risk the CCG and provider would need to work closely to ensure the appropriate communications are in place to advise sub-contractors, referrers (including patients) of the decision of the committee.

5.4 Should the service end and in the future be replaced by another provider the CCG would need to consider TUPE and check if this applies. This is being highlighted as a potential risk for information and would need some further discussion with contracting colleagues.

6 Recommendations

6.1 Continue to commission the service until the outcome of the GM direction of travel is confirmed, in terms of the primary eye care service framework proposal.

6.2 Begin negotiations with the provider to explore opportunities to reduce the cost envelope for the current service (2018/19).

6.3 Incorporate the MEC service into the wider review of Ophthalmology services being undertaken by the CCG, to inform the future service model(s) and CCGs commissioning intentions.

7 Actions Required

7.1 The Primary Care Commissioning Committee is required to:

- Approve the recommendations outlined in section 5, to minimise the risk to the CCG in the absence of the necessary data required, to fully understand the impact of the MECS on secondary care activity.

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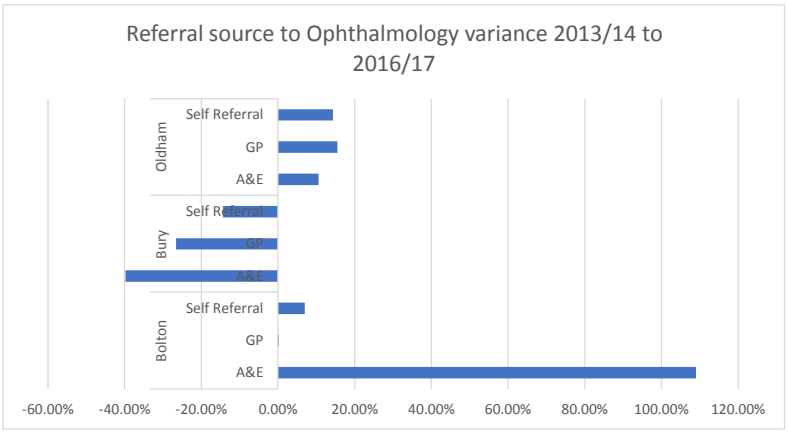
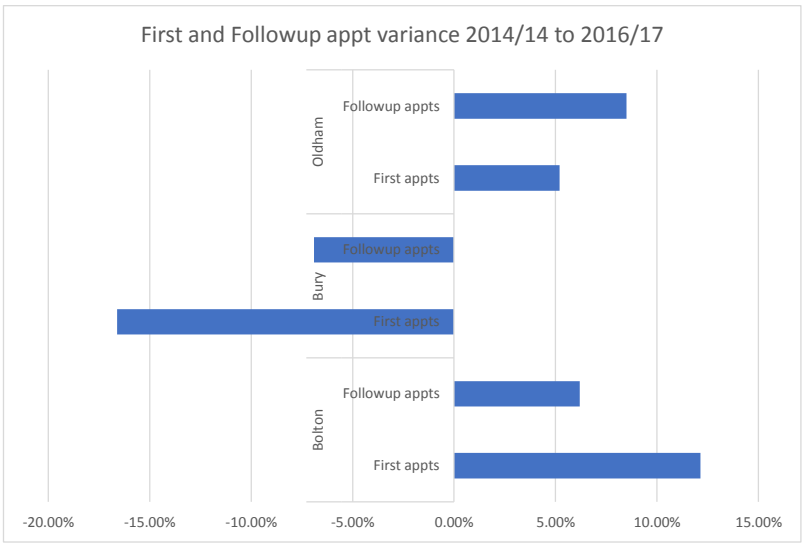
	Referral Source to Ophthalmology	2013/14	2016/17	Variance
	A&E	429	896	109.00%
	GP	14600	14632	0.20%
Bolton	Self Referral	1046	1119	7.00%
	A&E	1065	641	-39.80%
	GP	10030	7360	-26.60%
Bury	Self Referral	816	699	-14.30%
	A&E	937	1036	10.60%
	GP	11636	13436	15.50%
Oldham	Self Referral	816	699	14.30%

	First & Followup Appts	2013/14	2016/17	Variance
Bolton	First appts	14213	15940	12.15%
	Followup appts	29657	31497	6.20%
Bury	First appts	7316	6100	-16.60%
	Followup appts	16060	14946	-6.90%
Oldham	First appts	8514	8955	5.20%
	Followup appts	22290	24187	8.50%

All Ophthalmology provider activity	2013/14	2016/17	Variance
Bolton	44011	47438	7.80%
Bury	23422	21046	-10%
Oldham	30927	33145	7.20%


Referral source to Ophthalmology variance 2013/14 to 2016/17
Oldham
Self Referral
GP
A&E
Bury
Self Referral
GP
A&E
Bolton
Self Referral
GP
A&E
-60.00%
-40.00%
-20.00%
0.00%
20.00%
40.00%
60.00%
80.00%
100.00%
120.00%


First and Followup appt variance 2014/14 to 2016/17
Oldham
Followup appts
First appts
Bury
Followup appts
First appts
Bolton
Followup appts
First appts
-20.00%
-15.00%
-10.00%
-5.00%
0.00%
5.00%
10.00%
15.00%

Bury MECS

- Bury MECS launched May 2014. Commissioned by Bury CCG via Local Optical Committee provider company Greater Manchester Primary Eyecare Ltd (now Primary Eyecare North Ltd).
- Set up with 10 practices. Now increased to 13 practices (soon 14).
- Radcliffe now has a practice.

- MECS Activity
    - 14/15 1649 (partial Q1)
    - 15/16 2606
    - 16/17 3367
    - 17/18 2582 (first 3 quarters, will equate to 3440 approx full year)

- Source of referral into ophthalmology secondary care 14/15 compared with 16/17
    - GP 30% reduction (2838)
    - A&E 35% reduction (280)
    - Self-referral 30% reduction (275)
    - Optometry 46% increase (473)
    - 3393 patients less referred A&E/GP/self-referral be16/17 compared with 14/15

- Ophthalmology SUS data Bury CCG
    - Activity 14/15 First attendances 7244, Follow up 17845
    - Activity 15/16 First attendances 7950, Follow up 19792
    - Activity 16/17 First attendances 6100, Follow up 14946
    - Activity 17/18 First attendances 5700, Follow up 13208 (to 31/1/18)

    - 15.8% decrease in all ophthalmology first attendances 16/17 c/w 14/15 (1144)
    - 25.5% decrease in all ophthalmology first attendances 16/17 c/w 15/16 (1850)
    - 16.2% decrease in all ophthalmology follow-up attendances 16/17 c/w 14/15 (2899)
    - 24.5% decrease in all ophthalmology follow-up attendances 16/17 c/w 15/16 (4846)
    - These reductions do not take in to account the expected rise in out-patients activity

    - Pennine 33% decrease in activity (4688) comparing between 13/14 and 16/17 (block contract?)
    - Care UK 169% increase in activity (513) comparing between 13/14 and 16/17
    - Spa Medica 2331% increase in activity (1142) comparing between 13/14 and 16/17

- MECS report data
    - Based on MECS report 1373 appointments referred from other health care providers GP/A&E/Pharmacy/out of hours into MECS
    - Survey 16/17 Bury MECS Px 1976 would have visited GP and 465 A&E had MECS not been available.
    - 84.41% of patients were managed exclusively within the service 16/17
    - 99.22% of patients were either extremely likely or likely to recommend the service to family of friends. There was an 83.87% completed and returned rate of PROMS 16/17

Summary

The financial return on investment in a MEC service is seen in the reduction of activity within secondary care ophthalmology. Bury MECS got off to a slow start due to the large increase in cataract surgeries performed by other providers for Bury CCG in 2014/2015/2016. Each extra cataract surgery would have created a minimum of 3 appointments per eye. The Local Optical Committee have worked hard with local optometrists and the referral centre to ensure cataract surgeries are being referred only via the referral centre rather than direct to providers, this way EUR compliance is now confirmed.

SUS data 2016/17/18 now shows significant reductions ophthalmology outpatients activity first appointments and follow-ups for Bury CCG patients. This doesn't take account of the rise in activity in ophthalmology which is being seen elsewhere and so the reduction is most likely underestimated using SUS data.

This analysis shows that the introduction of the MECS service in Bury has resulted in reduced referrals to ophthalmology from GPs (30%), reduced activity in ophthalmology outpatients (16% first appointments, 16% follow-up). It is difficult to get accurate data from A&E for eyes, but a 35% reduction of referrals to out-patients from A&E indicates reduced overall activity. An added benefit of a MEC service is that it supports pressures in General Practice by creating extra capacity. By seeing patients using the right professional first time the number of patient contacts with primary and secondary care are reduced. Patients are very supportive of the service as seen by the PROMS data.